NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, MARCH 7, 2019
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, 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. Homeless Health Initiatives
   b. Knox-Keene Licensure Proposal
   c. Medi-Cal Pharmacy Advocacy
   d. Quality Improvement Plans for FY 2019-20
   e. CalOptima Retirement Plan Vendor

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. Consider Approving Minutes of the February 7, 2019 Regular Meeting and February 22, 2019 Special Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the November 15, 2018 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the January 17, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the December 13, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the January 17, 2019 Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

3. Consider Approval of the CalOptima 2019 Quality Improvement (QI) Program and 2019 QI Work Plan

4. Consider Approval of the 2019 CalOptima Utilization Management Program

5. Consider Approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

6. Consider Extending and Authorizing Allocations/Reallocations of Spending Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to Grievances and Appeals, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), and Annual Policy Review

8. Consider Approval of Policy GG.1657, the Medical Board of California and the National Practitioner Data Bank Reporting Policy

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

10. Consider Ratification of Amendment to CalOptima's Medi-Cal Fee-For-Service Specialist Physician Contract with Children's Hospital of Orange County (CHOC), Authorization of Pediatric Network Recruitment Fee to Ensure Access to Specialists for CalOptima Health Networks, and Authorization of WCM Contract Amendments with CHOC-Affiliated Specialists

REPORTS

11. Consider Authorizing Amendment of the Kaiser Foundation Health Plan, Inc. Contract to Address the Payment Terms Related to CalOptima's Whole-Child Model Program

12. Consider Authorizing Contracts with Additional Community-Based Adult Services Centers to Serve as Alternative Care Setting Sites for CalOptima Program of All-Inclusive Care for the Elderly (PACE) Members

13. Consider Modifications of CalOptima Policies and Procedures Related to the CalOptima Provider Directory and Provider Education and Training

14. Consider Authorizing Expenditures in Support of CalOptima's Whole-Child Model Family Advisory Committee Representative Attending the California Children's Services Advisory Group

15. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2019-20

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

17. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year (FY) 2018-19 Operating Budget for Translation Expenses

ADVISORY COMMITTEE UPDATES

18. Whole-Child Model Family Advisory Committee Update

19. Provider Advisory Committee Update

INFORMATION ITEMS

20. Homeless Health Update

21. Health Homes Update

22. January 2019 Financial Summary

23. Compliance Report

24. Federal and State Legislative Advocates Reports

25. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, April 4, 2019 at 2:00 p.m.

MEMORANDUM

DATE:	March 7, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Special Board Meeting Approves Immediate Action on Homeless Health Initiatives
In response to your Board's special meeting on February 22, I will be presenting an Information Item at the March 7 meeting to summarize Board-authorized actions related to homeless health, including our clinical field team pilot program and CalOptima Homeless Response Team, as well as follow up on additional initiatives discussed at the Board meeting.

CalOptima Focuses Advocacy Efforts on Detrimental Licensure Proposal
On February 13, CalOptima participated in meetings with the Governor's office and legislators with representatives of the California Medical Association, California Hospital Association, California Association of Health Plans, Local Health Plans of California and America's Physician Groups to raise concerns with the General Licensure regulation proposed by the Department of Managed Health Care (DHMC). As you are aware, the proposed regulation provides that any entity that takes "global risk" (i.e., risk for both physician and hospital services) from a full-service health plan would be required to obtain a Knox-Keene license or seek an exemption. During our meeting with the Governor's Deputy Cabinet Secretary Richard Figueroa, the coalition questioned the broad definition of global risk and the undefined criteria for obtaining an exemption. The representatives requested that the Governor pull back the proposed regulation and initiate a stakeholder process so concerns can be addressed. I also met with five members of our Orange County delegation, including Assemblywoman Sharon Quirk-Silva, Assemblyman Phillip Chen, Assemblyman Tyler Diep, Sen. John Moorlach and Sen. Tom Umberg to discuss the proposed rule. More recently, the California Hospital Association worked with Sen. Umberg to introduce SB 714, a bill that may address the concerns with the proposed regulation. The bill will be considered next by the Senate Health Committee.

Meetings With State Officials Address Proposed Change to Pharmacy Benefits
In January, Gov. Gavin Newsom issued an executive order calling for the transition of Medi-Cal pharmacy benefits from managed care to fee-for-service (FFS). To raise awareness about the member impact of a FFS pharmacy program, CalOptima, L.A. Care and Inland Empire Health Plan leaders participated in a series of Sacramento meetings on February 26 arranged by Local Health Plans of California and California Association of Health Plans. The group met representatives from the Assembly Republican Caucus, Senate Budget Committee, Senate Republican Caucus and the governor's office to make suggestions about alternate ways to

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achieve reduced pharmacy costs without affecting the managed care system already in place for more than 10 million Medi-Cal members statewide.

Programs Supporting Quality Care Are Ready for New Fiscal Year
Quality care for members is central to our mission. This month, your Board is considering two items that set quality priorities for Fiscal Year 2019–20. These programs were thoroughly reviewed and approved in advance by your Quality Assurance Committee on February 20. The 2019 Quality Improvement Program and Work Plan incorporates new initiatives, including Whole-Person Care, Whole-Child Model, Health Homes and population health management. The overall goal is to improve our National Committee for Quality Assurance rating from 4.0 to 4.5 by 2021, with special attention on bettering our member experience scores. Also, before your Board is the Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance and Performance Improvement Plan. New elements of the PACE plan focus on comprehensive diabetes care, reduced use of high-dose opioids, decreased day center falls, increased satisfaction with center meals and more.

CalOptima Successfully Completes Transition to Single Retirement Plan Vendor
To streamline and enhance retirement plan options for employees, CalOptima recently transitioned from two 457(b) deferred compensation plan vendors to a single vendor, Empower Retirement. More than 460 employees participate in the plan, which is the public agency equivalent of a 401(k) program at a private business. Selected through a competitive process, Empower is one of the nation's largest retirement product companies. CalOptima does not contribute to 457(b) plans on behalf of employees; all employee contributions are voluntary.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 7, 2019

A Regular Meeting of the CalOptima Board of Directors was held on February 7, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director DiLuigi led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger, Ron DiLuigi, Supervisor Andrew Do (at 2:05 p.m.), Alexander Nguyen, M.D., Lee Penrose (at 2:07 p.m.), Richard Sanchez, Scott Schoeffel, Supervisor Michelle Steel

Members Absent: All Members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

On behalf of the Board of Directors, Chair Yost presented recognition to former CalOptima Chief Medical Officer Richard Helmer, M.D., in honor of his service to CalOptima and the members it serves.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported on the continued preparations for the July 1, 2019 transition of the Whole-Child Model (WCM), including the Department of Health Care Services' preliminary approval of CalOptima's WCM provider network. Mr. Schrader also provided an update on the CalOptima's participation in the Be Well OC Regional Mental Health and Wellness Campus. On January 29, 2019, the Orange County Board of Supervisors approved a $16.6 million investment in the Be Well OC Regional Mental Health and Wellness Campus. This joins CalOptima's commitment of $11.4 million for services for CalOptima members in the new facility as well as a combined $12 million from Kaiser and St. Joseph Hoag Health. The campus aspires to create a new approach to mental health care that brings together a range of services from prevention and early intervention to acute care and recovery.

Supervisor Do requested that staff provide an information item on the Health Homes Program to the Board at the March 7, 2019 meeting.

PUBLIC COMMENT

Bill Barcelona, America's Physician Groups – Oral re: Agenda Item 23, Update on General Knox-Keene Licensure Requirements for Health Care Service Plans.

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CONSENT CALENDAR

2. Minutes
   a. Consider Approving Minutes of the December 6, 2018 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 12, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; October 11, 2018 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee, and the Provider Advisory Committee; and the November 8, 2018 Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

3. Consider Approval of CalOptima Population Health Management Strategy for 2019

4. Consider Approval of an Amendment to the Board-Approved Action for Fiscal Year 2019 (Measurement Year 2018) Pay for Value Program for Medi-Cal and OneCare Connect Lines of Business

5. Consider Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

Agenda Item 3 was pulled for discussion and separate vote.

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

3. Consider Approval of CalOptima Population Health Management Strategy for 2019
Director Penrose commented in support of this item and suggested incorporating population health management into the proposed FY 2020-2023 Strategic Plan. Supervisor Do suggested including the findings from the community assessment in terms of ethnic communities to reach populations that may be underserved.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the CalOptima Population Health Management Strategy for 2019. (Motion carried 9-0-0)***

REPORTS

6. Consider Selecting Vendor and Authorizing Contract for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

After considerable discussion of the matter, the Board selected Pacific Health Consulting Group for consulting services, revised the expenditure to up to $300,000, and directed staff to return to the Board if additional funding is recommended in order to complete the engagement.

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Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an agreement with Pacific Health Consulting Group for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system pursuant to the attached Scope of Work; and authorized the expenditure of unbudgeted funds in an amount not to exceed $300,000 from reserves to fund the agreement. Staff will return to the Board if additional funding is recommended to complete the engagement. (Motion carried 8-0-0; Director Schoeffel absent)***

7. Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors ratified an amendment of CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services to begin collecting Medi-Cal prescription drug rebates for utilization incurred effective October 1, 2018. (Motion carried 8-0-0; Director Schoeffel absent)***

8. Consider Authorizing Contracts with Hospitals for the Provision of Services to Facilitate the Payment of Department of Health Care Services Hospital Directed Payments

Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. 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 Penrose, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts at the equivalent of non-contracted Medi-Cal Rates with in-area and out-of-area hospitals providing Medi-Cal covered services to CalOptima Care Network, CalOptima Direct and Share Risk Group members to facilitate the payment of Department of Health Care Services Hospital Directed Payments; and 2) Authorized retroactive effective dates as far back as July 1, 2017 solely for purposes of the state's Hospital Directed Payment program, and to the extent permissible based on guidelines set by the Department of Health Care Services. (Motion carried 7-0-0; Supervisor Do recused; Director Schoeffel absent)***

9. Consider Actions Related to CalOptima's Whole-Child Model Program

Director Sanchez did not participate in this item due to his position at the Orange County Health Care Agency and left the room during the discussion and vote. 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 an amendment to the January 1, 2019 Whole-Child Model (WCM) Memorandum of Understanding with the County of Orange to reflect CalOptima's new implementation date of the WCM program, and enter into an amendment to the***

Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency to reflect changes related to the Whole-Child Model program. (Motion carried 8-0-0; Director Schoeffel absent)

10. Consider Amending CalOptima Community Care Specialist Physician Contracts Except Those Associated with the University of California, Irvine, Children's Hospital of Orange County, or St. Joseph Healthcare and its Affiliates, to add Provisions Related to the Whole-Child Model Program
Supervisors Do and Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. 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 Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network, Fee-For-Service Specialist Physician Contracts except those associated with the University of California, Irvine, Children's Hospital of Orange County, or St. Joseph Healthcare and its affiliates, to reflect changes related to the Whole-Child Model and other regulatory updates. (Motion carried 6-0-0; Supervisors Do and Steel recused; Director Schoeffel absent)***

11. Consider Amending CalOptima Community Care Specialist Physician Contracts Associated with St. Joseph Healthcare and its Affiliates, to add Provisions Related to the Whole-Child Model Program
Chair Yost did not participate in this item due to his affiliation with Providence St. Joseph Healthcare as an anesthesiologist physician, and he passed the gavel to Vice Chair Khatibi. Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. Directors Penrose and 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 Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network Fee-for-Service Specialist Physician Contracts associated with St. Joseph Healthcare and its Affiliates to reflect changes related to the Whole-Child Model and other regulatory updates. (Motion carried 5-0-0; Chair Yost and Supervisor Do recused; Directors Penrose and Schoeffel absent)***

12. Consider Amending CalOptima Community Care Specialist Physician Contracts Associated with the University of California, Irvine, to add Provisions Related to the Whole-Child Model Program
Supervisors Do and Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. Directors Nguyen and 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 Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network Fee-for-Service Specialist Physician Contracts associated with the University of California, Irvine to reflect changes related to the Whole-Child Model and other regulatory updates. (Motion carried 5-0-0; Supervisors Do and Steel recused; Directors Nguyen and Schoeffel absent)***

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13. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policies and CalOptima Employee Handbook

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors adopted Resolution No. 19-0207, approving updates to Human Resources Policies and CalOptima Employee Handbook. (Motion carried 9-0-0)***

14. Consider Ratifying 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 ratified Amendment 37 to the Primary Agreement between the Department of Health Care Services and CalOptima. (Motion carried 9-0-0)***

15. Consider Authorizing Amendment of the HMO Service Contract with Vision Service Plan (VSP) to Modify the Covered Benefits for Medi-Cal Members Diagnosed with Diabetes

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 execute an amendment to the HMO Service Contract with Vision Service Plan to add one routine eye exam every 12 months for Medi-Cal members diagnosed with diabetes as an additional covered benefit. (Motion carried 9-0-0)***

16. Consider Ratifying and Authorizing Expenditures to Enhance Building Security at 505 City Parkway West, Orange, California

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized capital expenditures of up to $43,250 from existing reserves for architectural fees to develop a remodeling plan for the existing Member Services Lobby at 505 City Parkway West in Orange (505 Building), ratified $11,334 and authorized $73,666 in unbudgeted expenditures from unspent budgeted funds for an additional security guard at CalOptima facility located at the 505 Building. (Motion carried 9-0-0)***

ADVISORY COMMITTEE UPDATES

17. Provider Advisory Committee (PAC) Update

PAC Chair John Nishimoto, OD, reported on the nominations process for the Hospital and Nurse Representatives on the PAC, and an ad hoc committee will be formed to review the goals and objectives.

18. Member Advisory Committee (MAC) Update

Sally Molnar, MAC Chair, provided a brief update on an ad hoc that will be formed to review applications received for the Child Representative on the MAC.

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19. Whole-Child Model Family Advisory Committee (WCM FAC) Update

WCM FAC Chair Maura Byron reported that the WCM FAC is comprised of parents of the children served by the Whole-Child Model program, and the Committee will have the opportunity to discuss pertinent items related to the program.

INFORMATION ITEMS

20. Overview of Marketing and Educational Efforts

Bridget Kelly, Communications Director, presented a review of CalOptima's marketing and educational efforts, including marketing campaign development process, and the Fiscal Year 2015-2019 budgets. An overview of the current educational campaign related to quality care, and the current OneCare Connect marketing campaign was provided to the Board for discussion.

21. Homeless Health Update

Cheryl Meronk, Strategic Development Director, presented an overview of the proposed initiative to address and optimize care for CalOptima's members who are homeless. Options under evaluation to address the medical needs of CalOptima homeless members include a contracted clinical field outreach team to provide limited medical services to CalOptima members in support of the current delivery system and provide services to where members are located, partnering with County Comprehensive Health Assessment Team – Homeless (CHAT-H) public health nurses and Behavioral Health Services Outreach and Engagement, engaging with a provider or vendor that currently provide mobile services to this population, and providing after hours and weekend coverage. It was noted that CalOptima funding can only be used to provide services for CalOptima members, and it will be important to contract with an organization that can provide services to homeless individuals who are not CalOptima members through other funding sources. Next steps include an evaluation of the feasibility and permissibility of these options, as well as vetting and seeking input from stakeholders. Staff will return to the Board with options and recommendations for consideration at a future meeting.

22. CalOptima Strategic Plan Update

Mr. Schrader presented a Year 2 progress report of CalOptima's 2017-2019 Strategic Plan in the areas of Innovation, Value, Partnerships and Engagement, Workplace Performance, and Financial Strength. It was noted that the current Strategic Plan expires at the end of the 2019 calendar year. An overview was provided of the 2020-2023 Strategic Plan process, and a high-level timeline that includes gathering input via a strategic planning session with the Board of Directors, as well as collaborative stakeholder input and feedback.

23. Update on General Knox-Keene Licensure Requirements for Health Care Service Plans

TC Roady, Director, Regulatory Affairs and Compliance, reviewed the proposed Department of Managed Health Care (DMHC) regulation that seeks to establish new requirements to clarify who must apply for health care service plan licensure (Knox-Keene licensure) with the DMHC. The proposed regulation would require any entity that takes both professional and institutional risk from a full-service health care service plan must apply for a licensure or exemption from licensure. A review of the rulemaking process, including the recent fourth public comment period and the potential impact to CalOptima and its HMO health networks was provided. It was noted that CalOptima is a full-service health care service plan, and is Knox-Keene licensed for its OneCare and OneCare Connect lines of business, but has a statutory exemption for Medi-Cal. It is anticipated that the Office of Administrative Law (OAL) will render a decision on DMHC's proposed regulation by March 5, 2019,

that will apply to contracts issued, amended or renewed on or after a date to be determined by the OAL.

After considerable discussion of the matter, the Board directed staff to continue to meet with impacted health networks, hospitals and APG, continue working with Local Health Plans of California (LHPC) and other associations in advocacy efforts, and engage CalOptima's lobbyist in these activities.

The following Information Items were accepted as presented.
24. November 2018 and December 2018 Financial Summaries
25. Compliance Report
26. Federal and State Legislative Advocates Reports
27. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Chair Yost formed an ad hoc committee to review proposals and make recommendations for community grants related to IGT 6 and 7 expenditure plan approved by the Board in September 2018, and asked for volunteers to serve on this ad hoc.

CLOSED SESSION
CS 1. Pursuant to Government Code Section 54956.9, subdivision (d) (2) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. One Case.
This item was continued to a future Board of Directors meeting.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 5:45 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: March 7, 2019

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MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 22, 2019

A Special Meeting of the CalOptima Board of Directors was held on February 22, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 3:30 p.m. Supervisor Do led the Pledge of Allegiance.

ROLL CALL

Members Present:	Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ron DiLuigi, Supervisor Andrew Do, Alexander Nguyen, M.D., Lee Penrose, Richard Sanchez
Members Absent:	Ria Berger, Scott Schoeffel, Supervisor Michelle Steel
Others Present:	Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENT

1) Lou Noble, Homeless Advocate; 2) Fr. Dennis Kriz, O.S.M., St. Philip Benizi Church; 3) David Duran; and 4) Mike Robbins, Peoples Homeless Task Force – Oral and Written (Attachment 1) re: Agenda Item 1, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting.

REPORTS

1. Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting

Chief Executive Officer Michael Schrader provided an overview of the current system of health care for homeless individuals, proposals to enhance the health care delivery system to better meet the needs of homeless individuals, the allowable uses of CalOptima Medi-Cal funds, and housing subsidy programs in Los Angeles, Riverside and San Bernardino counties. It was noted that a housing pool is not in existence today under County of Orange the Whole-Person Care pilot; however, if established, CalOptima could contribute funds for housing supportive services, not rent.

Mr. Schrader presented the following recommendations for consideration: establish a Clinical Field pilot program, which will involve contracting with qualifying Federally Qualified Health Centers (FQHCs); reallocate up to $1.6 million in Intergovernmental (IGT) 1 and IGT 6 and 7 funds for the start-up cost for the Clinical Field Team pilot program; authorize eight (8) unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to serve as part of CalOptima's Homeless Response Team; and direct staff to return to the Board with a ratification request for further implementation details.

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CLOSED SESSION

Chair Yost reported that there currently is litigation initiated by advocates on behalf of homeless Orange County residents, a number of whom are Medi-Cal members. While the litigation has been brought against the County of Orange and several Orange County cities, CalOptima was advised by the judge presiding over the matter that it may be brought into the case. Based on this development, the Board adjourned to closed session at 4:42 p.m., pursuant to Government Code Section 54956.9, subdivision (d) (2) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. One Case.

The Board of Directors reconvened to open session at 5:10 p.m. with no reportable action taken.

After considerable discussion, the Board took the following action.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors: 1) Authorized establishment of a Clinical Field Team pilot program; 2) Authorized reallocation of up to $1.6 million in Intergovernmental (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot program; 3) Authorized eight (8) unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to serve as part of CalOptima's Homeless Response Team; 4) Directed staff to return to the Board with a ratification request for further implementing details; 5) Consider other options to work with the County on a System of Care; and 6) Obtain legal opinion related to using Medi-Cal funding for housing related activities. (Motion carried 6-0-0; Directors Berger and Schoeffel, and Supervisor Steel absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Yost extended his appreciation to the Board for proceeding with a creative and innovative start to improving health care delivery to the homeless.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 5:27 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Attachments:
1. United States Interagency Council on Homelessness, Housing First, January 18, 2017
2. Funding Ideas - distributed to the Board of Directors by Supervisor Do

Approved: March 7, 2019

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United States Interagency Council on Homelessness

Last updated on January 18, 2017

Housing First

Housing First is a proven approach in which people experiencing homelessness are offered permanent housing with few to no treatment preconditions, behavioral contingencies, or barriers. It is based on overwhelming evidence that all people experiencing homelessness can achieve stability in permanent housing if provided with the appropriate levels of services. Study after study has shown that Housing First yields higher housing retention rates, reduces the use of crisis services and institutions, and improves people's health and social outcomes. Housing First is an approach that can be adopted by housing programs, organizations, and across the housing crisis response system. The approach applies in both short-term interventions, like rapid re-housing, and long-term interventions, like supportive housing. For crisis services like emergency shelter and outreach, the Housing First approach means referring and helping people to obtain permanent housing.

A community-wide Housing First approach has the following elements:

Emergency shelter, street outreach providers, and other parts of the crisis response system are aligned with Housing First and recognize that their role encompasses housing advocacy and rapid connection to permanent housing. **Staff in crisis response system services believe that all people experiencing homelessness are housing ready.**

- Strong and direct referral linkages and relationships exist between crisis response system (emergency shelters, street outreach, etc.) and rapid rehousing and supportive housing. **Crisis response providers are aware and trained in how to assist people experiencing homelessness to apply for and obtain permanent housing.**
- The community has a **unified, streamlined, and user-friendly community-wide process** for applying for rapid re-housing, supportive housing, and/or other housing interventions.
- The community has a **coordinated assessment system** for matching people experiencing homelessness to the most appropriate housing and services.
- Policymakers, funders, and providers **collaboratively conduct planning** and align resources to ensure that a range of affordable and supportive housing options and models are available to maximize housing choice among people experiencing homelessness.
- Policies and regulations related to supportive housing, social and health services, benefit and entitlement programs, and other essential services do not inhibit the implementation of the Housing First approach. For instance, **eligibility and screening policies for benefit and entitlement programs or housing do not require the completion of treatment or achievement of sobriety as a prerequisite.**
- Every effort is made to offer a tenant a **transfer** from one housing situation to another, if a tenancy is in jeopardy. Whenever possible, eviction back into homelessness is avoided.

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Funding Ideas

Physical Health Improvements

1. **Launch Mobile Teams**
    a. Identify direct contact for deployment
    b. Include personal care coordinator on team for increased case management
2. **Daily Physical Health Treatment available at Shelters**
    a. CalO can pay community clinics to do so
    b. Establish satellite FQHC's at permanent shelter sites (including Yale)
3. **Increase access and care coordination for both duals (Medi/Medi) and Medi-Cal only population to Long Term Care facilities**

Whole Person Care/Housing

4. **Recuperative Care**
    a. Need a medical stabilization period after 90 day WPC recuperative care prior to re-entering a shelter or until able to find appropriate housing
    b. Need recuperative care site with a behavioral health focus
5. **Funding for WPC clients needing additional time in Recuperative Care (i.e. chemo, hospice but not yet meeting requirements for skilled nursing/long term care)**
    a. WPC can utilize part of $10 million previously allocated for recup care; however, currently held by Cal Optima
6. **Funding for WPC Navigators at non-funded WPC Hospitals**
    a. Approximate single navigator cost: $100,000/annually
    b. This will help hospitals meet their SB 1152 needs
    c. These hospitals don't have funding because at the time of the grant, they did not have Tobacco Settlement Revenue dollars available for the necessary match.
        i. Anaheim Global Medical Center (on WPC Connect)
        ii. Chapman Global Medical Center (on WPC Connect)
        iii. Orange County Global Medical Center (on WPC Connect)
        iv. South Coast Global Medical Center (on WPC Connect)
        v. West Anaheim Medical Center
        vi. Garden Grove Hospital and Medical Center
        vii. Huntington Beach Hospital and Medical Center
        viii. La Palma Intercommunity Hospital
        ix. Fountain Valley Regional Hospital & Medical Center (in discussion re: WPC Connect)
        x. Los Alamitos Medical Center (in discussions re: WPC Connect)
        xi. Placentia-Linda Community Hospital (in discussions re: WPC Connect)
        xii. AHMC Anaheim Regional Medical Center
        xiii. Foothill Regional Medical Center
        xiv. Kaiser Anaheim (in discussions re: WPC Connect)
        xv. Kaiser Irvine (in discussions re: WPC Connect)
        xvi. CHOC
        xvii. CHOC at Mission
7. **Expand Housing Navigation/Housing Support Services**
8. **Housing Pool**
    a. Mission Hospital interested in facilitating for South County
    b. Could fund housing funds through existing rental assistance housing providers in each SPA, to expand beyond south county with Mission

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9. **Micro Communities Program**
    a. Funding for master agreement to facilitate shared micro-community housing for homeless individuals transitioning out of recuperative care or those managing physical health issues. Can include housing for those with Housing Vouchers, HUD VASH, or independent funding/SSI.

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 15, 2018

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:01 p.m. Director DiLuigi led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Ron DiLuigi

Members Absent: Scott Schoeffel

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

PUBLIC COMMENT
There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report
Greg Hamblin, Chief Financial Officer, presented an overview of the Treasurer's Report for the period July 1, 2018 through September 30, 2018. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

2. Approve the Minutes of the September 18, 2018 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the July 23, 2018 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

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REPORTS

3. Consider Recommending Board of Directors' Approval of Proposed Changes to the Annual Investment Policy for Calendar Year 2019

Mr. Hamblin presented the action to recommend that the Board of Directors approve proposed changes to Policy GA.3400: Annual Investments, for Calendar Year 2019. A review of the proposed revisions was provided to the Committee, including: increase the maximum term of the Operating Fund from 450 days to two years; modify language from "rated 'A' or better to "A" rating category; added Secured Overnight Financing Rate (SOFR) to variable and floating rate securities to the allowed index list; and revised glossary terms pertaining to State and California Local Agency Obligations. It was noted that the proposed changes reflect the recommendations of CalOptima's investment managers, and concurrence by the Board of Directors' Investment Advisory Committee.

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended Board of Directors' approval of the proposed changes to Policy GA.3400, Annual Investments, as presented. (Motion carried 2-0-0; Director Schoeffel absent)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended that the Board of Directors appoint David Young for a two-year term on the CalOptima Board of Directors' Investment Advisory Committee ending October 7, 2020. (Motion carried 2-0-0; Director Schoeffel absent)***

INFORMATION ITEMS

5. Intergovernmental Transfer (IGT) Funding Update

Mr. Hamblin presented an overview of the usage of CalOptima's share of IGT 1 through 7 funds to provide enhanced benefits to Medi-Cal members for services not already paid for or provided under CalOptima's contract with the Department of Health Care Services (DHCS). Effective July 1, 2017, the Final Rule prohibits retrospective payments to Medicaid managed care plans, and the DHCS implemented a new payment model for IGT funding. Beginning with IGT 8, IGT funds must be used for Medi-Cal members, must be tied to Medi-Cal covered services provided under CalOptima's contract with the DHCS, must be authorized only one year at a time, and the IGT expenditures must be for a limited time and amount. It was noted that IGT 8 and 9 will include an Affordable Care Act (ACA) funding formula for the Medicaid Expansion population, and ACA enhanced federal funding for the Children's Health Insurance Program (CHIP) population. An overview of potential strategic areas for IGT 8 and 9 funds was provided for discussion, including incentives to increase member satisfaction and access to care, increase provider rates, and increased incentives related to Medi-Cal Pay for Value Program measures.

After considerable discussion, the Committee requested that staff solicit input from the Provider Advisory Committee and CalOptima's contracted health networks, and that staff present an update at a future Finance and Audit Committee and/or Board of Directors meeting.

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6. September 2018 Financial Summary
Mr. Hamblin provided an overview of the balance sheet, Board-Designated Reserves and tangible net equity (TNE) requirement as of September 30, 2018.

The following Information Items were accepted as presented:
7. CalOptima Information Systems Security Update
8. Cost Containment Improvements/Initiatives
9. 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 IGT update.

ADJOURNMENT
Hearing no further business, Chair Penrose adjourned the meeting at 3:11 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 21, 2019

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

January 17, 2019

CALL TO ORDER
Chair Paul Yost called the meeting to order at 4:09 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger (at 4:17 p.m.), Dr. Nikan Khatibi, Alexander Nguyen M.D.

Members Absent: All Members present

Others Present: Michael Schrader, Chief Executive Officer; Betsy Ha, Executive Director, Quality Analytics; Diana Hoffman, Deputy Chief Counsel; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the September 12, 2018 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

2. Consider Recommending Board of Directors' Approval of CalOptima Population Health Management Strategy for 2019

Betsy Ha, Executive Director, Quality Analytics, presented the action to recommend Board of Directors' approval of the CalOptima Population Health Management (PHM) Strategy for 2019. The National Committee for Quality Assurance (NCQA) created a PHM standard set effective July 1, 2018. The recommended PHM Strategy aims to ensure the care and services provided to CalOptima members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span. As proposed, the year one approach of

the CalOptima PHM Strategy is to align current and new programs to the new PHM framework, and address four focus areas: keeping members healthy, managing members with emerging risk, patient safety or outcomes across all settings, and managing multiple chronic conditions. An overview of the PHM conceptual framework, new standards, proposed PHM strategy, and the timeline and accomplishments to date were provided for Committee discussion.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Population Health Management strategy for 2019. (Motion carried 4-0-0)***

3. Consider Recommending Board of Directors' Approval of an Amendment to the Board-Approved Action for Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect Lines of Business

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the amendment to the Board-approved Fiscal Year (FY) 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect, so that "continuous enrollment" is assessed at the health plan level instead of at the health network level. (Motion carried 4-0-0)***

4. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval of the Fiscal Year 2020 (Measurement Year 2019) Pay for Value Program 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. (Motion carried 4-0-0)***

INFORMATION ITEMS

5. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, provided an overview of the activities at the PMAC meetings held on September 17, 2018 and December 17, 2018.

6. Longitudinal Retrospective Quality Improvement Evaluation

Ms. Ha reported on a tool developed to review longitudinal HEDIS Access and Availability and Member Experience results and establish HEDIS metrics to drive the 2019 Quality Improvement Workplan. Kelly Rex-Kimmet, Quality Analytics Director, provided a demonstration of the tool, Tableau, for Committee review and feedback.

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7. Provider Coaching Pilot Update

Ms. Rex-Kimmet provided an update on the progress of the Provider Coaching Pilot. CalOptima contracted with a health care consultant, SullivanLuallin Group, to implement the pilot with the goals to reduce grievances and potential quality issues and improve customer service performance and member experience and satisfaction. Next steps include continued outreach to health networks and providers on the availability of the coaching and customer service workshops, and to evaluate the effectiveness of the training and interventions.

8. Whole-Child Model Clinical Advisory Committee Update

Emily Fonda, M.D., Medical Director, provided an update on the activities at the Whole-Child Model Clinical Advisory Committee meetings held on January 15, 2019. The Committee received an overview of health network adequacy, the development of quality measures, and a review of the recent Department of Health Care Services (DHCS) All Plan Letter that includes a high-risk infant follow up program that helps identify infants who might develop California Childrens Services (CCS)-eligible conditions after discharge from a neo-natal intensive care unit.

9. Improve Access to Annual Eye Exam for Medi-Cal Members with Diabetes

Ms. Ha provided a brief update on a proposed amendment to CalOptima's contract with Vision Services Plan (VSP) to modify the covered benefit for routine eye exams from one routine exam every 24 months to one annual eye exam every 12 months for Medi-Cal members diagnosed with diabetes. The proposed amendment aligns with the DHCS Medi-Cal and American Diabetes Association approved clinical guidelines. A recommendation to amend the VSP contract will be presented at the February 7, 2019 Board meeting for consideration.

10. Quarterly Reports to the Quality Assurance Committee

The Committee accepted the following reports as presented:

a. Quality Improvement Committee Update
b. Member Trend Report

COMMITTEE MEMBER COMMENTS

Director Berger requested additional information on CalOptima's role in the continuity of care for the homeless population. Committee members thanked staff for their work and wished everyone a Happy New Year.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 5:40 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 20, 2019

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MINUTES

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

December 13, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 13, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:04 a.m. Member Lazo-Pearson led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D. (at 8:10 a.m.); Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen (at 8:50 a.m.); Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.

Members Absent: Brian Lee, Ph.D.

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Greg Hamblin, Chief Financial Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Arif Shaikh, Director, Government Affairs; Pallavi Patel, Director, Process Excellence; Cheryl Meronk, Director, Strategic Development; Thanh-Tam Nguyen, M.D., Medical Director; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the September 13, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Vice Chair Miranti, seconded and carried, the Committee approved the minutes of the September 13, 2018 meeting. (Motion carried 9-0-0; Member Lee absent)***

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Approve Minutes of the October 11, 2018 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC)

Action: ***On motion of Member Myers, seconded and carried, the Committee approved the minutes of the October 11, 2018 meeting as presented. (Motion carried 9-0-0; Member Lee absent)***

PUBLIC COMMENTS
Pamela Pimentel, MOM's of Orange County, Oral re: Service on PAC

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update
Michael Schrader, Chief Executive Officer, reported that at their December 6, 2018 meeting, the CalOptima Board of Directors approved the allocation of up to $11.4M from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area funds for enhanced services to be provided to CalOptima Medi-Cal members at the Be Well Wellness Hub. The Wellness Hub must accept all CalOptima members for at least the first five years of operation or later if all the funds have not been exhausted by that date. The remaining $3.4M in IGT 5 funds will be allocated by the Board for community grants consistent with state-approved funding categories.

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, updated the committee on the Whole-Child Model (WCM) postponement. She noted that member notification of the implementation delay is ongoing. To date, seven health networks have met the provider network adequacy standards; four require additional contracts and two have eight to nine deficiencies.

CalOptima is also outreaching to members who have Medicare Part B in order to check their eligibility for Medicare Part A. An update on the Program of All-Inclusive Care for the Elderly (PACE) program was provided, and it was noted that the Department of Health Care Services (DHCS) issued guidance to County Organized Health Systems (COHS) on rules to assist with approving non-COHS PACE providers.

Chief Medical Officer Update
David Ramirez, M.D., Chief Medical Officer, introduced Thanh-Tam Nguyen, M.D. as the Medical Director for the Whole-Child Model program. Dr. Ramirez also discussed the Pay for Value (P4V) incentives.

Chief Financial Officer Update
Greg Hamblin, Chief Financial Officer, reported that CalOptima anticipates that the Fiscal Year (FY) 2019/200 rates from the state will be released in March or April of 2019. He also noted that CalOptima had recently paid over $100M back to the DHCS related to the 85%, Medical Loss Ratio (MLR)requirements related to the Medi-Cal expansion population. Mr. Hamblin also

discussed the possibility that the Centers for Medicare & Medicaid Services (CMS) may look at rate setting based on encounters/visits and noted that accurate submittal of patient encounters will be extremely important going forward.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, discussed Medi-Cal enrollment by physicians and noted that at their November 1, 2018 meeting, the Board of Directors authorized CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019. To be eligible, each provider must provide proof of submittal of enrollment documentation to the DHCS prior to January 1, 2019. The Board also authorized Letters of Authorization (LOA) with non-Medi-Cal enrolled specialist providers as required for access to services or continuity of care for members through December 31, 2019.

Federal and State Legislative Update

Arif Shaikh, Director, Government Affairs, reviewed November 6, 2018 election results related to the Orange County legislative delegation.

INFORMATION ITEMS

Whole-Child Model Update

Pallavi Patel, Director, Process Excellence, provided a brief update on the Whole-Child Model postponement and noted that additional information is anticipated during the week of January 7, 2019, and staff will solicit input from the advisory committees when this new information is released. The PAC will hold a special meeting at 8:00 a.m. on Tuesday, January 15, 2019 to review CalOptima's proposed implementation plan.

Intergovernmental Transfer Funds (IGT) 8 and 9 Update

Cheryl Meronk, Director, Strategic Development, presented an update on IGT 8 and 9 funding. Funds for IGT 8, which total approximately $43M, are expected to be received during the second quarter of 2019. IGT 9, which totals approximately $42M, has been delayed per DHCS, and a timeline for the funding has not yet been provided. As with all IGTs, IGT 8 and 9 funding must be used for Medi-Cal members. However, rather than being used exclusively for enhanced benefits for existing beneficiaries, these funds must be used for Medi-Cal covered services that are included in CalOptima's DHCS contract. Ms. Meronk reviewed the requirements CalOptima must meet in order to receive IGT funding and noted that the IGT program is subject to change or could face possible elimination from DHCS. Ms. Meronk also noted that proposed expenditure plans for IGT funds will be vetted through the advisory committees and other stakeholder groups.

Children's Hospital of Orange County (CHOC) Pediatric and Adolescent Mental Health Initiative

PAC Traditional/Safety Net Representative Jena Jensen, Chief Government Relations Officer, CHOC, presented an overview of the new CHOC mental health unit for adolescents.

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PAC Member Updates

Chair Nishimoto noted that nominations for the Hospital and Nurse Representatives would open in January and asked the PAC members to assist with the recruitment. The selected applicants would fill the remaining term in each seat. The Hospital Representative would serve through June 30, 2020, and the Nurse Representative would serve through June 30, 2021.

ADJOURNMENT

There being no further business before the Committee, Chair Nishimoto wished everyone a happy holiday and adjourned the meeting at 10:05 a.m.

*/s/ Cheryl Simmons*____
Cheryl Simmons
Project Manager/Staff to the PAC

Approved: February 14, 2019

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MINUTES

SPECIAL MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

January 17, 2019

A Special Meeting of the CalOptima Board of Directors' Whole Child Model Family Advisory Committee (WCM FAC) was held on January 17, 2019, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Byron called the meeting to order at 11:45 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members: Maura Byron, Chair, Pamela Patterson, Vice Chair (at 12:15 p.m.); Sandra Cortez-Schultz; Melissa Hardaway; Diane Key; Grace Leroy-Loge; Kristen Rogers; Malissa Watson

All voting members were present.

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Dr. David Ramirez, Chief Medical Officer; Arif Shaikh, Government Affairs; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, MD, Medical Director; Sesha Mudunuri, Executive Director, Operations; Betsy Ha, Executive Director Quality; Thanh-Tam Nguyen, M.D. Medical Director; Michelle Laughlin, Executive Director Network Operations; Belinda Abeyta, Director, Customer Service; Cheryl Simmons, Sr. Program Specialist; Samantha Fontenot, Program Specialist

PUBLIC COMMENT

There were no requests for Public Comment.

MINUTES

Approve the Minutes of the November 8, 2018 Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Member Advisory Committee

Action: ***On motion of Member Sandra Cortez-Schultz, seconded and carried, the Committee approved the minutes of the November 8, 2018 meeting (Motion carried 7-0-0)***

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REPORTS

Consider Approval of FY 2018-19 Whole-Child Model Family Advisory Committee (WCM FAC) Meeting Schedule.

Chair Byron presented the revised FY2018-2019 Whole-Child Model Family Advisory Committee Meeting Schedule.

Action: ***On motion of Member Malissa Watson, seconded and carried, the committee approved the revised FY 2018-19 Whole-Child Model Family Advisory Committee Meeting Schedule. (Motion Carried 7-0-0)***

CHIEF EXECUTIVE OFFICER AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, informed the WCM FAC members of the Department of Health Care Services (DHCS) California Children Services (CCS) Advisory Group (AG), which meets quarterly to discuss and improve the delivery of health care to CCS children and their families. Mr. Schrader recommended that Chair Byron represent CalOptima's WCM FAC and attend CCS AG's quarterly meetings in Sacramento. Mr. Schrader also requested a volunteer from the Committee to attend as an alternate if Chair Byron is unable to attend. Member Rogers volunteered to serve as alternate.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, informed the Committee that CalOptima will participate in the Family Voices of California (FVCA) 17th Annual Summit and Legislative Day on March 10-12, 2019 in Sacramento. FVAC is a statewide collaborative of parent-run centers working to ensure quality health care for children with special health care needs. Sponsorship includes travel, lodging and meal expenses for a CalOptima representative to attend the summit. Ms. Khamseh asked interested Committee to contact the Staff to the Advisory Committees.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, introduced Thanh-Tam Nguyen, M.D., Medical Director. Dr. Nguyen will have responsibility for the Whole-Child Model program. He also noted that CalOptima was exploring the possibility of standardizing the navigation for the families at the Plan and Network levels.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, provided an update on the status of the network adequacy for the Whole-Child Model Program and noted that all Health Networks had met the network adequacy for specialty coverage, which was reported to the Department of Health Care Services (DHC); DHCS feedback is anticipated in mid-March 2019. Ms. Laughlin also noted that Children's Hospital Los Angeles has recently signed a contract with CalOptima for this program.

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INFORMATION ITEMS

Whole-Child Model Status Update

Candice Gomez, Executive Director, Program Implementation, and Pallavi Patel, Director, Process Improvement, presented an update on CalOptima's implementation of WCM.

Whole Child Model Family Advisory Committee Member Updates

Chair Byron announced that the next WCM FAC meeting is Tuesday, February 26, 2018 at 9:30 a.m. Chair Byron formed a nominations ad hoc committee to include herself, Vice Chair Patterson and Member Leroy-Loge, to review a new applicant for an Authorized Family Member seat and provide a recommendation at the February 26, 2019 meeting.

ADJOURNMENT

Hearing no further business, Chair Byron adjourned the meeting at 12:32 p.m.

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

Approved: February 26, 2019

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Approval of the CalOptima 2019 Quality Improvement (QI) Program and 2019 QI Work Plan

Contact

David Ramirez, M.D., Chief Medical Officer, 714-246-8400
Betsy Ha, Executive Director, Quality & Population Health Management, 714-246-8400

Recommended Actions

Recommend approval of the recommended revisions to the 2019 Quality Improvement Program and 2019 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program ("QI Program") and Quality Improvement Work Plan ("QI Work Plan") must be reviewed, evaluated and approved annually by the Board of Directors.

The QI Program defines the structure within which quality improvement activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operation and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detail objectives, scope, timeline, monitoring, and accountable persons for each activity. Progress against the QI Work Plan is monitoring throughout the year and reported to QIC quarterly.

CalOptima staff has updated the 2019 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks and strategic organizational changes. This will ensure that all regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

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The revisions are summarized as follows:

1. Updates signature page (replaces CMO to David Ramirez, MD).
2. Simplifies the plans we offer, scope of services and who we work with, including an updated list of our Health Networks.
3. Updates new initiatives on the horizon, including Whole-Person Care, Whole-Child Model, Health Homes Program, and Population Health Management.
4. Updates Quality Improvement Program purpose to include Population Health accountability, annual review, and acceptance not limited to Utilization Management.
5. Updates Authority, Board of Directors' – Quadruple Aim which includes enhancing provider satisfaction.
6. Updates the QI committee structure and subcommittees that support the QI Program.
7. Incorporates the description of CalOptima's approach to Population Health Management in the design and delivery of care.
8. Establishes 2019 QI Goals and Objectives aligned with CalOptima's strategic objectives.
9. Updates the 2019 QI Work Plan to reflect new goals and objectives.
10. Introduces methodology of lead and lag indicators reflected in the QI Work Plan.
11. Includes communication of QI activities to Quality Forum.
12. Updates staff responsibilities and position descriptions.
13. Adds QI Lean Training Curriculum to CalOptima University in 2019.
14. Includes de-credentialing to Corrective Action Plans.
15. Adds new sections: Population Health Management, Long-Term Services and Supports, and Behavioral Health Integration.
16. Adds Group Needs Assessment and Population Health Management to Safety Section
17. Adds Chinese and Arabic to Cultural & Linguistic services.
18. Updates 2019 Delegation Grid to include NCQA elements for Population Health Management.

The recommended changes are designed to better review, analyze, implement and evaluate components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare and Medicaid services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2019 QI Program and 2019 QI Work Plan has no additional fiscal impact for Fiscal Year (FY) 2018-19. To the extent that there is any fiscal impact due to increases in Quality Improvement Program resources and incentives from July 1, 2019, through December 31, 2019, such impact will be addressed in separate Board actions or the CalOptima FY 2019-20 Operating Budget.

Concurrence

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

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Attachments

1. Proposed 2019 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2019 Quality Improvement Program and QI Work Plan
3. Power Point Presentation to the Board of Directors' Quality Assurance Committee: 2019 Quality Improvement Program and Work Plan

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

2/27/2019 — **Date**

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Quality Improvement (QI) Program 2019
Executive Summary of Revisions

1. Updates signature page (replaces CMO to David Ramirez, MD).
2. Simplifies the plans we offer, scope of services and who we work with, including an updated list of our Health Networks.
3. Updates new initiatives on the horizon, including Whole-Person Care, Whole-Child Model, Health Homes Program, and Population Health Management.
4. Updates Quality Improvement Program purpose to include Population Health accountability, annual review, and acceptance not limited to Utilization Management.
5. Updates Authority, Board of Directors' – Quadruple Aim which includes enhancing provider satisfaction.
6. Updates the QI committee structure and subcommittees that support the QI Program.
7. Incorporates the description of CalOptima's approach to Population Health Management in the design and delivery of care.
8. Establishes 2019 QI Goals and Objectives aligned with CalOptima's strategic objectives.
9. Updates the 2019 QI Work Plan to reflect new goals and objectives.
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11. Includes communication of QI activities to Quality Forum.
12. Updates staff responsibilities and position descriptions.
13. Adds QI Lean Training Curriculum to CalOptima University in 2019.
14. Includes de-credentialing to Corrective Action Plans.

15. Adds new sections: Population Health Management, Long-Term Services and Supports, and Behavioral Health Integration.
16. Adds Group Needs Assessment and Population Health Management to Safety Section.
17. Adds Chinese and Arabic to Cultural & Linguistic services.
18. Updates 2019 Delegation Grid to include NCQA elements for Population Health Management.

2019

QUALITY IMPROVEMENT PROGRAM

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2019 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. **Date**

Board of Directors Chair:

_____ _____

Paul Yost, M.D. **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

C ollaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

A ccountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, Quality Assurance Committee and Finance and Audit Committee meetings are open to the public.

R espect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

E xcellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

CalOptima's 2017–19 Strategic Plan honors our long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optional health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources and expertise
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

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Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49% between 2014 and 2016!

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

Certain services are not covered by CalOptima, but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.
- Eligible conditions under California Children's Services (CCS). Effective July 1, 2019, or such later date as the program becomes effective, this program will be managed by CalOptima through the Whole-Child Model (WCM) program.

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through CalOptima's member liaisons and through specific Memoranda of Understanding (MOU) with certain community agencies, including OC HCA, CCS (through June 30, 2019, or such later date as the Whole-Child Model becomes effective) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

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- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for the dual eligible members, enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute and preventive care services covered under Medi-Cal and Medi-Care benefits, CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym membership.

OneCare Connect

OneCare Connect is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results is a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities. while ensuring timely access to the comprehensive scope of acute and preventive care services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits

such as vision care and gym benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)
In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services
PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieticians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

NEW PROGRAM INITIATIVES

Whole-Person Care
Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2020 strategic plan. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC Connect information sharing platform was launched in November 2018. For 2019 the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model
CCS is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. In Orange County, OC HCA manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

Through SB 586, the State has required CCS services to become a Medi-Cal managed care plan benefit in select counties. The goal is to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. This approach is known as the Whole-Child Model (WCM). Under this model, in Orange County, eligibility determination processes and the Medical Therapy Program will remain with OC HCA, while other CCS program components are transferred to CalOptima.

CalOptima had originally expected to launch WCM effective January 1, 2019, but recently DHCS delayed the WCM implementation in Orange County, and the new implementation date is now no sooner than July 1, 2019.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implement HHP in the following two phases: July 1, 2019 for members with chronic physical conditions or substance use disorders (SUD), and January 1, 2020 for members with serious mental illness or Serious Emotional Disturbance (SMI).

DHCS is targeting the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. DHCS will send a targeted engagement list of members to CalOptima for review and outreach, as appropriate. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions; and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima will be the Lead Administrative Entity and is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary health home providers. In addition to CalOptima's Community Network, some HNs may serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

Population Health Management (PHM)

CalOptima has developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy including plan of action for addressing our culturally diverse member needs across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards released in July 2018. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in

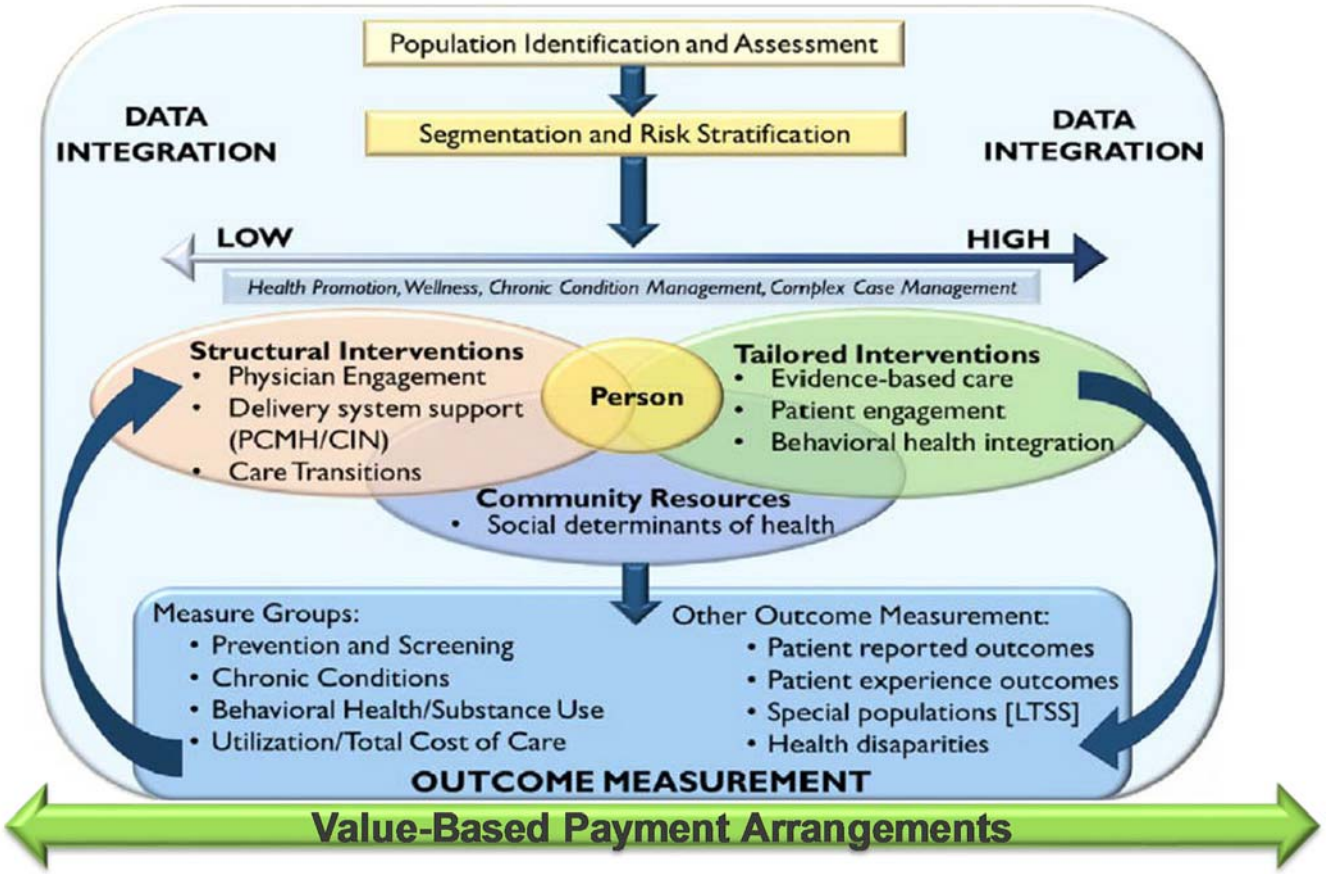
March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes.

In the first year, the PHM Strategy will be focused on expanding the Model of Care while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus, with an integrated model as illustrated below in Figure 1. The PHM Conceptual Model is adapted from the model created by the Association of Community Affiliated Plans. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.

See Appendix C — 2019 PHM Strategy

Figure 1.PHM Conceptual Model



WHOM WE WORK WITH

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima HN, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of 14 HNs, representing more than 8,400 practitioners.

Health Networks
CalOptima contracts with a variety of HN models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 Primary Care Providers (PCPs), more than 6,800 specialists, 23 hospitals and 23 clinics and 100 long-term facilities.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

The following are CalOptima's contracted HNs:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		

Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2019

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

Membership Data as of November 30, 2018

Total CalOptima Membership
769,216

Program	Members
Medi-Cal	752,888
OneCare Connect	14,610
OneCare (HMO SNP)	1,423
Program of All-Inclusive Care for the Elderly (PACE)	295

Note: The Fiscal Year 2018-19 Membership Data started on July 1, 2018.

Member Age (All Programs)

11%	0 to 5
30%	6 to 18
29%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
28%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

43%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, clinical services and organizational services provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care coordination, PHM, complex case management, behavioral health integration, and palliative care. Our comprehensive person-centered approach leverages the care delivery systems and community partners for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction, on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA, and meet DHCS/CMS quality requirements and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes.
- Supports the provision of a consistent level of high quality of care and service for members throughout the contracted provider networks, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensures certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — OC HCA — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.
- Promotes patient safety and minimizes risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and works with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences.
- Educates the workforce and promotes a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes apply to populations served by CalOptima's contracted HNs, including CCN and/or COD-A Network Providers, to:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
- The continuous improvement of clinical care and services quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- The timely identification of important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care.
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- The accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- The continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- The reliability of risk prevention and risk management processes.
- The compliance with regulatory agencies and accreditation standards.
- The accountability cadence of annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.

- The effectiveness and efficiency of internal operations.
- The effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
- The compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the QI Program annually.

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim moving upstream from the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health

3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC HCA, Behavioral Health
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OC HCA, which maintains a standing seat. The meetings are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse
- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC will provide advice and recommendations to the Board and staff on issues concerning WCM, serve as liaison between interested parties and the Board, and assist the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: 7 to 9 seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are a current recipient of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
    - Community-based organizations; or

- Consumer advocates

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meetings are open to the public.

Role of CalOptima Officers for Quality Improvement Program

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Medical Officer (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business, and Human Resources.

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving improvements in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining commendable accreditation with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and programs throughout the company and makes certain that quality initiatives are aligned with Clinical Operations within Medical Affairs. Reporting to the ED of Q&PHM: Director, Quality Analytics; Director, Population Health Management; Director, Behavioral Health Services; and Director of Quality Improvement.

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, LTSS and MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Public Affairs (ED of PA) serves as the State Liaison; and is responsible for the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees Strategic Development and the integration of activities for the Community Relations Program.

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its HMOs, PHCs, SRGs, and other FDRs meet the

requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

Executive Director, Network Operations (ED of NO) leads and directs the integrated operations of the HNs, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders. The ED of NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives, and Electronic Business.

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, and MBHOs to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, and MBHOs and their contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include the following:

- Recommends policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- Oversees the analysis and evaluation of QI activities.
- Makes certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI program activities.
- Identifies and prioritizes needed actions and interventions to improve quality.

- Makes certain that there is follow-up as necessary to determine the effectiveness of quality-improvement-related actions and interventions.

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, and MBHOs are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, and MBHOs.

The QI Program adopts the classic Continuous Quality Improvement cycle with 4 basic steps:

- **Plan** Detailed description and goals
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter, and includes, but may not be limited to, the following:

Voting Members

- Four (4) physicians or practitioners, with at least two (2) practicing physicians or practitioners
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Executive Director, Quality & Population Health Management
- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six (6) voting members of which at least four (4) are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year, and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. In addition, the CPRC reviews and monitors sentinel events, quality of care and services trends across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, and health care delivery organizations to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports

through the QIC. The voting member composition and quorum requirements of the GARS are defined in its charter.

Utilization Management Committee (UMC)
The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, and MBHOs to identify areas of under or over utilization that may adversely impact member care. The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UMC meets quarterly and reports through the QIC. The voting member composition (including a Behavioral Health practitioner*) and the quorum requirements of the UMC are defined in its charter.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Pharmacy & Therapeutics Committee (P&T)
The P&T committee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)
The purpose of the BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC, and also ensures that benefit updates are implemented, and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, SRGs, MBHOs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

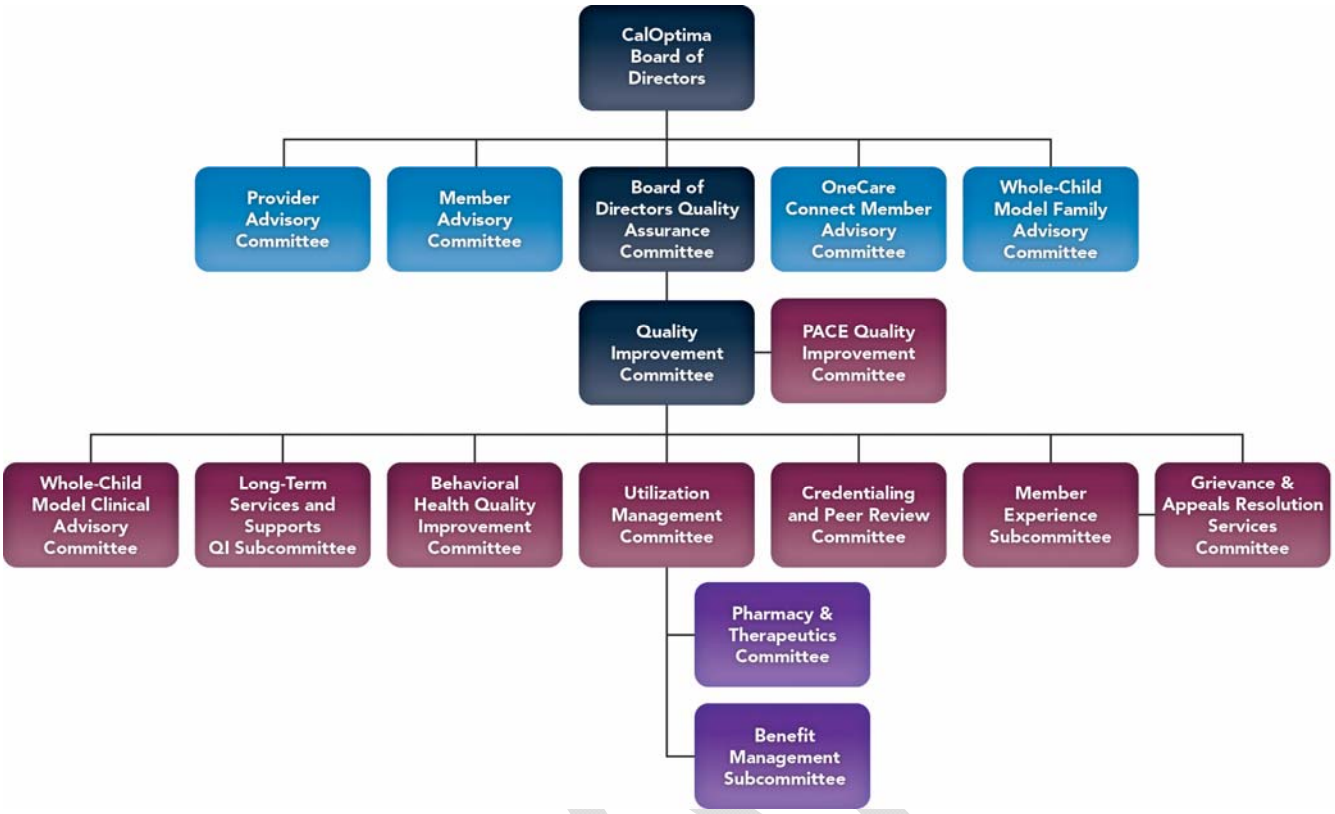
Long-Term Services and Supports QI Subcommittee (LTSS-QISC)
The LTSS subcommittee is composed of representatives from the LTC, CBAS, and MSSP communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of criteria and methodologies to measure and report quality and access standards with HCBS and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify best practices, monitor over and underutilization patterns, and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through the Clinical Operations subcommittee, and through the QIC. The voting member composition and quorum requirements of the LTSS-QISC are defined in its charter.

Behavioral Health Quality Improvement Committee (BHQIC)
The BHQIC ensures members receive timely and satisfactory behavioral health care services, through enhancing integration and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement, and guiding CalOptima towards the vision of bi-directional behavioral health care integration. The designated chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for chairing the committee and reporting through the QIC. The BHQIC meets, at a minimum, on a quarterly basis, or more often as needed. The voting member composition and quorum requirements of the BHQIC are defined in its charter.

Member Experience Subcommittee (MEMX)
Improving member experience is a top priority of CalOptima. The MEMX was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction. CalOptima's QI Program focuses on the performance in each of these areas. The MEMX is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. In 2019, the MEMX will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the 2020 CAHPS survey results. This subcommittee meets at least bi-monthly and is reported through the QIC. The voting member composition and quorum requirements of the MEMX are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)
The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC will advise on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensure they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee, and HN CCS providers. The WCM CAC meets 4 times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

2019 Committee Organization Structure — Diagram



Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, SRGs and MBHOs hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a Confidentiality Agreement. This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

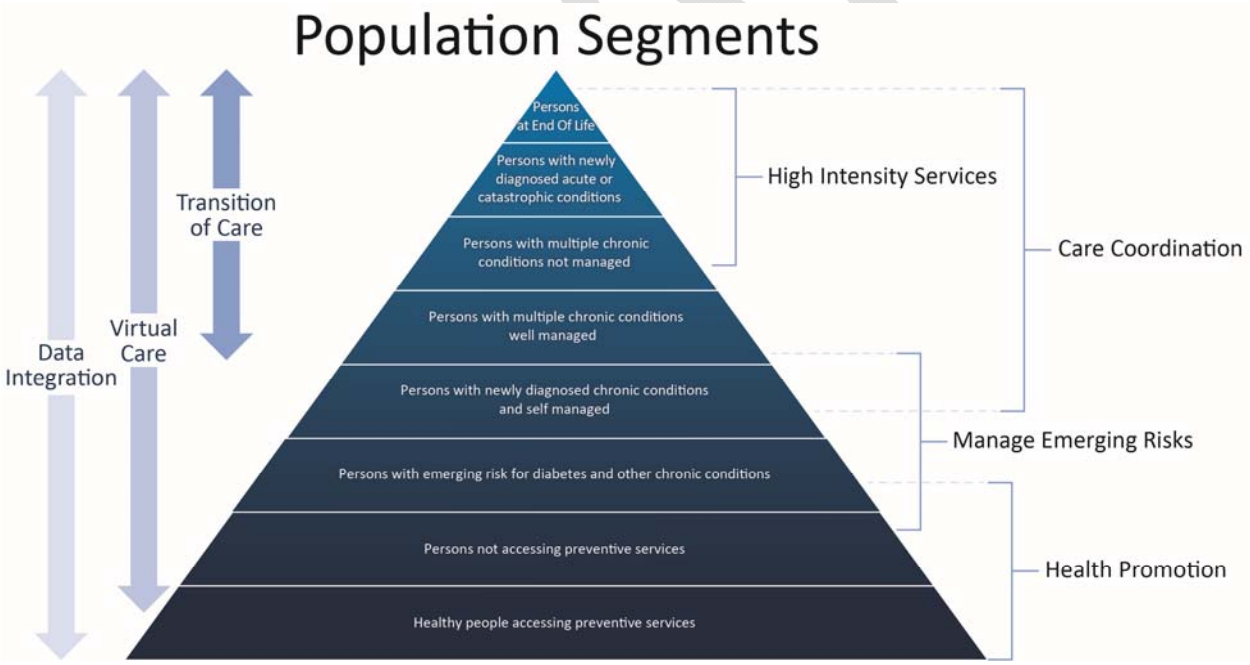
Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM Committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program supports a Population Health Management (PHM) approach, stratifying our population based on their health needs, conditions, and issues and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care, the 2019 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health.

The Population Segments with an integrated intervention hierarchy, is shown below:



CalOptima's Model of Care (MOC) recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of the high-risk members one-by-one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile

technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2019 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2017–2019 strategic goals.

1. **Goal: Achieve NCQA overall rating as the #1 Medi-Cal Health Plan in California by:**
   1.1. Improving NCQA ratings in Member Experience from 1.5 to 3.0
   1.2. Improving NCQA ratings in Treatment from 3.5 to 4.0
2. **Goal: Improve overall Health Networks, including CCN, quality performance rankings by:**
   2.1. Implementing practice transformation technical assistance in 5 high volume CCN practices by December 2019.
   2.2. Expanding provider coaching and customer services training to include all health networks and all PQI providers and office staff in CCN by December 2019.
3. **Goal: Improve Member Experience CAHP performance from 25th percentile to exceed 50th percentile by:**
   3.1. Increasing the number of providers who have a high rate of grievances and PQIs who will participate in provider coaching and customer services training by December 2019.
   3.2. Expanding provider coaching and customer services training to all health networks providers and office staff on the PQI list by December 2019.

Detailed strategies for achieving 2019 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly, and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect lines of business. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.
The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. QI Work Plan addenda may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan which includes, but is not limited to:

- Quality of Clinical Care
- Safety of Clinical Care
- Quality of Service
- Member Experience
- Compliance
- QI Program Oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of CalOptima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of CalOptima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2019 QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e)

satisfaction surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.
- Measures required by regulators such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability, as described in the UM Program and in policy and procedure
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement, and is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QIC, UMC, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence and the rationale for selection of the lead quality measure must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers, or predictors of the desired outcome measures or lag quality measure such as HEDIS and STARS measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, and MBHO, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse below.

For outcomes studies or measures that require data from sources other than administrative data (e.g. medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small test of change using rapid improvement cycle methodology. For example, a pilot sample of 30 or 100 % of the sample size when sample is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI work plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forum and other ongoing ad-hoc meetings
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED of Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement (Credentialing)
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - QI Program Specialists
  - QI Nurse Specialists
  - Program Policy Analyst and Data Analyst
  - Credentialing Coordinators
  - Program Specialists
  - Program Assistants

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics QI Initiatives Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health

programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health Services provides operational oversight for behavioral health benefits and services provided to members. The director is responsible for monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management assists in the development and implementation of the UM program, policies, and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management (PM) program, develops and implements PM department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics committee and QI Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management is responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports is responsible for LTSS programs, which include CBAS, LTC, and MSSP. The position supports a "Member-Centric" approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures, and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies & procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency training
- QI Lean training curriculum will be added to CalOptima University in 2019

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for

formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of each QI Activity, including QI Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement.
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.
- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors review and approval.

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical Care and Service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions

- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

*** CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.**

QUALITY IMPROVEMENT

The QI department is responsible for the execution and coordination of quality assurance and improvement activities. It also supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both division and department-specific as well as agency-wide
- Evaluate and monitor provider credentials

- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agency-wide practices that support accreditation and meeting regulatory requirements.

Peer Review Process For Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to the CPRC and are also reviewed at time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities are delegated to the HNs and performed by CalOptima for CCN.

Health Care Delivery Organizations

CalOptima performs credentialing and re-credentialing of Health Care Delivery Organizations (HDOs), also known as Organizational Providers (OPs) for providers such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations

on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR) and Medical Record Review (MRR) for the non-delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, and SRGs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.

Corrective Action Plan(s) To Improve Care, Service

When monitoring by either CalOptima's QI department or Audit & Oversight department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e. quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education or office training
- De-delegation
- De-Credentialing
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken, and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines.
- Support efforts to improve internal and external customer satisfaction.

- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement.
- Coordinate and communicate organizational information, both division and department specific, and agency-wide.
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews.
- Facilitate satisfaction surveys for members and practitioners.
- Provide agency-wide oversight of monitoring activities that are:

  Balanced: Measures clinical quality of care and customer service
  Comprehensive: Monitors all aspects of the delivery system
  Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- QI Projects: Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement CCIP)
- Health Risk Assessment (HRA) data

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARS and HOS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, and MBHOs, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined

- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population.
- Description of data sources and evaluation of their accuracy and completeness.
- Description of sampling methodology and methods for obtaining data.
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines.
- Data abstraction tools and guidelines.
- Documentation of training for chart abstraction.
- Rater to standard validation review results.
- Measurable objectives for each quality measure.
- Description of all interventions including timelines and responsibility.
- Description of benchmarks.
- Re-measurement sampling, data sources, data collection, and analysis timelines.
- Evaluation of re-measurement performance on each quality measure.

DRAFT

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between healthcare departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes across settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS and Behavioral Health Services areas.

Health Promotion

Health Education provides program development and implementation for agency-wide population health programs**.** PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management and Tobacco Cessation.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provides a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources, and support to members as they learn to care for themselves and their condition. The PHM program also identifies those members in need of closer management, coordination and

intervention. CalOptima assumes responsibility for the PHM program for all of its lines of business, however members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data.
- Documented process to assess the needs of member population.
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory.
- Ability of member to opt-out.
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs.
- Use of evidenced- based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD).
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services.
- Ongoing assessment of outcomes.

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager.

The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP
      - Communication with members or their representatives, vendors, and medical group
      - Review and update the ICP at least annually, and when there is a change in the member's health status
      - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN or Health Plan for Community Network
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Case management of high-risk members
      - Coordination of ICPs for high risk members
      - Facilitating member, PCP and specialists, and vendor communication
      - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization.
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals.
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning.

Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home and Community Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing, when clinically indicated, to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger that meet medical necessity criteria. BHT services are provided under a specific

behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including utilization management, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC
CalOptima has contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Functions delegated to Magellan include provider network, UM, credentialing, and customer service.

CalOptima OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a Magellan representative for behavioral health assistance. If office-based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and

diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2018 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff reviews and approves requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2019 UM Program Description and related Work Plan.

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and roadmap for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the roadmap. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the EA team develops or extends the data architecture and data definitions which expresses a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions, and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts specific to member safety.

This safety program is based on a needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations

- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Group needs assessment
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications

    - Sentinel events, critical incident identification, appropriate investigation and remedial action
    - Administration of flu and pneumonia vaccines
- Administrative offices
    - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The seven most common languages spoken for all CalOptima programs are: English 56%, Spanish 28%, Vietnamese 11%, Farsi 1%, Korean 1%, Chinese 1%, Arabic 1% and all others at 3%, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- OC member materials are provided in three languages: English, Spanish and Vietnamese
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 — Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas.
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved.
- Considering outcomes of member grievances and complaints.
- Conducting patient-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks.
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.
- Providing information, training and tools to staff and practitioners to support culturally competent communication.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, and MBHO contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services.
- QI program for all lines of business, HMOs, PHCs, SRGs, and MBHOs must comply with all quality related operational, regulatory and accreditation standards.
- Medi-Cal Behavioral Health.
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program.
- Health Education (as applicable).
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases.
- Development of system-wide measures, thresholds and standards.
- Satisfaction surveys of members, practitioners and providers.
- Survey for Annual Access and Availability.
- Access and availability oversight and monitoring.
- Second level review of provider grievances.
- Development of credentialing and re-credentialing standards for both practitioners and health care delivery organizations (HDOs).
- Credentialing and re-credentialing of HDOs.
- Development of UM and Case Management standards.
- Development of QI standards.
- Management of Perinatal Support Services (PSS).
- Risk management.
- Pharmacy and drug utilization review as it relates to quality of care.
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2018 Delegation Grid.

See Appendix B — 2019 Delegation Grid

IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

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Appendix A — 2019 QI Work Plan

Appendix B — 2019 Delegation Grid

Appendix C — 2019 PHM Strategy

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2019 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2019 QI Annual Oversight of Program and Work Plan
B. 2018 QI Program Evaluation
C. 2019 UM Program
D. 2018 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee Oversight
G. BHQIC Oversight
H. UMC Oversight
I. Member Experience SubCommittee Oversight
J. LTSS QISC Oversight
K. Whole Child Model - Clinical Advisory Committee
L. GARS Committee
M. PACE QIC
N. Quality Program Oversight - Quality Withold
O. Quality Program Oversight - QIPE/PPME Monitoring for OC/OCC

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date: 1/8/2019
Submitted and approved by QAC: Date:
Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

David Ramirez, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, MD Date:

II. QUALITY OF CLINICAL CARE- ADULT HEALTH- MENTAL

A. Antidepressant Medication Management (AMM): Continuation Phase Treatment
B. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

III. QUALITY OF CLINICAL CARE - ADULT HEALTH-PHYSICAL

A. Statin Use in Persons with Diabetes (SUPD)
B. Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
C. Use of Imaging Studies for Lower Back Pain (LBP)
D. Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)
E. Cervical Cancer Screening (CCS)
F. Colorectal Cancer Screening (COL)
G. Breast Cancer Screening (BCS)
H. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

IV. QUALITY OF CLINICAL CARE - CHILD/ADOLECENT HEALTH

A. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase
B. Depression Screening and Follow-Up for Adolescents (DSF)
C. Childhood Immunization Status (CIS): Combo 10
D. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)
E. Well-Care Visits in first 15 months of life (W15)

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F. Adolescent Well-Care Visits (AWC)
G. Appropriate Testing for Children with Pharyngitis (CWP)
H. Children and Adolescents' Access to Primary Care (CAP)

V. QUALITY OF CLINICAL CARE - CHRONIC CONDITIONS

A. Improve HEDIS measures related to Asthma (AMR)
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Including HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention to Nephrology

VI. QUALITY OF CLINICAL CARE - COORDINATION OF CARE

A. Plan All-Cause Readmissions (PCR)

VII. QUALITY OF CLINICAL CARE - MATERNAL CHILD HEATH

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum

VIII. QUALITY OF CLINICAL CARE

A. Improving the quality performance of all HNs, including CalOptima Community Network (CCN).

IX. QUALITY OF SERVICE

A Review and Report GARS for all Lines of Business, Include review of quality issues (QOC, QOS, Access) related to member experience.

X. SAFETY OF CLINICAL CARE

A. Use of Opiods at High Dosage (UOD)
B. Use of Opioids from Multiple Providers (UOP)
C. Follow-up on Potential Quality Of Care Complaints

XI. MEMBER EXPERIENCE

A. Review of Member Experience (CAHPS)
-Increase CAHPS score on Getting Needed Care
B. Review of Member Experience (CAHPS)
-Increase CAHPS score on Getting Care Quickly
C. Review of Member Experience (CAHPS)
-Increase CAHPS score on How Well Dr Communication
D. Review of Member Experience (CAHPS)
-Increase CAHPS score on Care Coordination

XII. COMPLIANCE

A. Delegation Oversight of HN Compliance (UM, CR, Claims)
B. HN Compliance with CCM NCQA Standards

Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Program Oversight		2019 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2019 QI Program and Workplan by February 2019	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Betsy Ha	Quality Improvement	QIC
Program Oversight		2018 QI Program Evaluation	Complete Evaluation 2018 QI Program by January 2019	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Betsy Ha	Quality Improvement	QIC
Program Oversight		2019 UM Program	Obtain Board Approval of 2019 UM Program by Q1 2019	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Tracy Hitzeman	Utilization Management	QIC
Program Oversight		2018 UM Program Evaluation	Complete Evaluation of 2018 UM Program by Q1 2019	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Tracy Hitzeman	Utilization Management	QIC
Program Oversight		Population Health Management Strategy	Obtain Board Approval of 2019 Population Health Management Strategy and start implementation by July 1, 2019	Implement PHM Strategy. Review and adopt on an annual basis	Annual Adoption	Betsy Ha	Quality & Population Health Management	QIC
Program Oversight		**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network per regulatory and contract requirement	Peer Review of Credentialing and Re-credentialing files, and Quality of Care and Quality of Service cases related to CalOptima's provider network.	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima	Quality Improvement	QIC
Program Oversight		**Behavioral Health Quality Improvement Committee (BHQIC) Oversight** - Conduct Internal and External oversight of BHI QI Activities per regulatory and contract requirement	Ensure member's have access to quality behavioral health services, while enhancing continuity and coordination between physical health and behavioral health providers.	BHQI meets quarterly to: monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report	Donald Sharps MD/ Edwin Poon	Behavioral Health	QIC
Program Oversight		**Utilization Management Committee (UMC) Oversight** - Conduct Internal and External oversight of UM Activities per regulatory and contract requirement	Monitors the utilization of health care services of CalOptima Direct and delegated HMO's, PHCS, SRGs to area identifies over and under utilization that may adversely impact the member's care.	UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results	Quarterly Adoption of Report	Frank Federico MD/ Tracy Hitzeman	Utilization Management	QIC
Program Oversight		**Member Experience (MEMX) Subcommittee Oversight** - Oversight of Member Experience activities to improve member experience to achieve the 2019 QI Goal	Improve member experience to meet 2019 strategic objectives. Increase CAHP performance from 25th percentile to exceed 50th percentile.	The MEMX Subcommittee assesses the annual results of CalOptima s CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the “pain points” in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet	Quality Analytics	QIC
Program Oversight		**Long Term Services and Supports Quality Improvement Sub-Committee (LTSS-QISC) Oversight** - Conduct Internal and External oversight of LTSS QI Activities per regulatory and contract requirement	Monitor and review the quality and outcomes of services provided to members in both Nursing Facility Services for Long-Term Care and Home and Community Based Services.	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory, safety, quality and clinical initiatives.	Quarterly Adoption of Report	Emily Fonda, MD/ Steven Chang	LTSS	QIC
Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Conduct Clinical Oversight for WCM per regulatory and contract requirement	Provide clinical advice for issues related to Whole Child Model.	Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	Tracy Hitzeman	Medical Affairs	QIC
Program Oversight		**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals per regulatory and contract requirement	Resolve provider complaints and appeals expeditiously for all CalOptima providers in a timely manner.	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report	Ana Aranda	GARS	QIC
Program Oversight		**PACE QIC** - Quarterly review and update of PACE QIC activities	Provide all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). Plan, coordinate and deliver the most fitting and personalized health care to participants.	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Quarterly Adoption of Report	Miles Masatsugu, MD	PACE	QIC

Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Program Oversight		Quality Program Oversight - Quality Withhold	Earn 100% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2019	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment	Kelly Rex-Kimmet/ Tracy Hitzeman	Quality & Analytics	QIC
Program Oversight		Quality Program Oversight - QIPE/PPME Monitoring	Meet and exceed goals set forth on the QIPE/PPE dashboard for OC/OCC measures.	Conduct quarterly oversight of specific goals on QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals	As specified on dashboard	Tracy Hitzeman/ Betsy Ha	Medical Affairs	QIC
Quality of Clinical Care	Adult Health - Mental	Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	Continuation Phase: MC: 42.31% 75th Percentile OC: 67.87% 90th percentile OCC: 49% 25th percentile	Create report of new members in measure Outreach to these members to assess barriers to adherence Provider Incentives for improvement above baseline rate Provider Training and Education	12/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Adult Health - Mental	Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	OC OCC 30 day: 56% 33rd percentile OC: N/A OCC: 7 day: 28.97% 50th percentile	CalOptima to manage mental health services for OC/OCC Develop transition of care process for post-discharge Outreach to members post discharge to coordinate follow-up appointments Add ADT and/or EDIE Reporting Incentives for urgent appointments for providers	12/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Adult Health - Physical	Statin Use in Persons with Diabetes (SUPD)	Therapy OC:74% 66th percentile OCC:74% 66th percentile Adherence OC: 80.75% 75th percentile OCC: 74.56% 50th percentile	Provider Incentives Practice Transformation Initiative (PTI) Member Incentives Provider Report Card Provider Training and Education Academic Detailing	12/31/2019	Nicki Ghazanfarpour Pshyra Jones	Pharmacy	QIC
Quality of Clinical Care	Adult Health - Physical	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	MC: 79.67% 50th percentile OC: N/A OCC: 90.23% 50th percentile	Provider Incentives Align case management post discharge outreach (create workflow in GC) DM/CM/Pharmacy followup after 6 months Provider Report Card	12/31/2019	Nicki Ghazanfarpour	Pharmacy	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Adult Health - Physical	Use of Imaging Studies for Lower Back Pain (LBP)	MC: 71.71% 50th percentile	Move spine x-rays to auth required list (all networks). For CCN: Offer DME in home PT assessments as an option for providers or UM to order (would need guidelines). Auto-approve PT for CCN. Ask about exclusions on auth request form (CCN). Outreach to requesting providers to request documentation of exclusions. Provider Report Card.	12/31/2019	Tracy Hitzeman	Utilization Management	QIC
Quality of Clinical Care	Adult Health - Physical	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	MC: 75.84% 25th percentile	Pay for Value Continue implementing MC PIP activities through 6/30/2019 Member Incentives Lists of members: no visits after 6 and 9 months, no visits over multiple years; Send list to PCP's Provider Incentives	6/30/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Adult Health - Physical	Cervical Cancer Screening (CCS)	MC: 63.26% 66th percentile	Member Incentives Pay for Value UCI Quality Initiative to improve cancer screening targeting Asian American	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Adult Health - Physical	Colorectal Cancer Screening (COL)	OC: 4 STAR OCC: 3 STAR	Pay for Value Member Incentives Possible opportunities for FOBT test kits UCI Quality Initiative to improve cancer screening targeting Asian American For CCN: Update Auto-approval rules UM MA call members with approved auths to offer to schedule appointments	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Adult Health - Physical	Breast Cancer Screening (BCS)	MC: 65.30% 75th percentile	Pay for Value Member Incentives Conduct Mobile Mammography events for CCN members UCI Quality Initiative to improve cancer screening targeting Asian American CCN: Auto-Approve screening requests and send letter and/or call members if auth approved	12/31/2019	Mimi Cheung	Quality Analytics	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Adult Health - Physical	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	MC; 27.63% 25th percentile	Pay for Value Urgent Care Center Provider Incentives	12/31/2019	Pshyra Jones/ Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	MC; Continuation Phase: 45% 50th percentile	Provider Report Card Virtual Care/Texting Members Pharmacist Outreach Provider Incentives	12/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Child/Adolescent Health	Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)	New in 2019, DHCS required, for MC, no external benchmarks	Continue depression screening incentive through May 2019 Expand provider incentive to kids 12 and older	5/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Child/Adolescent Health	Childhood Immunization Status (CIS): Combo 10	MC: Combo 10: 48.42% 90th percentile Last year final rate 45.01 75%, our goal is to move from 75% to 90%	Pay for Value Implement CalOptima Days (with Member and Provider Incentive) Practice Transformation Initiative	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	MC: 83.70% 90th percentile	Pay for Value Implement CalOptima Days (with Member and Provider Incentives) Practice Transformation Initiative	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Well-Care Visits in first 15 months of life (W15)	MC: 58.54% 25th percentile	Pay for Value Implement CalOptima Days (with Member and Provider Incentives) Practice Transformation Initiative Bright Steps Program Implementation	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Adolescent Well-Care Visits (AWC)	MC: 54.57% 50th percentile	Pay for Value Implement CalOptima Days (with Member and Provider Incentives) Practice Transformation Initiative	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Appropriate Testing for Children with Pharyngitis (CWP)	MC: 72.52% 25th percentile	Pay for Value Target urgent care centers and high volume provider offices. Distribute pharyngitis kits to targeted offices. Provider Report Card Urgent Care Center Provider Incentives Offer provider incentive for administering the test and documenting appropriately.	12/31/2019	Mimi Cheung	Quality Analytics	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Child/Adolescent Health	Children and Adolescents' Access to Primary Care Practitioners (CAP)	MC 12-24 Months 93.64% 25-6 years: 89.26% 7-11 years: 90.69% 12-19 years: 89.56% 50th percentile	Pay for Value (12-19 years only) Implement CalOptima Days (with Member and Provider Incentives)	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Chronic Conditions	Improve HEDIS measures related to Asthma: Asthma Medication Ratio (AMR)	MC: 65.30% 66th percentile	Pay for Value Member Incentives Identify high risk patients (ratio < 0.5 and/or exacerbation coded); Outreach to educate members and offer pulmonology referrals; Identify providers with low scores and educate/train and/or offer pharmacists to help them manage their asthma patients; Contract with vendor for home RT assessments and recommendations.	12/31/2019	Pshyra Jones	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	A1c Testing: MC: 91.58% 75th percentile OC: 92.15% 25th percentile OCC: 92.15% 25th percentile	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	A1c (<8%): MC: 59.49% 90th percentile OC: 77.26% 66th percentile OCC: 71.29% 66th percentile	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	Eye Exams: MC: 66.42% 75th percentile OC: 80% 66th percentile OCC: 80% 66th percentile	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	Nephropathy: MC: 92.05% 75th percentile OC: 95% 25th percentile OCC 97% 66th percentile	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Coordination of Care	Plan All-Cause Readmissions (PCR)	MC: N/A OC: 8% 50th percentile OCC: 10%	Update Transition of Care post-discharge program Obtain real time ER data	12/31/2019	Sloane Petrillo	Case Management	QIC
Quality of Clinical Care	Maternal Child Health	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	Prenatal: 87.06% 75th percentile	Bright Steps Program Implementation Provider Incentives Member Incentives	12/31/2019	Pshyra Jones/ Ann Mino	Population Health Mgmt.	QIC
Quality of Clinical Care	Maternal Child Health	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	Postpartum: 73.97% 90th percentile	Bright Steps Program Implementation Provider Incentives Member Incentives	12/31/2019	Pshyra Jones/ Ann Mino	Population Health Mgmt.	QIC
Quality of Clinical Care		Improving the quality performance of all HNs, including CalOptima Community Network (CCN).	Implement practice transformation technical assistance in 5 high volume CCN practices by December 2019 Expand provider coaching and customer service training to include all health networks, and all PQI Providers and CCN office staff by December 2019	Pay for Value Provider Report Card Provider Incentive targeting measures not in P4V Practice Transformation Initiative in partnership with California Quality Coalition Expand provider coaching and customer service training	12/31/2019	Marsha Choo / Esther Okajima	Quality Analytics	QIC
Quality of Service		Review and Report GARS for all Lines of Business, Include review of quality issues (QOC, QOS, Access) related to member "pain points" and provide recommendation to assure appropriate actions are taken to improve member experience.	Address quality issues related to (Quality of Service, Access, and Quality of Care).	Provider Data Initiative to address accuracy issues with on-line provider directory which may impact member experience Provider Coaching Initiative	12/31/2019	Ana Aranda	GARS	MEMX
Safety of Clinical Care		Use of Opioids at High Dosage (UOD)	New in 2019, Need to establish benchmark and goals	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics Prescriber monitoring and education	12/31/2019	Kris Gericke	Pharmacy	UMC
Safety of Clinical Care		Use of Opioids from Multiple Providers (UOP)	New in 2019, Need Goals	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics Prescriber monitoring and education	12/31/2019	Kris Gericke	Pharmacy	UMC
Safety of Clinical Care		Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	Provider Report Card Expand Provider Coaching	12/31/2019	Esther Okajima/ Laura Guest	Quality Improvement	CPRC

Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Member Experience		Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile	Pay for Value Incentives for providers in select difficult to access specialties CalOptima Days for Specialists Virtual Care Streamline CCN prior auth process	12/31/2019	Kelly Rex-Kimmet/ Marsha Choo	Quality Analytics	MEMX
Member Experience		Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Care Quickly	Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	Pay for Value Incentives for providers in select difficult to access specialties CalOptima Days for Specialists Virtual Care Streamline CCN prior auth process	12/31/2019	Kelly Rex-Kimmet/ Marsha Choo	Quality Analytics	MEMX
Member Experience		Review of Member Experience (CAHPS)-Increase CAHPS score on How Well Dr Communication	Improve Member Experience for **How Well Drs Communicate** from 25th to 50th percentile	Pay for Value Provider Coaching Practice Transformation Initiative Health Literacy Training	12/31/2019	Kelly Rex-Kimmet/ Marsha Choo	Quality Analytics	MEMX
Member Experience		Review of Member Experience (CAHPS)-Increase CAHPS score on Care Coordination	Improve Member Experience for **Care Coordination** from 25th to 50th percentile	Pay for Value Practice Transformation Initiative	12/31/2019	Sloane Petrillo	Medical Affairs	MEMX
Compliance		Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of **UM, CR, Claims**	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations; Credentialing, Claims etc. **Report from AOC	12/31/2019	Solange Marvin	A&O	AOC
Compliance		HN Compliance with CCM NCQA Standards	Delegation Oversight of Health Networks to assess compliance of **CCM**	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CCM; **Report from AOC	12/31/2019	Sloane Petrillo	Case Management	AOC

2019 Medi-Cal Delegation Grid "Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI1A: QI Program Structure	X		X		CO responsibility S&P component, even if delegated
QI1B: Annual Evaluation	X		X		CO responsibility S&P component, even if delegated
QI2A: QI Committee Responsibilities	X		X		CO responsibility S&P component, even if delegated
QI2B: Informing Members	X		X		CO responsibility S&P component, even if delegated
QI3A: Practitioner Contracts	X		X		CO responsibility S&P component, even if delegated
QI3B: Affirmative Statement	X		X		CO responsibility S&P component, even if delegated
QI3C: Provider Contracts	X		X		CO responsibility S&P component, even if delegated
QI4A: Member Services Telephone Access	X	X	X		
QI4B: BH Telephone Access Standards	X		X		CO responsibility S&P component, even if delegated
QI4C: Annual Assessment-Member Experience	X				CO fields CAHPS, Kaiser complaint data included
QI4D: Opportunities for Improvement-Member Experience	X				
QI4E: Annual Assessment of BH and Services-Member Experience	X		X		Kaiser: Factor1 & Factor2
QI4F: BH Opportunities for Improvement-Member Experience	X				

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI4G: Assessing Experience with the UM Process-Member Experience	X				CO utilizes Kaiser data
QI5A: Identifying Opportunities-Continuity & Coordination of Care (C&C)	X		X		
QI5B: Acting on Opportunities-C&C	X		X		
QI5C: Measuring Effectiveness-C&C	X		X		
QI5D: Transition to other Care-C&C	X	X	X		
QI6A: Data Collection- C&C Behavioral Health	X		X		
QI6B: Collaborative Activities- C&C Behavioral Health	X		X		
QI6C: Measuring Effectiveness- C&C Behavioral Health	X		X		
PHM1A: Strategy Description-PHM	X		X		(new) CO responsibility S&P component, even if delegated
PHM1B: Informing Members-PHM	X		X		(new)
PHM2A: Data Integration-PHM	X		X		(new)
PHM2B: Population Assessment-PHM	X		X		(new)

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
PHM2C: Activities and Resources-PHM	X		X		(new)
PHM2D: Segmentation-PHM	X		X		(new)
PHM3A: Practitioner or Provider Support	X		X		(new)
PHM3B: Value-Based Payment Arrangement	X		X		(new)
PHM4A: Health Appraisal (HA) Components	X		X		
PHM4B: HA Disclosure	X		X		
PHM4C: HA Scope	X		X		
PHM4D: HA Results	X		X		
PHM4E: HA Formats	X		X		
PHM4F: Frequency of HA Completion	X		X		
PHM4G: Review and Update Process	X		X		
PHM4H: Topics of Self- Management Tools	X		X		
PHM4I: Usability Testing of Self-Management Tools	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
PHM4J: Review and Update Process for Self-Management Tools	X		X		
PHM4K: Self- Management Tool Formats	X		X		
PHM5A: Access to Case Management-CCM	X	X	X		
PHM5B: Case Management Systems-CCM	X	X	X		
PHM5C: Case Management Process-CCM	X	X	X		CO responsibility S&P component, even if delegated
PHM5D: Initial Assessment-CCM	X	X	X		
PHM5E: Case Management- Ongoing Management-CCM	X	X	X		
PHM5F: Experience with Case Management-CCM	X				
PHM6A: Measuring Effectiveness-PHM	X		X		(new) CO responsibility S&P component, even if delegated
PHM6B: Improvement and Action -PHM	X		X		(new) CO responsibility S&P component, even if delegated
NET1A: Cultural Needs and Preferences	X		X		
NET1B: Practitioners Providing Primary Care	X				CO responsibility S&P component Factors 1&2, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET1C: Practitioners Providing Specialty Care	X				CO responsibility S&P component Factors 1-4, even if delegated
NET1D: Practitioners Providing Behavioral Health (BH)	X		X		CO responsibility S&P component Factors 1-3, even if delegated. Factor 4 Kaiser (need to confirm with Marsha)
NET2A: Access to Primary Care	X		X		CO responsibility S&P component, even if delegated
NET2B: Access to BH	X		X		CO responsibility S&P component, even if delegated
NET2C: Access to Specialty Care	X		X		
NET3A: Assessment of Member Experience Accessing the Network	X		X		Kaiser Factor 1&2, factor 3 is new.
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X		Kaiser Factor 1&2, factor 3 is new.
NET3C: Opportunities to Improve Access to BH Services	X		X		Kaiser Factor 1&2, factor 3 is new.
NET5A: Notification of Termination	X	X	X		
NET5B: Continued Access to Practitioners	X	X	X		
NET6A: Physician Directory Data	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET6B: Physician Directory Updates	X		X		
NET6C: Assessment of Physician Directory Accuracy	X		X		
NET6D: Identifying and Acting on Opportunities	X		X		
NET6E: Physician Information Transparency	X		X		
NET6F: Searchable Physician Web-Based Directory	X		X		
NET6G: Hospital Directory Data	X		X		
NET6H: Hospital Directory Updates	X		X		
NET6I: Hospital Information Transparency	X		X		
NET6J: Searchable Hospital Web-Based Directory	X		X		
NET6K: Usability Testing	X		X		
NET6L: Availability of Directories	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM1A: Written Program Description	X		X		CO responsibility S&P component, even if delegated
UM1B: Physician Involvement	X		X		CO responsibility S&P component, even if delegated
UM1C: BH Practitioner Involvement	X		X		CO responsibility S&P component, even if delegated
UM1D: Annual Evaluation	X		X		CO responsibility S&P component, even if delegated
UM2A: UM Criteria	X	X	X		CO responsibility S&P component, even if delegated
UM2B: Availability of Criteria	X	X	X		
UM2C: Consistency in Applying Criteria	X	X	X	X	
UM3A: Access to Staff	X	X	X		
UM4A: Licensed Health Professionals	X	X	X	X	CO responsibility S&P component, even if delegated
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	CO responsibility S&P component, even if delegated
UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X		
UM4D: Practitioner Review of BH Denials	X		X		
UM4E: Practitioner Review of Pharmacy Denials	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM4F: Use of Board-Certified Consultants	X	X	X		
UM4G: Affirmative Statement About Incentives	X	X	X		
UM5A: Timeliness of Non-Behavioral UM Decision Making	X	X	X		
UM5B: Notification of Non-Behavioral Decisions	X	X	X		
UM5C: Timeliness of Behavioral Healthcare UM Decision Making	X		X		
UM5D: Notification of Behavioral Healthcare Decisions	X		X		
UM5E: Timeliness of Pharmacy UM Decision Making	X		X	X	
UM5F: Notification of Pharmacy Decisions	X		X	X	
UM5G: UM Timeliness Report	X	X	X	X	HN Factor1, 2; Med Impact Factor 5; CO Factor 3, 4, 6
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X		
UM6B: Relevant Information for BH Decisions	X		X		
UM6C: Relevant Information for Pharmacy Decisions	X		X		
UM7A: Discussing a Denial with a Reviewer	X	X	X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X		
UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X		
UM7D: Discussing a BH Denial with a Reviewer	X		X		
UM7E: Written Notification of BH Denials	X		X		
UM7F: BH Notice of Appeal Rights/Process	X		X		
UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X		
UM7H: Written Notification of Pharmacy Denials	X		X	X	
UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	X	
UM8A: Internal Appeals (Policies and Procedures)	X		X		CO responsibility S&P component, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X		
UM9B: Timeliness of the Appeal Process	X		X		
UM9C: Appeal Reviewers	X		X		
UM9D: Notification of Appeal Decision/Rights	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X		
UM11B: Pharmaceutical Restrictions/Preferences	X		X		
UM11C: Pharmaceutical Patient Safety Issues	X		X		
UM11D: Reviewing and Updating Procedures	X		X		
UM11E: Considering Exceptions	X		X		
CR1A: Practitioner Credentialing Guidelines	X	X	X		CO responsibility S&P component, even if delegated
CR1B: Practitioner Rights	X	X	X		CO responsibility S&P component, even if delegated
CR2A: Credentialing Committee	X	X	X		
CR3A: Verification of Credentials	X	X	X		
CR3B: Sanction Information	X	X	X		
CR3C: Credentialing Application	X	X	X		
CR4A: Recredentialing Cycle Length	X	X	X		
CR5A: Ongoing Monitoring and Interventions	X	X	X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
CR6A: Actions Against Practitioners	X	X	X		CO responsibility S&P component, even if delegated
CR7A: Review and Approval of Provider	X	X	X		
CR7B: Medical Providers	X	X	X		
CR7D: Assessing Medical Providers	X	X	X		
CR1C: Performance Monitoring for Re-Credentialing (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR1D: Contracts Opt-Out Provisions (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR1E: Medicare-Exclusions/Sanctions (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR3D: Hospital Admitting Privileges (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR3E: Facility Site Review (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR3F: Enrollment & Screening (DHCS APL 17-019)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR3G: Review of Performance Information -Recred (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR5B: Monitoring Medicare opt Out (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR5C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	*X*	*X*	*X*		*DHCS Requirement*

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2019 Medi-Cal Delegation Grid "Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
CR6B: Appeals Process for Termination/Suspension (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR9A: ID of HIV/AIDS Specialists: Written Process	*X*	*X*	*X*		*DHCS Requirement*
CR9B: ID of HIV/AIDS Specialists: Evidence of Implementation	*X*	*X*	*X*		*DHCS Requirement*
CR9C: ID of HIV/AIDS Specialists: Distribution of Findings	*X*	*X*	*X*		*DHCS Requirement*
RR1A: Rights and Responsibility Statement	X				
RR1B: Distribution of Rights Statement	X				
RR2A: Policies and Procedures for Complaints	X		X		CO responsibility S&P component, even if delegated
RR2B: Policies and Procedures for Appeals	X		X		CO responsibility S&P component, even if delegated
RR3A: Subscriber Information	X				
RR3B: Interpreter Services	X	X	X		
MEM1B: Functionality: Telephone Requests	X	X	X		
MEM2A: Pharmacy Benefit Information: Website	X		X	X	PBM delegate possibility for Factors 6-8
MEM2B: Pharmacy Benefit Information: Telephone	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
MEM2C: QI Process on Accuracy of Information	X		X		
MEM2D: Pharmacy Benefit Updates	X		X		
MEM3A: Functionality: Web Site	X		X		CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
MEM3B: Functionality: Telephone	X	X	X		
MEM3C: Quality and Accuracy of Information	X	X	X		HN For telephone only
MEM3D: E-Mail Response Evaluation	X		X		
MEM4A: Supportive Technology	X		X		

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CalOptima Population Health Management (PHM) Strategy

PHM Strategy Description [PHM1 A]

BACKGROUND

Who We Are

Orange County is unique in that it does not have county-run hospitals or clinics. CalOptima was created in 1993 by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County, and is the largest COHS nationwide. As a public agency, CalOptima is governed by a Board of Directors with voting members from the medical community, business, county government and a CalOptima member. CalOptima's mission is to provide members with access to high quality health services delivered in a cost-effective and compassionate manner.

CalOptima contracts with the State of California Department of Health Care Services (DHCS) to arrange and pay for covered services to Medi-Cal members, and also contracts with the Centers for Medicare & Medicaid Services (CMS) for Medicare-reletad programs. As of October 2018, CalOptima's total membership is more than 775,000, which includes members in Medi-Cal; a Medicare Advantage SNP; a Cal MediConnect Plan (Medicare-Medicaid); and the Program for All-Inclusive Care for the Elderly (PACE).

Medical services are delivered to CalOptima's Medi-Cal members through a variety of contractual arrangements. As of May 2018, CalOptima contracts with 13 health networks, including four Health Maintenance Organizations (HMOs), three Physician/Hospital Consortia (PHCs) composed of a primary medical group and hospital, and five Shared Risk Medical Groups (SRGs). CalOptima is able to fulfill its mission in Orange County because of its successful partnership with its outstanding providers.

Intent

CalOptima has a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe,

effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

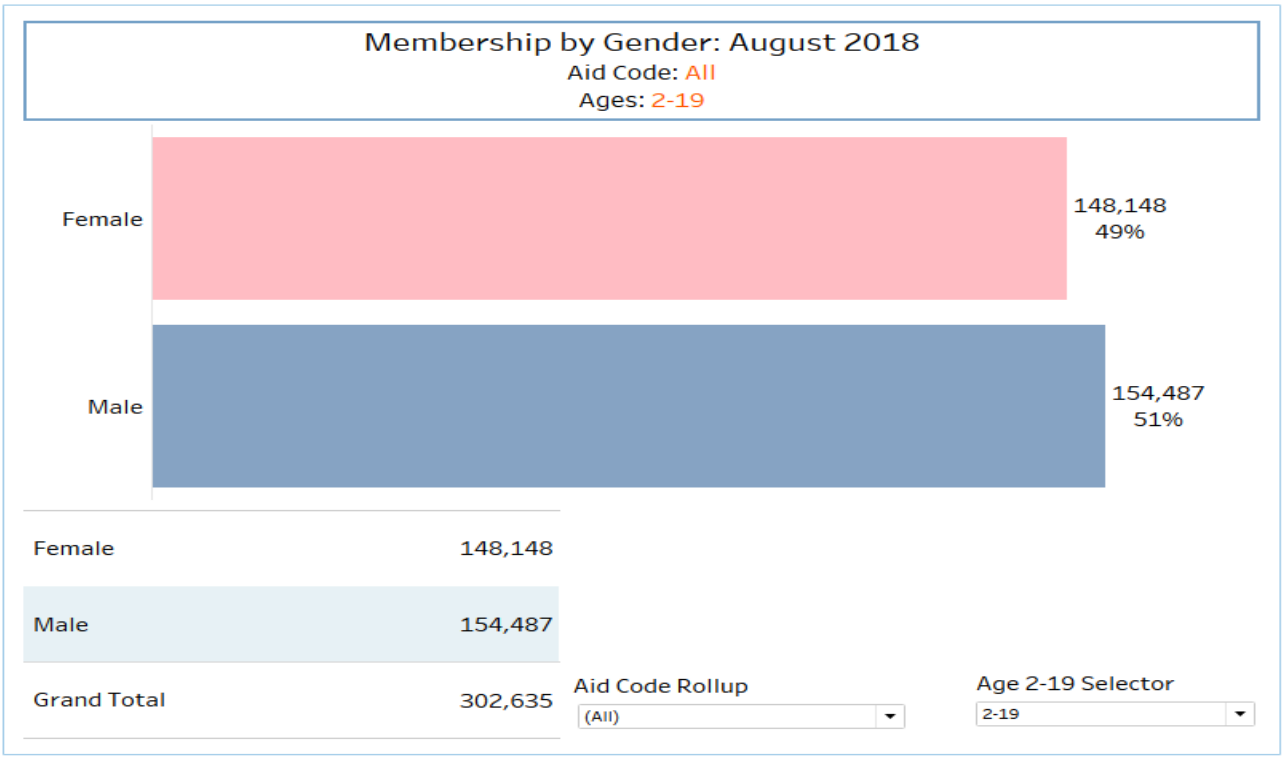
- **CalOptima's Target Population**
  - **Population Identification [PHM2]**
    - CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. The PHM plan of action addresses the unique needs and challenges of specific ethnic communities, including economic, social, spiritual, and environmental stressors, to improve health outcomes. The PHM plan of action, as part of the Quality Improvement (QI) Work Plan, is updated annually through the comprehensive annual QI Program Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflects the changing demographics and local population needs of the Orange County community. Since CalOptima members represent 25% of Orange County residents, other examples of external reports used to help identify trends that may impact CalOptima population are identified below.
      - The 2016 Orange County Community Indicators Report
      - The 2017 Conditions of Children in Orange County Report
      - Children eligible for California Children's Services (CCS) Report from the county CCS Program
      - Prenatal Notification Report (PNR)
  - **Data Integration [PHM2 A]**
    - CalOptima integrates multiple internal and external data sources in its data warehouse to support population identification and various PHM functions. Some examples of internal and external data sources are:
      - Member data from the Department of Health Care Services (DHCS)
      - Medical and Behavioral claims from DHCS and Orange County Health Care Agency (OC HCA) Mental Health inpatient claims
      - Encounters data from contracted health networks
      - Pharmacy claims
      - Laboratory claims and results from Quest and LabCorp
      - Other advanced data sources (e.g., member data of homeless status from Illumination Foundation, Regional Center of Orange County, Utilization Management (UM) authorization data, and qualitative data from health appraisals)

- **CalOptima Population and Sub-Population Segments [PHM2 B]**
  - In addition to external data sources, CalOptima leverages Tableau, an enterprise analytic platform, for segmenting and stratifying our membership, including the subsets to which members are assigned (e.g. high-risk pregnancy, multiple inpatient admissions, co-morbid conditions, disabilities, polypharmacy, high risk and high cost cases, transgender population etc.). The Enterprise and Quality Analytics departments provide standard and ad hoc reports specifying the numbers of members in each category and the programs or services for which they are eligible.

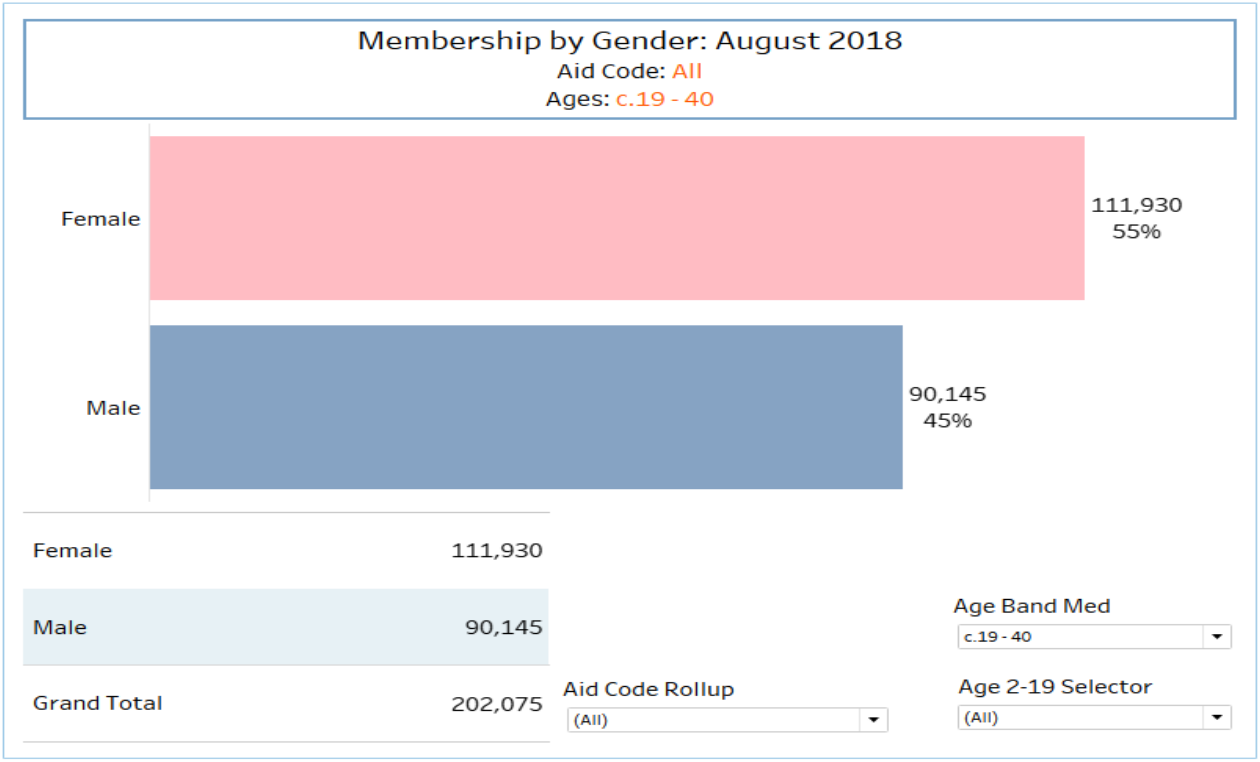
    Example of Member Segmentation – *Source: Tableau_f_dx_v33_m95_08.24.18*

  - *By Age and Gender*

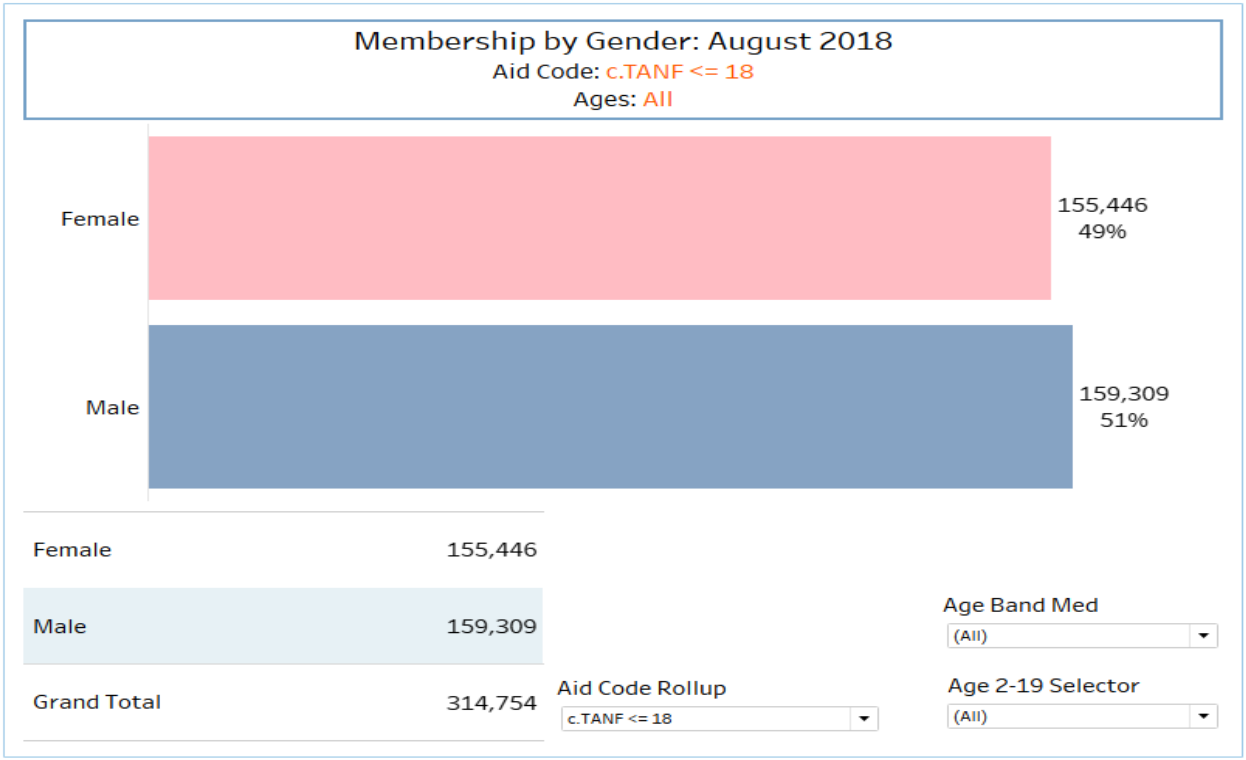
    - *Ages 2–19*



- *Adults 19–40*

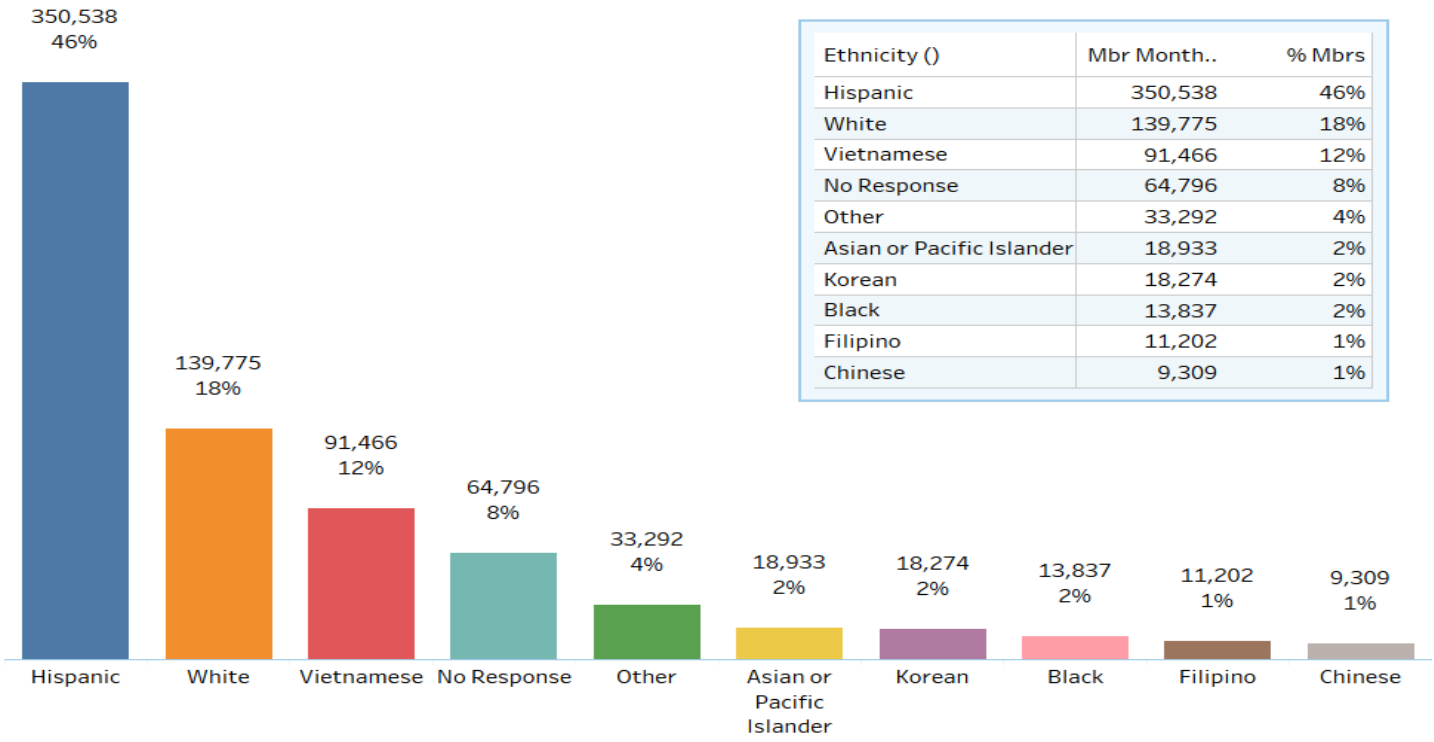


- *TANF (<18 Non-SPD)*



- *Ethnicity*

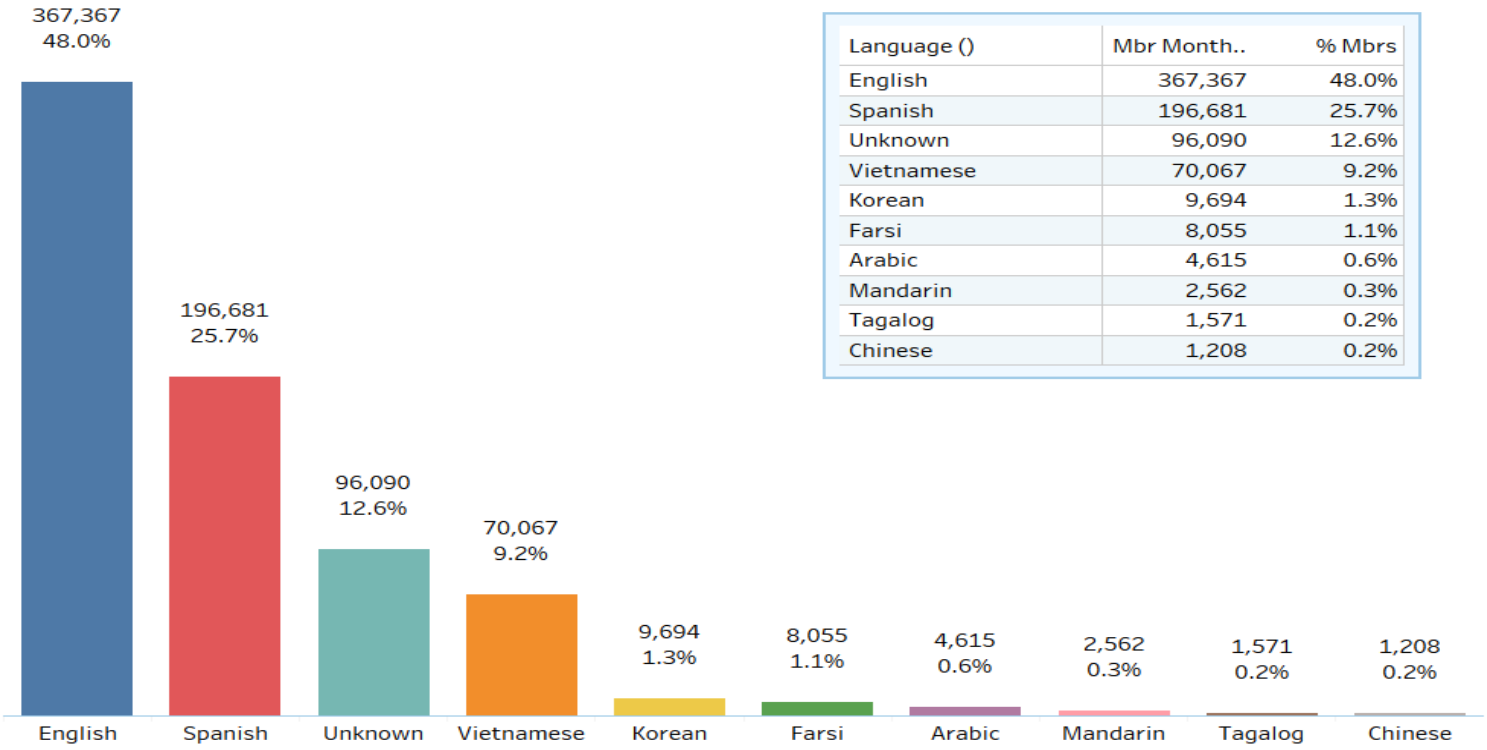
CalOptima Top Ten Member Ethnicities
Aid Code: All
Ages: All
Total Members: 764,774



Ethnicity ()	Mbr Month..	% Mbrs
Hispanic	350,538	46%
White	139,775	18%
Vietnamese	91,466	12%
No Response	64,796	8%
Other	33,292	4%
Asian or Pacific Islander	18,933	2%
Korean	18,274	2%
Black	13,837	2%
Filipino	11,202	1%
Chinese	9,309	1%

- *Language*

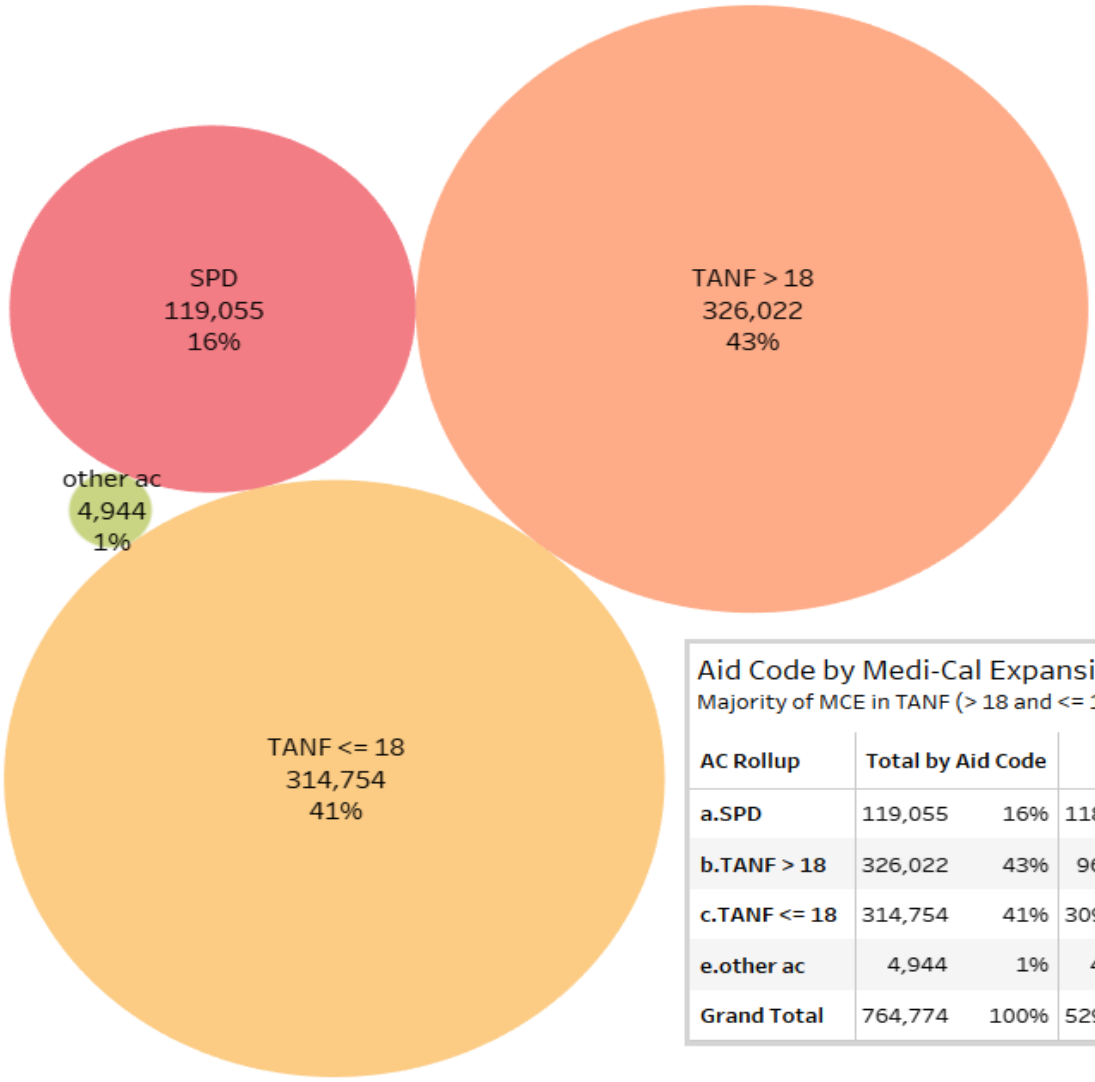
CalOptima Top Ten Member Languages
Aid Code: All
Ages: All
Total Members: 764,774



Language ()	Mbr Month..	% Mbrs
English	367,367	48.0%
Spanish	196,681	25.7%
Unknown	96,090	12.6%
Vietnamese	70,067	9.2%
Korean	9,694	1.3%
Farsi	8,055	1.1%
Arabic	4,615	0.6%
Mandarin	2,562	0.3%
Tagalog	1,571	0.2%
Chinese	1,208	0.2%

- *By Aid Code*

Membership by Aid Code: August 2018

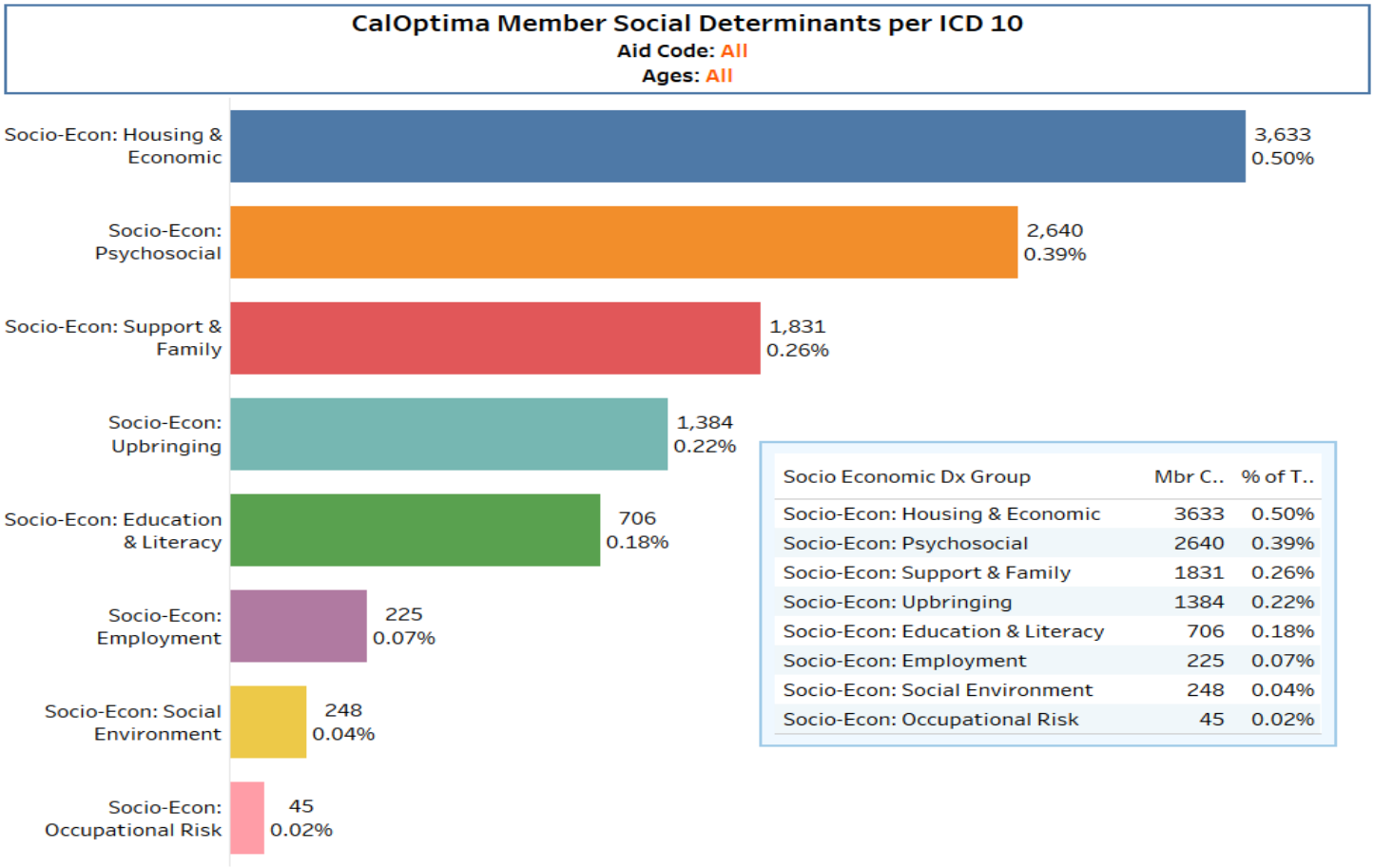


Aid Code by Medi-Cal Expansion (MCE)

Majority of MCE in TANF (> 18 and <= 18) aid codes

AC Rollup	Total by Aid Code		Not MCE		MCE	
a.SPD	119,055	16%	118,657	22%	398	0%
b.TANF > 18	326,022	43%	96,110	18%	229,912	98%
c.TANF <= 18	314,754	41%	309,583	58%	5,171	2%
e.other ac	4,944	1%	4,944	1%		
Grand Total	764,774	100%	529,294	100%	235,481	100%

- *Social Determinants*



Socio Economic Dx Group	Mbr C..	% of T..
Socio-Econ: Housing & Economic	3633	0.50%
Socio-Econ: Psychosocial	2640	0.39%
Socio-Econ: Support & Family	1831	0.26%
Socio-Econ: Upbringing	1384	0.22%
Socio-Econ: Education & Literacy	706	0.18%
Socio-Econ: Employment	225	0.07%
Socio-Econ: Social Environment	248	0.04%
Socio-Econ: Occupational Risk	45	0.02%

➢ **Other Sub-Populations**
- Women during pregnancy
- Children with obesity
- Children with California Children's Services (CCS) eligible condition
- Children and adults with autism
- Adult with disability and chronic conditions
- Persons with substance abuse disorder
- Persons requiring organ transplants
- Person with multiple chronic conditions and homelessness
- Frail elderly adults at risk for institutional care
- Transgender population
- Persons at end of life

❖ **Population Assessment [PHM2 B]**

➢ CalOptima conducts an annual population health risk assessment through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, member experience surveys in all threshold languages by Health Networks, members complaints and grievances trends, and

inpatient utilization trends. To date, CalOptima serves eligible Medi-Cal beneficiaries from birth to 111 years of age! CalOptima serves a broad spectrum of population with health care needs from the cradle to the grave. Our population segments include well infants, children, adolescents, young adults, pregnant mothers, children with disabilities, children with CCS conditions, well adults, adults with chronic conditions and disabilities, members with serious and persistent mental illness (SPMI), well seniors, frail elderly with deteriorating functional status, and members residing in long-term care (LTC) facilities. The sub-populations include, but are not limited to, populations with health disparities due to race and ethnicity, transgender identity, food insecurity, and homelessness. As the Orange County demographic assessment changes every five years, CalOptima conducts a comprehensive Member Health Needs Assessment of Orange County residents to assess the characteristics and needs of the member population in the community we serve.

2019 PHM STRATEGY

- **Strategies to Keep Members Healthy [PHM1 A Factor 1, 2]**
  - **Bright Steps — Improve Prenatal and Postpartum Care**
    - **Goal:** Demonstrate significant improvement in prenatal and postpartum care rates to achieve 90th percentile by December 2020
      - Improve 2018 HEDIS Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
      - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
    - **Target Population:** Members in the first trimester of pregnancy newly identified through the pregnancy notification form.
    - **Description of Programs or Services:** CalOptima contracts with certified Comprehensive Perinatal Service Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Bright Steps is designed to support CalOptima Medi-Cal moms through a healthy pregnancy and postpartum care. Annually the program will be evaluated for increased Prenatal and Postpartum Care (PPC) HEDIS rate, reduced rates for neonatal intensive care unit usage, reduced number of low birth weights and preterm births, and member satisfaction with the program.
    - **Activities:** CalOptima staff provide member outreach and coordination with CPSP providers. In areas with limited CPSP providers, CalOptima staff will provide direct health education and support program interventions aligned with the CPSP guidelines.

  - **Shape Your Life — Prevent Childhood Obesity**

- **Goal:** Maintain 2018 HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures year-over-year
  - BMI Percentile (WCC)
  - Counseling for Nutrition (WCC)
  - Counseling for Physical Activity (WCC)
- **Target Population:** Members age 5-18 with a Body Mass Index (BMI) equal to or above the 85th percentile.
- **Description of Programs or Services:** CalOptima's Shape Your Life health education and physical fitness activity program aims to increase youth member access to weight management program(s), increase doctor/patient communication regarding healthy weight and nutrition and physical activity counseling, and increase member nutrition and physical activity knowledge and improve behaviors. Annually the program will be evaluated for program effectiveness. Measurement goals include pre/post BMI, knowledge gains (pre/post validated survey) and member satisfaction with program.
- **Activities:** The program uses the licensed Kids-N Fitness curriculum which is evidenced-based and validated through Children's Hospital Los Angeles. Interventions includes up to 12 group classes, which include nutrition education and physical activity, and an incentive for a follow up visit with provider after 6 consecutive classes. All classes are conducted in members' community using appropriate threshold language of the participants.

❖ **Strategies to Manage Members with Emerging Risk [PHM1 A Factor 1,2]**

➢ **Health Management Programs — Improving Chronic Illness Care Prevention and Self-Management**

- **Goals:** Develop chronic illness program interventions to support improvements in HEDIS and Member Experience scores
  - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP), and Comprehensive Diabetes Care (CDC)
  - Increase overall Member Satisfaction by improving Rating of All Health Care to 90th Percentile by 2021
  - Reduce ED and IP rates by 3% for program participants in 2018
- **Target population:** Members discovered to be at risk for Asthma, Diabetes and/or Heart Failure based on primary care physician referral, new diagnosis codes, or pharmacy claims. Specific criteria detailed below.

- Members > 3 (Asthma); Members > 18 (Diabetes, Heart Failure) for Medi-Cal, OneCare, and OneCare Connect line of business
- Two year look back period for Asthma, Diabetes, or Heart Failure Related Utilization
- Exclusion Criteria:
  - Ineligible CalOptima Members
  - Members Identified for LTC or diagnosed with Dementia
  - Members Delegated to Kaiser

- **Description of Programs or Services:** CalOptima's Health Management Programs focus on disease prevention and health promotion for members with Asthma, Diabetes and Heart Failure. Health Management Programs are designed to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention. To assess the effectiveness of each Health Management Program, measures are set annually against organization or national benchmark standards. The evaluation takes into consideration program design, methodology, implementation and barriers to provide an analysis with quantitative and qualitative results for CalOptima's population with chronic illness. Measurement goals for each program include improvement in HEDIS measures related to the chronic conditions managed, reduced IP/ED for members with chronic illness, and member satisfaction with health management program.
- **Activities:** Health education using evidence-based clinical practice guidelines and self-management tools, relevant to members for the provision of preventive, acute, or chronic, medical services and behavioral health care services standards and requirements. *(Refer activities list in Policies and Procedures GG.1211.)*

➢ **Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction**

- **Goal:** Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
- **Target Population:** Members with diagnosis of opioid substance abuse disorder
- **Description of Programs or Services:** A multi-departmental and health collaborative aim at reducing opioid misuse and related death.
- **Activities:** Includes, but is not limited to, pharmacy lock-in program, physician academic detailing for safer prescribing, increased access to Medication Assisted Treatment (MAT), and case management outreach.

❖ **Strategies to Ensure Patient Safety [PHM1 A Factor 1,2]**

- **Behavioral Health Treatment (BHT) Services**
  - **Goal:** Establishing baseline
  - **Target Population:** Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age, as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.
  - **Description of Programs or Services:** Provide medically necessary BHT services to children with Autism Spectrum Disorder through early identification and early intervention in collaboration with the parents to promote optimal functional independence before aging out of the Regional Center system. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
  - **Activities:** Treatments include direct observation, measurement, and functional analysis of the relations between environment and behavior of children with ASD.

- **Practice Facilitation Team — Improve Practice Health & Safety Leveraging the QI Practice Facilitators Team**
  - **Goals**: Achieve and sustain 100% compliance in all Facility Site Review (FSR) audits year-over-year for primary care practices.
  - **Target Population:** Medi-Cal adults and children accessing primary care.
  - **Description of Programs or Services:** Enhancing the existing FSR nursing function by training nurses in QI facilitation skills to address any gaps from FSR audits to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Networks (CCN).
  - **Activities:** CalOptima will develop Practice Facilitator functions for the FSR nurses to identify opportunities to improve practice site health and safety, and provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. CalOptima will coordinate with the community clinics, Federally Qualified Health Centers (FQHC), and eventually expand to other potential settings such as PACE to promote patient safety practices.

  - **Activities:** Collaborate with Health Networks' Transition of Care Home Visit Team, and/or community home health agencies to complete medication reconciliation during home visits post discharge.

- **Strategies to Manage Members with Multiple Chronic Illnesses [PHM1 A Factor 1,2]**

- **Whole-Child Model — Ensure Whole-Child-Centric Quality and Continuity Care for Children with CCS Eligible Conditions**
  - **Goal:** Improve Children and Adolescent Immunization HEDIS measures by 10% from the 2018 baseline by December 2020 (excluding children and adolescent under cancer treatment)
    - Improve Childhood Immunization Status Combo10 for Children with CCS eligible conditions to ≥37.0% (2018 Baseline = 33.3 %)
    - Improve Immunization for Adolescents with CCS eligible conditions to ≥ 50.0% (2018 Baseline = 45.33%)
  - **Targeted Population:** Children with CCS Eligible Conditions
  - **Description of Programs or Services:** The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results. Currently, children who have CCS-eligible diagnoses are enrolled in and get care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions, routine care and preventive health. Beginning July 1, 2019, Orange County Medi-Cal CCS eligible children will receive services for both CCS and non-CCS conditions from CalOptima. Children whose CCS care will be transitioning under WCM to CalOptima on July 1, 2019, are referred to as Transitioning WCM members.
    Activities: CalOptima identifies children with potentially eligible CCS conditions. Upon confirmation of CCS Program eligibility, CalOptima assigns a Personal Care Coordinator (PCC) to each Member. The PCC assists the members and family to navigate the health care system, accessing high quality primary care providers, CCS-paneled specialists, care centers and Medical Therapy Units. The primary goal is facilitation of timely, appropriate health care and coordination among the health care team, especially including the member and family.

- **Health Home Program (HHP) — Improve clinical outcomes of members with multiple chronic conditions and experiencing homelessness**
  - **Goal:** Establishing baseline measures in 2018
    - Member Engagement Rate
    - Inpatient Readmissions
    - Emergency Department (ED) Visits
  - **Target Population:** DHCS identified list of *highest risk 3-5 % of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria:*
    - Specific combination of physical chronic conditions and/or substance use disorder (SUD) or specific serious mental illness (SMI) condition;

- Meet specified acuity/complex criteria
- Eligible members consent to participate and receive Health Home Program services.

- **Description of Programs or Services:** A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- **Activities:** Core services as defined by DHCS are detailed below.
    - Comprehensive care management
    - Health promotion
    - Care coordination
    - Individual and family support services
    - Comprehensive transitional care
    - Referral to community and social support services
    - Other new services
        - Accompany participants to critical appointments
        - Provider housing navigation services for members experiencing homelessness
        - Manage transition from non-hospital or nursing facility settings, such as residential treatment programs
        - Trauma informed care

❖ **PHM Activities and Resources [PHM 1A Factor 3]**

➢ CalOptima will use our annual population assessment to review and update our PHM structure, activities and resources. The annual population assessment helps CalOptima to set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity, and proactively mitigate emerging risk, such as partnering with Orange County Health Care Agency to address social determinants that adversely impacting the health and wellness of the CalOptima member population and relevant sub-populations. CalOptima actively seeks out community partners and leverages the Inter-Government Transfer (IGT) funds to support community collaborations.

➢ As the various health care sectors adopt technology to address the changing demographic of the population and bring needed care to members in non-traditional ways, CalOptima will be exploring the feasibility of advancing our mission to provide members with access to quality health care services leveraging advanced virtual technology. In order to bring timely care and services to a broader population, CalOptima will explore the feasibility of leveraging telehealth usage in cases ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in members' homes. CalOptima plan to seek the IGT funding to demonstrate the feasibilities of innovative telehealth approaches in Medi-Cal via pilot.

- **Expanding Strategies to Inform Members Leveraging Technology [PHM1 A5, PHM B]**
  - CalOptima deploys multiple methods for informing members about PHM programs and services. Based on the members' language preferences, members are informed of various health promotion programs, and how to contact Care Management, via the initial Member Packet in the mail, CalOptima website, personal telephone outreach or Robo calls, in person, and by email. One of the PHM strategies to support members age 19–40 is to develop telehealth technology enhanced methods of informing members, such as text or other mobile applications.
  - CalOptima PHM programs are accessible to eligible Orange County Medi-Cal beneficiaries who meet the PHM program criteria.
  - CalOptima provides instruction on how to use these services in multiple languages and at appropriate health literacy levels.
  - CalOptima honors member choice; hence, all the PHM programs are voluntary. The members can decline the program or opt out any time.

- **Delivery System for Practitioner/Provider Support [PHM3 A]**
  - **Information Sharing**
    - CalOptima Provider Relations and QI departments provide ongoing support to practitioners and providers in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids and continuing education sessions, and providing comparative quality and cost information. CalOptima will continue to improve information sharing with Health Network providers using integrated and actional data.
  - **Practice Transformation Technical Assistance (New Idea)**
    - One of the PHM strategies is to offer practice transformation support through Lean QI training, practice site facilitations and/or individualized technical assistance to improve member experience.
  - **Provider Coaching and Leadership Development (New Idea)**
    - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices and the top 30 providers with high volume grievances and potential quality of services issues.
    - Allocate one scholarship to sponsor community clinic physician leadership development through the California Health Care Foundation (CHCF) Health Care Leaders Fellowship.
  - **Pay for Value [PHM3 B]**
    - CalOptima already incentivizes providers based on quality performance in its directly contracted CalOptima Community Network (CCN) and the contracted Health Networks.

- **Population Health Management Impact [PMH 6]**

- **Measuring Effectiveness**
  - CalOptima annually conducts a comprehensive analysis of the PHM strategy's impact and effectiveness as part of the annual QI Program evaluation. The comprehensive analysis includes quantitative results for relevant clinical, cost, utilization, and qualitative member experience. CalOptima regularly compares its performance results with external benchmarks and internal goals. The results are reviewed and interpreted by the interdisciplinary through various QI Committees. Given the capability of Tableau, an enterprise analytic platform, CalOptima has the capability to conduct longitudinal QI Program Evaluation to ensure sustained effectiveness year over year.
- **Improvement and Action**
  - Based on the annual PHM program evaluation using internal and external data, CalOptima annually updates its QI Work Plan to improve CalOptima's PHM program and act on at least one opportunity for improvement within each of the quality domains (e.g., Member Experience, Effectiveness of Care, Provider Satisfaction, and Clinical Affordability) to achieve the Quadruple Aim.

***APPENDICES**:*

2018 NCQA PHM Standards

2019 Quality Improvement Program and QI Work Plan

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Betsy Chang Ha, RN, MS, LSS MBB
Executive Director, Quality & Population Health Management

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2019 QI Program Description Revisions

- Simplified description of Scope of Services for each line of business
- Updated the new program initiatives
  - Whole-Person Care (WPC)
  - Whole-Child Model (WCM)
  - Health Homes Program (HHP)
  - Population Health Management (PHM)
- Updated QI Program purpose to include Population Health accountability, annual review and acceptance process
- Update Authority, Board of Directors' — Quadruple Aim

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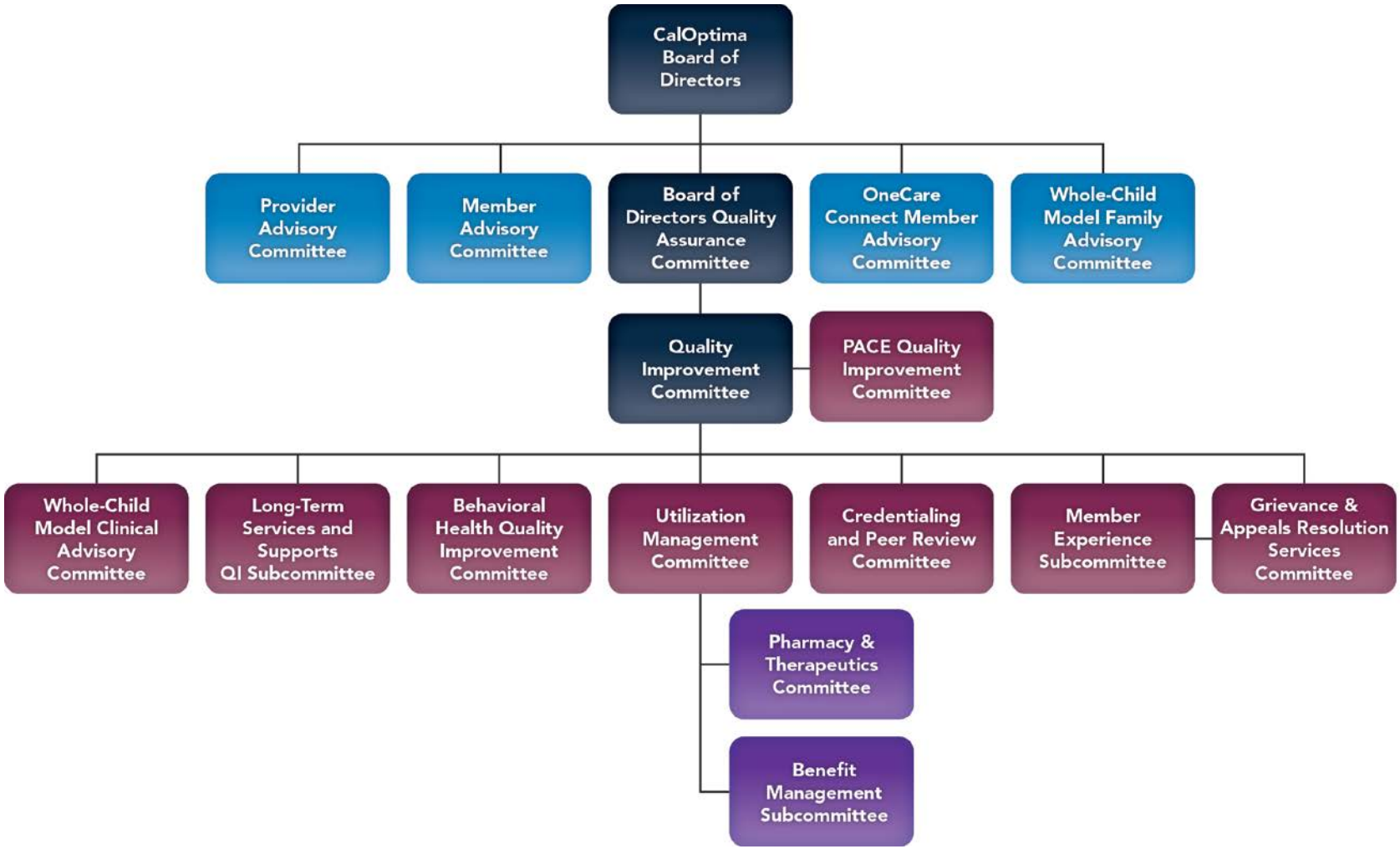
2019 QI Program Description Revisions (cont.)



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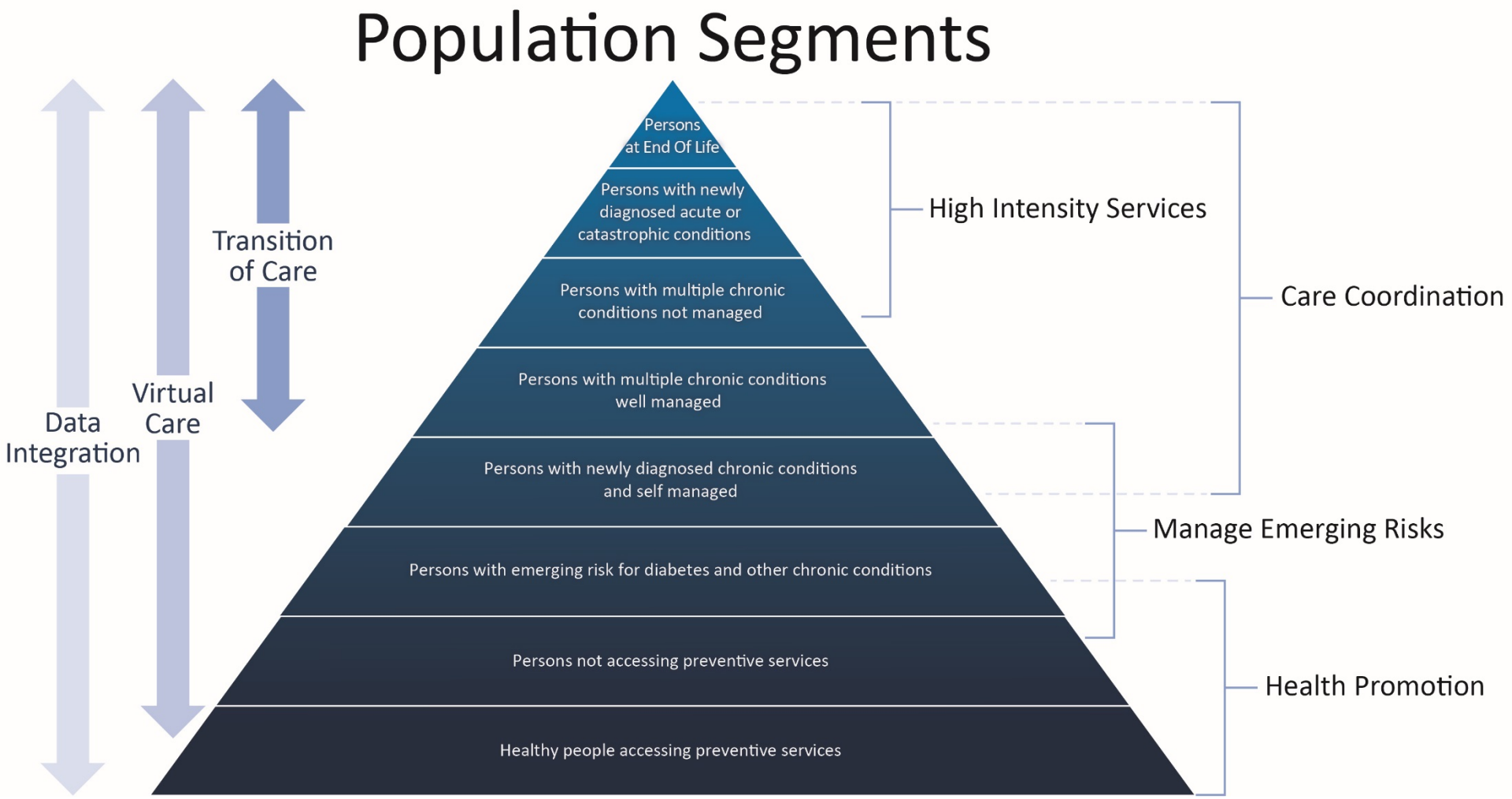
2019 QI Program Description Revisions (cont.)



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2019 QI Program Description Revisions (cont.)

- Established 2019 QI Goals and Objectives
  - Goal 1: Improve NCQA rating as the #1 Medi-Cal Health Plan in California, moving from 4.0 to 4.5 rating by 2021
  - Goal 2: Improve CalOptima Community Network (CCN) performance ranking to #3 among all health networks
  - Goal 3: Improve Member Experience from 25th percentile to exceed 50th percentile by 2020
- Developed 2019 QI Work Plan (Appendix A)

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2019 QI Program Description Revisions (cont.)

- Other revisions
  - Methodology — Introduced lead and lag measures
  - Communication of QI Activities to include Quality Forum
  - Staff responsibility and positions updated
  - QI Lean Training Curriculum added to CalOptima University in 2019
  - Include de-Credentialing to Corrective Action Plans
  - Added new sections: PHM, Long-Term Services and Supports, and Behavioral Health Integration
  - Added Group Needs Assessment and PHM to Safety section
  - Added Chinese and Arabic to C&L services

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2019 QI Program Description Revisions (cont.)

- Updated Delegated and Non-Delegated Activities (Appendix B)
  - Changed pre-delegation review to Readiness Assessment
  - PHM program renamed from Disease Management or Chronic Care Improvement Program
  - Renumbered based on 2018 Standards

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2019 QI Work Plan (Appendix A)

- QI Work Plan measures aligned with 2019 QI Goals and Objectives
- Utilize SMART goals incorporating both lag and lead measures in Work Plan
- Clinical Measures organized by populations:
  - Adult Health — Mental
  - Adult Health — Physical
  - Child/Adolescent Health
  - Chronic Conditions
  - Maternal Child Health

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2019 QI Work Plan (Appendix A) (cont.)

- Carried over measures that did not meet goals in 2018, and includes measures requiring extra focus and attention
- Includes measures for Safety of Clinical Care, Quality of Service and Member Experience
- Removed maintenance of business goals on the Work Plan, measures tracked in other areas, and measures that are performing well
- Reduced from 124 in 2018 to less than 40 in 2019

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Approval of the 2019 CalOptima Utilization Management Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400

Recommended Action

Recommend approval of the 2019 Utilization Management (UM) Program.

Background

Utilization Management activities are conducted to ensure that members' needs are always at the forefront of any determination regarding care and services. The program is established and conducted as part of CalOptima's purpose and mission to ensure the consistent delivery of medically necessary, quality health care services. It provides for the delivery of care in a coordinated, comprehensive and culturally competent manner. It also ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does the program encourage decisions that result in underutilization. Additionally, the Utilization Management Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") must be reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes processes for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2019 UM Program Description to ensure that it is aligned to reflect health network and strategic organizational changes. This will ensure that all regulatory and NCQA accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

Discussion

The 2019 Utilization Management Program is based on the Board-approved 2018 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

The revisions are summarized as follows:

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1. Aligned program descriptions and committee references with the Quality Management Program and approved committee charter updates.
2. Updated program to reflect the transition of California Children's Services program to the Whole Child Model program effective July 1, 2019.
3. Included a description of the Health Homes program and CalOptima's implementation plan.
4. Included a description of CalOptima's Population Health Management strategy for 2019.
5. Updated description of responsibilities for various key positions.
6. Modified reference to CalOptima's health networks to reflect changes in participating networks since 2018.

The recommended changes are designed to better review, analyze, implement and evaluate the components of the UM Program, and are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact
There is no fiscal impact.

Concurrence
CalOptima Utilization Management Subcommittee
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
1. Proposed 2019 Utilization Management Program
2. PowerPoint Presentation to the Board of Directors' Quality Assurance Committee: 2019 Utilization Management Program Description

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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2019~~8~~ UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

20189 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Francesco Federico, M.D. **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Paul Yost, M.D. **Date**

Board of Directors Chair:

_____ _____

Paul Yost, MD **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision
To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all ~~our~~ members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, Quality Assurance Committee and Finance and Audit Committee meetings are open to the public.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
-
-
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
CalOptima's 2017–19 Strategic Plan honors our long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.
-

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is ~~unique~~ unusual in that **IT IS** both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optional health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources and expertise
- Ensure transparency in our governance procedures**,** including providing opportunities for stakeholder input
- Be accountable for the decisions we make

WHAT WE OFFER~~:~~

Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49% ~~percent~~ between 2014 and 2016!

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

~~Acupuncture~~	~~Hospice care~~	~~Outpatient mental health services – limited~~
~~Adult preventive services~~	~~Hospital/inpatient care~~	~~Pediatric preventive services~~
~~Community based adult services~~	~~Immunizations~~	~~Child health and disability prevention (CHDP)~~
~~Doctor visits~~	~~Laboratory services~~	~~Physical therapy~~
~~Durable medical equipment~~	~~Limited allied health services~~	~~Prenatal care~~
~~Emergency care~~	~~Medical supplies~~	~~Specialty care services~~
~~Emergency transportation~~	~~Medications~~	~~Speech therapy~~
~~Non-emergency medical transportation (NEMT) and non-medical transportation (NMT)~~	~~Newborn care~~	~~Substance use disorder preventive services – limited~~
~~Hearing aid(s)~~	~~Nursing facility services~~	~~Vision care~~
~~Home health care~~	~~Occupational therapy~~	

Certain services are not covered by CalOptima, ~~or~~ but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

- Eligible conditions under California Children's Services (CCS) ~~will be covered by the CCS program through June 30, 2019. Beginning~~Effective July 1, 2019 or such later date as the program becomes effective, this program ~~eligible conditions under California Children's Services (CCS)~~ will be ~~covered~~managed by CalOptima ~~under~~through the Whole--Child Model (WCM) Program.
-
-

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management (UM) Program and Case Management (CM) Programthe Population Health Management (PHM) Strategy .

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through as special programs, such as the services through CalOptima's Mmember Lliaisons program, and through specific Memoranda of Understanding (MOU) with certain community agencies, including OC HCA, CCS (through June 30, 2019, or such later date as the Whole Child Model becomes affective) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)
-

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for the dual eligible members, enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for OCC.

Scope of Services

In addition to the comprehensive scope of acute and preventive care services covered under Medi-Cal and Medi-Care benefits, CalOptima OC members are eligible for enhanced services such as

transportation to medical services and gym membership.~~OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.~~

~~These services include but are not limited to the following:~~

~~Acupuncture and other alternative therapies~~	~~Gym membership~~	~~Prescription drugs~~
~~Ambulance~~	~~Hearing services~~	~~Preventative care~~
~~Chiropractic care~~	~~Home health care~~	~~Prosthetic devices~~
~~Dental services – limited~~	~~Hospice~~	~~Renal dialysis~~
~~Diabetes supplies and services~~	~~Inpatient hospital care~~	~~Skilled nursing facility~~
~~Diagnostic tests, lab and radiology services, and X-rays~~	~~Inpatient mental health care~~	~~Transportation for medical and pharmacy visits~~
~~Doctor visits~~	~~Mental health care~~	~~Urgently needed services~~
~~Durable medical equipment~~	~~Outpatient rehabilitation~~	~~Vision services~~
~~Emergency care~~	~~Outpatient substance abuse~~	
~~Foot care~~	~~Outpatient surgery~~	

OneCare Connect

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, ~~and enhanced dental benefits~~ and an out of the country urgent/emergency care benefit.~~.~~ Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results is a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute and preventive care services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care and gym benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

~~Acupuncture (pregnant women)~~	~~Hearing aids – limited~~	~~Rehabilitation services~~
~~Ambulance services~~	~~Hearing screenings~~	~~Renal dialysis~~
~~Case management~~	~~Incontinence supplies – limited~~	~~Screening tests~~
~~Chiropractic services~~	~~Inpatient hospital care~~	~~Skilled nursing care~~
~~Community-based adult services (CBAS)~~	~~Inpatient mental health care~~	~~Specialist care~~
~~Diabetes supplies and services~~	~~Institutional care~~	~~Substance abuse services~~
~~Disease self-management~~	~~Lab tests~~	~~Supplemental dental services~~
~~Doctor visits~~	~~Medical equipment for home care~~	~~Transportation for medical and pharmacy visits~~
~~Durable medical equipment~~	~~Mental or behavioral health services~~	~~Transgender services~~
~~Emergency care~~	~~Multipurpose Senior Services Program (MSSP)~~	~~Occupational, physical or speech therapy~~
~~Eye exams~~	~~Over-the-counter drugs – limited Prescription drugs~~	~~Urgent care~~
~~Foot care~~	~~Outpatient care~~	~~"Welcome to Medicare" preventive visit~~
~~Glasses or contacts – limited~~	~~Preventive care~~	
~~Gym membership~~	~~Prosthetic devices~~	
~~Health education~~	~~Radiology~~	

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

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in ~~our~~ Orange County ~~service area~~, be determined ~~as~~ to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

~~PACE is a managed care service delivery model 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 program provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support coordinated from a central location. CalOptima currently serves approximately 300 members via the CalOptima PACE center and four (4) operating alternative care settings. Financing for the program is capped, which allows providers to deliver all services participants need rather than limit them to those reimbursable under Medicare and Medicaid fee-for-service plans.~~

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieticians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for participants, based on their needs as indicated by the Interdisciplinary Team.~~

PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

NEW PROGRAM INITIATIVES ~~ON OUR HORIZON~~

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by Department of Health Care Services (DHCS) as part of California's Medi-Cal 2020 strategic plan. In Orange County, the pilot is being

led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC Connect information sharing platform was launched in November 2018. For 2019 the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole--Child Model ~~(WCM)~~

CCS is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. In Orange County, OC HCA manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

Through SB 586, the State has required CCS services to become a Medi-Cal managed care plan benefit in select counties. The goal is to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. This approach is known as the Whole-Child Model (WCM). Under this model, in Orange County, eligibility determination processes and the Medical Therapy Program will remain with OC HCA, while other CCS program components are transferred to CalOptima. CalOptima had originally expected to launch WCM effective January 1, 2019, but recently DHCS delayed the WCM implementation in Orange County, and the new implementation date is now no sooner than July 1, 2019. ~~No sooner than July 1, 2019, CalOptima shall assume responsibility for CCS for CalOptima Members who are eligible for the California Children's Services (CCS) Program, and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions. CalOptima and CalOptima's delegated Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, which include authorization activities, claims processing and payment, case management, and quality oversight and coordination of all Medi-Cal and CCS-covered services, as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), for enrolled Members.~~

Health Homes Program (HHP)

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implement HHP in the following two phases: July 1, 2019 for members with chronic physical conditions or substance use disorders (SUD), and January 1, 2020 for members with serious mental illness or Serious Emotional Disturbance (SMI).

DHCS is targeting the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. DHCS will send a targeted engagement list of members to CalOptima for review and outreach, as appropriate. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions; and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima will be the Lead Administrative Entity and is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary health home providers. In addition to CalOptima's Community Network, some HNs may serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
   - Referral to community and social support services~~No sooner that July 1, 2019, CalOptima shall implement the Health Homes Program (HHP) for members with eligible chronic conditions or substance use disorders. The program is designed to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries and will provide six core services:~~
   - ~~Comprehensive care management~~
   - ~~Care coordination (physical health, behavioral health, community based LTSS)~~
   - ~~Health promotion~~
   - ~~Comprehensive transitional care~~
   - ~~Individual and family support~~
   - ~~Referral to community and social support services, including housing~~
6.

Population Health Management (PHM)

CalOptima has developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy includ~~ing~~es a plan of action for addressing our culturally diverse member needs across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards released in July 2018. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

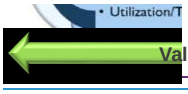
The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March

2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes.

In the first year, the PHM Strategy will be focused on expanding the Model of Care while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus~~,~~ with an integrated model ~~as illustrated below in Figure 1. The PHM Conceptual Model is adapted from the model created by the Association of Community Affiliated Plans~~. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.

~~See Appendix A — 2019 PHM Strategy~~



~~**Whole Person Care**~~

~~Whole Person Care is a five-year pilot established by DHCS as part of California's Medi-Cal 2020 strategic plan and led by the Orange County Health Care Agency. It will focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness.~~

CALOPTIMA'S PROVIDER NETWORKS:

~~WHOM WE WORK WITH:~~

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima ~~health network~~HN, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of ~~15~~ 143 ~~health networks (~~HNs~~)~~, representing more than ~~7,500~~8,3~~4~~00 practitioners.

Health Networks

CalOptima contracts with a variety of HN models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to more than 1,600 Primary Care Providers (PCPs), more than 6,7~~8~~00 specialists, 23 hospitals, 23 clinics and 100 long-term care facilities.

~~**CalOptima Community Network (CCN)**~~

~~The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 14~~ 12 ~~HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th~~ 13th ~~network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.~~

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's ~~MA-D SNP~~OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not ~~health network~~HN eligible.

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

~~**Health Networks**~~

~~CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to more than 1,594~~3 ~~Primary Care Providers (PCPs), nearly 6,092~~ 731 ~~specialists, 30~~ 23 ~~hospitals, and 36~~ 23 ~~community health centers,~~ clinics. ~~and 100 long-term care facilities. New health networks that demonstrate the ability to comply with CalOptima's delegated~~

~~requirements are added as needed with CalOptima Board approval.~~

The following are CalOptima's contracted health networks:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western ~~Health Network~~Medical Group	SRG	SRG	SRG
~~CCN~~			
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage ~~Provider Network Regal~~	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
~~OC Advantage Medical Group~~	~~PHC~~		~~PHC~~
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities
-

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2019

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

Membership Data as of November 30, 2018

Total CalOptima Membership
769,216

Program	Members
Medi-Cal	752,888
OneCare Connect	14,610
OneCare (HMO SNP)	1,423
Program of All-Inclusive Care for the Elderly (PACE)	295

Note: The Fiscal Year 2018-19 Membership Data started on July 1, 2018.

Member Age (All Programs)

11%	0 to 5
30%	6 to 18
29%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
28%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

43%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes to review health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term, and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, National Committee for Quality Assurance (NCQA) Standards and evidence evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse benefit determination is made.
- Identify and refer high-risk members to Care CoordinationCase Management Programs, including Complex Case Management, Long-Term Services and Supports (LTSS), Behavioral Health and/or Health Education & Disease Population Health Management Programsservices as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promotes improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), County Specialty Mental Health and California Children's Services (CCS).

- Educate practitioners and other providers, including delegated ~~Health Networks~~HNs on CalOptima's UM Program, policies and procedures.
- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM p~~P~~olicies and p~~P~~rocedures, ~~;~~ including timeframes outlined in CalOptima's ~~policy~~ policies and procedures. (GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications.)

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent ~~Monthly~~ reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization ~~M Committee~~Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs utilization management activities by the Audit and Oversight ~~D~~department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and ~~state~~ program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

Long-Term Services and Supports

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and ~~community based~~community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the

following levels of care:
    - Nursing Facility Level B
    - Nursing Facility Level A
    - Subacute Adult and Pediatric
    - Intermediate Care Facility ~~/~~ Developmentally Disabled, (ICF/DD)
    - Intermediate Care Facility ~~/~~ Developmentally ~~Disabled~~ Disabled Habilitative, (ICF/DD-H)
    - Intermediate Care Facility ~~/~~ Developmentally ~~Disabled~~ Disabled Nursing, (ICF/DD-N)
- Medical necessity for LTC is evaluated based upon the ~~Department of Health Care Services (~~DHCS~~)~~ Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections~~:~~ 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.

Home and Community ~~-~~ Based Services:

- ~~Community Based Adult Services (~~CBAS~~)~~: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. ~~-~~CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT).
- ~~Multipurpose Senior Services Program (~~MSSP~~)~~: Home and ~~community based~~community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long ~~-~~ term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria.
-

Behavioral Health Services

Medi-Cal ~~Outpatient Behavioral Health Services~~

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services ~~include, but~~include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger that meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.

~~CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits~~

~~including utilization management, claims, credentialing the provider network, member services, and quality improvement.~~

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting ~~Behavioral health services within the scope of practice for primary care physicians (PCPs) include screening, brief intervention, and referral to treatment (SBIRT) services~~ to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary. ~~In addition, PCPs frequently manage the treatment of their patients' mental health conditions.~~

~~If a member needs behavioral health services not provided by their PCP,~~ CalOptima members can access mental~~behavioral~~ health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan. ~~representative for behavioral health assistance. The member will be provided with several behavioral health practitioners contact information, based upon geographic proximity to the member's residence and their clinical needs. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima~~

~~In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).~~

CalOptima ensures members with coexisting medical and mental~~behavioral~~ health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental~~behavioral~~ health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental~~behavioral~~ health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits including utilization management, claims, credentialing the provider network, member services, and quality improvement.

~~OneCare~~ OC and O~~ne~~Care ~~Connect~~CC ~~Behavioral Health Services~~

CalOptima has contracted with Magellan Health Inc. to directly manage the mental health benefits for ~~for the behavioral health services portion of~~ O~~ne~~Care and O~~ne~~Care ~~Connect~~ members. Functions delegated to Magellan include provider network, ~~utilization management~~UM, credentialing, and customer service.

CalOptima O~~ne~~Care and O~~ne~~Care ~~Connect~~ members can access mental~~behavioral~~ health services by calling the CalOptima Behavioral Health Line ~~at 855-877-3885~~. By selecting the O~~ne~~Care or O~~ne~~Care ~~Connect~~ option, the member will be transferred to a Magellan representative for a brief mental health telephonic screening. The screening is to make an initial determination of the

member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within Magellan Health Inc. provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan. ~~behavioral health triage. If office based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.~~

CalOptima offers Alcohol Misuse Screening and Counseling (AMSAC) services ~~at~~in the ~~primary care physician~~~~pcp~~PCP setting~~screening, brief intervention, and referral to treatment (SBIRT) services~~ to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Linkages with Community Resources

In addition, CalOptima provides linkages with community programs to ~~ensure that~~ members with special health care needs, or high risk or complex medical and developmental conditions~~, receive wrap around services that enhance their medical benefits~~. These linkages are established through special programs, such as the CalOptima Community Liaisons, ~~Personal Care Coordinators (~~PCCs~~).~~ Behavioral Health Integration (BHI), Long~~-~~-Term Services and Supports (LTSS) and specific program ~~Contracts~~ contracts and ~~Memoranda of Understanding (~~MOUs~~)~~ with other community agencies and programs, such as the ~~Orange County Heath Care Agency'~~OC HCA's ~~California Children's Services~~CCS, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management ~~and/or Disease Management~~ department~~s~~ to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

~~CalOptima's Utilization Management Program~~Authority, Boards of Directors' Committees, and Responsibilities

~~CalOptima~~ Board of Directors

~~Authority, Responsibility and Accountability~~

The CalOptima Board of Directors has ultimate ~~authority,~~ accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the ~~Chief Executive Officer (~~CEO~~)~~ and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. CalOptima promotes ~~The Board of Directors~~ promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the Chief Medical Officer (CMO). Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the ~~Utilization Management Committee (~~UMC~~)~~, the ~~Quality Improvement Committee (~~QIC~~)~~ and the ~~Quality Assurance Committee (~~QAC~~)~~ on an annual basis.

Role of CalOptima Officers for Quality Improvement Program

~~CalOptima Officers and Directors~~

CalOptima's ~~Chief Medical Officer~~CMO, ~~Deputy CMO,~~ Chairperson of the ~~Utilization Management Committee~~UMC, ~~and~~ Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health ~~quality improvement~~QI, medical and behavioral health utilization review and authorization, case management, ~~disease management~~population health ~~management~~PHM and health education program implementations. ~~, with successful operation of the UMC, QIC and QAC.~~

Chief Medical Officer

The ~~Chief Medical Officer (~~CMO~~), along with the Deputy Chief Medical Office (DCMO)~~ — or physician designee — oversees CalOptima's ~~the~~ UM Program, including the strategies, programs, policies and procedures related to CalOptima's medical care delivery system. ~~The CMO and DCMO oversee CalOptima's UM Program.~~

~~**Deputy Chief Medical Officer**~~

~~The Deputy Chief Medical Officer (DCMO). along with the Chief Medical Office (CMO) oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system.~~

~~**Deputy Chief Medical Officer**~~

~~The Deputy Chief Medical Officer (DCMO). along with the Chief Medical Office (CMO) oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system.~~

Executive Director, ~~of~~ Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the ~~Utilization Management~~UM, Case Management, and Managed Long-Term Services and Support (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of C~~linical~~ O~~perations~~ serves as a member of the executive team, and, with the CMO ~~, DCMO~~ and the ~~ED of~~Executive Director, Quality & Analytics (ED of Q&A) ~~ensures~~ makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED of C~~linical~~ O~~perations~~ is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Medical Director, ~~of~~ Utilization Management, appointed by the CMO ~~and/or DCMO~~, is responsible for the direction of the UM Program objectives to drive the organization's mission, strategic goals and processes to provide high quality care to CalOptima members in a compassionate and cost-effective manner. The Medical Director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The Medical Director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical ~~necessity, and~~necessity and utilizes evidence- based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO, the Medical Director of UM also provides supervisory oversight and administration of the UM Program. In this role, the Medical Director oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process ~~The Medical Director of UM also oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions.~~ Medical Director of UM provides clinical education and in-services to staff ~~weekly and on an as needed basis~~, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The Medical Director of UM ensures physician availability to staff during normal business hours and on-call after hours. He or she serves as the Chair of the ~~Utilization Management Committee~~UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings , and participates in the CalOptima Medical Directors Forum and ~~Quality Improvement Committee~~QIC.

~~**Utilization Management Medical Director** ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. In this role, the Medical Director oversees the UM activities of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Ensures availability to staff during normal business hours and on-call after hours.~~

Medical Director, Behavioral Health provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and behavioral health care services for CalOptima members. The Medical Director provides clinical oversight for behavioral health benefits and services provided to members. The Medical Director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and

ensures quality behavioral health outcomes. The Behavioral Health Medical Director is involved in the implementation, monitoring and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OneCare and OneCare Connect), Managed LTSS (MLTSS) programs, Case Management and Transitions of Care programs. The Medical Director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The Medical Director works in collaboration with the other Medical Directors and the clinical staff within ~~Disease Management~~Population Health Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

Medical Director ~~Disease Management~~Population Health Management/Health Education/Program for All Inclusive Care for the Elderly (PACE) Programs is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of disease management and health education programs, while also providing clinical quality oversight of the PACE Program.

Director, ~~of~~ Utilization Management is responsible for directing and coordinating the planning, organization, implementation and evaluation of all activities and personnel engaged in UM d~~D~~epartmental activities. The ~~D~~director develops and implements the UM Program and UM Work Plan, maintains and updates policies, procedures and work flows to meet regulatory, contractual and accreditation standards.

Director, ~~of~~ Behavioral Health Services provides operational oversight for behavioral health benefits and services provided to members. The ~~D~~director is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors and executive staff, members, providers, ~~health network~~HN management, legal counsel, state and federal officials, and representatives of other agencies.

~~**Director of Quality Director of Quality** is responsible for ensuring that CalOptima and its HMOs PHCs and SRGs meet the requirements set forth by DHCS and Centers for Medicare/Medicaid Services (CMS. The Compliance staff works in collaboration with the CalOptima Quality Improvement department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as UM, Credentialing, and Grievance & Appeals Resolution Services (GARS), as appropriate. The staff evaluates the results of performance audits to determine the appropriate course of action to achieve desired results. Functions relating to fraud and abuse investigations, referrals, and prevention are handled by the Office of Compliance.~~

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Quality to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

~~The following positions report to the Director, Quality Improvement Director:~~

Supervisor, Quality Improvement (PQI)
Supervisor, Quality Improvement (Credentialing)
Supervisor, Quality Improvement, and Master Trainer (FSR)
QI Program Specialists
QI Nurse Specialists
Program Policy Analyst and Data Analyst
Credentialing Coordinators
- Program Specialists

Program Assistants

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

The following positions report to the Director, of Quality Analytics:
Quality Analytics HEDIS Manager
Quality Analytics Pay for Value Manager
Quality Analytics QI Initiatives Manager
Quality Analytics Analysts
Quality Analytics Project Managers
Quality Analytics Program Coordinators
Quality Analytics Program Specialists

Director, Population Health Management provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, Utilization ManagementC, Pharmacy, and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated Hhealth Pprograms such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the Model of CareMOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager

~~Program Specialists~~
~~Program Assistant~~

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The ~~D~~directors ensures that CalOptima and its subcontracted health networks perform consistently with both CMS and state requirements for all programs. Specifically, the ~~D~~directors leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the ~~D~~directors are ~~is~~ responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. The~~i~~s~~e~~ positions interact~~s~~ with the Board of Directors, CalOptima executives, departmental management, ~~health network~~HN management and Legal Counsel.

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Manager (Concurrent Review Manager [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The ~~M~~manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted ~~Registered Nurse (~~RN~~)~~ or ~~Licensed Vocational Nurse (~~LVN~~)~~ license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2-3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (Concurrent Review) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The ~~S~~supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training and in-servicing activities. The supervisor also m~~M~~onitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted ~~Registered Nurse (~~RN~~)~~ or ~~Licensed Vocational Nurse (~~LVN~~)~~ license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The ~~M~~manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- Current and unrestricted ~~Registered Nurse (~~RN~~)~~ or ~~Licensed Vocational Nurse (~~LVN~~)~~ license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in Utilization Management activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The ~~S~~supervisor makes recommendations regarding assignments based on assessment of ~~workload, and~~workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training and in-servicing activities. The supervisor also m~~M~~onitors for documentation adequacy, including clinical documentation to make a clinical determination, ~~also~~ and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted ~~Registered Nurse (~~RN~~)~~ license or ~~Licensed Vocational Nurse (~~LVN~~)~~ license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action RNs draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. ~~(S)He~~These positions audit~~s~~ clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, ~~and~~ is specific to the clinical information presented and

criteria referenced and is prepared using the appropriate threshold language template. ~~(S)He~~They works with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted ~~Registered Nurse License (~~RN~~)~~ in the State of California
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They ~~Case Manager is~~are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established ~~evidence based~~evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They ~~Case Manager~~ also provide~~s~~ concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act~~s~~ as ~~a~~ liaison~~s~~ to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board ~~Licensed Vocational Nurse (~~LVN~~)~~ or ~~Registered Nurse (~~RN~~)~~ license.
- Minimum of 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They ~~Medical Assistant~~ perform~~s~~ ~~medical, administrative,~~ routine medical administrative tasks specific to the assigned unit and office support functions. They ~~Medical Assistant~~ also authorize~~s~~ requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director~~, of~~ UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience preferred. Courses in basic administrative

education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The ~~Pharmacy D~~director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy ~~D~~director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy ~~M~~manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy ~~M~~manager develops and implements methods to measure the results of these programs, assists the Pharmacy ~~D~~director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee (P&T), interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a ~~Pharmacy & Therapeutics Committees~~P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy ~~D~~director in preparing drug monographs and reports for the ~~Pharmacy & Therapeutics Committee~~P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years' experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for a ~~Pharmacy & Therapeutics Committees.~~P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

PBM (Pharmacy Benefits Manager) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's ~~Pharmacy & Therapeutics Committee~~P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria. CalOptima pharmacists with a current license to practice without restriction perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term ~~Support~~ Support Services ~~and Supports (CBAS/LTC/MSSP)~~ develops, manages and implements LTSS, including Long-Term Care (LTC) facilities, CBAS and MSSP, and staff associated with those programs. The ~~D~~director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also d~~D~~evelops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF/ICF-DD/N/H) and other LTSS services.

Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including five years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term ~~Support~~ Support Services ~~and Supports, RN~~ (CBAS/LTC) ~~The Manager~~ is expected to develop and manage the LTSS department's work activities and personnel. The ~~M~~manager ~~will~~ ensures that services standards are met, and operations are consistent with ~~the health plan's~~CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are eligible for and/or receiving LTSS. ~~The~~ This ~~Manager~~ position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manager. The ~~M~~manager ~~will~~ works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC services.

Experience and Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

Supervisor, Long-Term ~~Support~~ Support Services ~~and Supports, RN,~~ (CBAS/~~,~~ LTC) ~~The Supervisor~~ is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. The~~is position~~ ~~Supervisor~~ is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the ~~S~~supervisor ~~will be resolving~~ resolves member~~s~~ and provider~~s~~ issues and barriers, ensuring excellent customer service. Additional responsibilities include: managing staff coverage in all areas of LTSS to complete assignments, and ~~orienting~~orientation~~,~~ and training of new employees to ensure contractual and regulatory requirements are met.

Experience and Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term ~~Support~~ Support Services ~~and Supports~~ (MCM LTSS) ~~(RN/LVN)~~, are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, ~~provides~~ providing coordination of care, and ~~provides~~ ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, ~~National Committee for Quality Assurance (~~NCQA~~)~~ standards, and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They ~~MCM LTSS~~ provide~~s~~ case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These ~~MCM LTSS is~~positions are the subject matter experts and acts as ~~a~~ liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience and Education

- A current and unrestricted RN license in the State of California or a current unrestricted LVN license in the State of California.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, CBAS is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The~~i~~s ~~CBAS Program Manager~~position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The ~~CBAS Program M~~manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required.
    - Masters preferred.
- Minimum of 3 years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).

Behavioral Health Integration (BHI) Resources

The following staff positions provide utilization management support for BHI operations:

~~**Manager, Behavioral Health** implements, manages and monitors contractual relationships with entities providing behavioral health services to CalOptima members. S/he coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and decision support when appropriate. The position represents CalOptima and interacts with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.~~

~~Experience & Education~~

- ~~Master's degree in Health Administration, Social Work, Psychology, Public Health, or other related degree is required.~~
- ~~2+ years of manager or director level experience in managed care environment, with specific experience in managing the behavioral health benefit for members covered by Medicare, Medi-Cal and/or Drug Medi-Cal.~~
- ~~3+ years of experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program.~~
- ~~Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).~~
- ~~Experience in managing Autism Spectrum Disorder Services in a Managed Care environment.~~
- ~~Experience in developing policies and procedures to meet federal and state regulatory requirements.~~
- ~~Experience in developing sound and responsible business plans and financial models.~~

~~**Manager, Behavioral Health, Clinical** is responsible for overseeing the clinical operation of CalOptima's Behavioral Health. S/He ensures the delivery of quality and consistent clinical assessment and referrals in accordance with CalOptima policies and procedures. The manager collaborates with other internal CalOptima departments to ensure all regulatory requirements are met. S/He assists the Director of Behavioral Health Services in developing and implementing behavioral health initiatives and projects. S/He represents CalOptima interacting with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.~~

Experience & Education

- Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or other related degree is required.
- Licensed (LCSW, LMFT, or Licensed Psychologist) is required.
- 4+ years of supervisor or manager level experience in managed care environment, with specific experience in providing telephonic behavioral health assessment and triage required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in developing policies and procedures to meet federal and state regulatory requirements.
- Experience in developing sound and responsible business plans and financial models.

Clinicians, Behavioral Health assist and monitor clinical service relationships with practitioners providing behavioral health services to CalOptima members. The position coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and support.

Experience & Education

- Advanced degree required such as a Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or related field of study is required.
- License preferred.
- Minimum 5-6 years of experience is required.
- Strong written and analytical skills required.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialists are responsible for assisting members with behavioral health care management needs, which includes, but not limited to, securing behavioral health appointment for members, following up with members before and after appointment, providing member information and referring to community resources, conducting utilization review, and assisting members in navigating the mental health system of care. This position acts as a consultative liaison to assist members, health networks and community agencies to coordinate behavioral health services.

Experience & Education

- High school diploma or equivalent required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's License and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Manager, Behavioral Health (BCBA) is responsible for managing Bbehavioral Hhealth Ttreatment (BHT) services, including Aapplied Bbehavior Aanalysis (ABA), for members that meet medical necessity criteriadiagnosed with Autism Spectrum Disorder (ASD). The Mmanager oversees will oversee Ccare Mmanagers who review assessments and treatment plans submitted by

providers for adherence to BHT~~ASD~~ "best practice" guidelines. ~~-~~The ~~M~~manager designs~~will design~~ and implements processes to ensure effective delivery of BHT~~ABA~~ services. This position ~~Manager will~~ collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- Licensed (LCSW, LMFT, Licensed Psychologist) is preferred.
- 4+ years of supervisor or manager level experience in clinical management of ABA services is required.
- 3+ years of experience providing ABA therapy to children diagnosed with ASD is required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).

Experience in developing policies and procedures to meet federal and state regulatory requirements.~~Experience in developing policies and procedures to meet federal and state regulatory requirements.~~

-

Supervisor, Behavioral Health, UM is responsible for the UM functions within the BHI department. The supervisor monitors and oversees the department's UM work activities to ensure that member's behavioral health service needs are coordinated with medical service requests, and service standards are met. The supervisor serves as a resource to staff regarding CalOptima policies and procedures and is responsible for regulatory requirements governing authorization processing and monitoring utilization patterns. The position directly supervises the medical case managers.

Experience & Education

- Graduate of an accredited School of Nursing or bachelor's degree in behavioral health related area required.
- Current and unrestricted California Board Licensed RN or LCSW required.
- Minimum of 3 years of behavioral health experience.
- Minimum of 3 years of supervisory experience, preferably in a managed care setting.
- Strong written and analytical skills required.
- Experience with ABA preferred

Medical Case Managers (Behavioral Health) are responsible for the oversight and review of ABA services offered to members that meet the medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs. The position is also responsible for reviewing and processing authorizations for psychological testing.

Experience & Education

- Current LVN/RN license to practice in the State of California and a minimum of three (3) years current clinical experience or an equivalent combination of education and experience required.

- Active CCM certification preferred.
- Managed care experience preferred.
- Experience with ABA preferred

Care Manager ~~(BCBA)~~ is responsible for the oversight and review of BHT~~ABA~~ services offered to members that meet ~~with ASD, including screening, triaging, and assessing members to determine appropriate level of care based on~~ medical necessity criteria. The ~~Care M~~manager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management and monitoring activities of autism services provided in ~~community based~~community-based setting. The ~~Care M~~manager ~~will~~ directly interacts with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in Behavioral Health or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 4+ years providing ABA therapy to children diagnosed with ASD is required.
- Possess clinical, medical utilization review, and/or quality assurance experience is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria~~diagnosed with ASD~~ seeking BHT services, including ABA. ~~The~~ This ~~Member Liaison Specialist will~~position assists members in linking ~~ASD related behavioral health~~ BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the behavioral health system of care. ~~-~~This position will act as a consultative liaison to assist members, health networks and community agencies to coordinate ~~ASD related behavioral health~~ BHT services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's License and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

~~**Supervisor, Behavioral Health, UM**~~

~~The Supervisor is responsible for the utilization management (UM) functions within the Behavioral Health IntegrationBHI Ddepartment. He/sheThe supervisor monitors and oversees the department's UM work activities to ensure that member's behavioral health service needs are coordinated with medical service requests, and service standards are met,. The supervisor beserves as a resource to staff regarding CalOptima policies and procedures. The Ssupervisor, and is responsible for~~

regulatory requirements governing authorization processing and monitoring utilization patterns. The position directly supervises the Mmedical Ccase Mmanagers.

Experience & Education

- Graduate of an accredited School of Nursing or bachelor's degree in behavioral health related area required.
- Current and unrestricted California Board Licensed Registered Nurse (RN) or Licensed Clinical Social Worker (LCSW) required.
- Minimum of 3 years of behavioral health experience.
- Minimum of 3 years of supervisory experience, preferably in a managed care setting.
- Strong written and analytical skills required.
- Experience with Applied Behavior AnalysisABA preferred

Medical Case Managers (Behavioral Health)

Medical Case Manager isare responsible for the oversight and review of ABA services offered to members that meet the medical necessity criteria. The Medical Case Mmanager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management and monitoring activities of autism services provided in community based setting. The Medical Case Mmanager directly interacts with provider callers, acting as a resource for their needs. The position is also responsible for reviewing and processing authorizations for psychological testing.

Experience & Education

- Current LVN/RN license to practice in the State of California and a minimum of three (3) years current clinical experience or an equivalent combination of education and experience required.
- Active CCM certification preferred.
- Managed care experience preferred.
- Experience with Applied Behavior AnalysisABA preferred

Qualifications and Training

CalOptima seeks to recruit highly-qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation;.
- HIPAA and Privacy/Corporate Compliance;.
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.);.
- UM Program, policies/procedures, etc.;.
- MIS data entry;.
- Application of Review Criteria/Guidelines;.
- Appeals Process; and.
- Seniors and Persons with Disabilities Awareness Training;.

- OneCare and OneCare Connect Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and behavioral health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure~~. This licensure is specific to~~ from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on~~:~~

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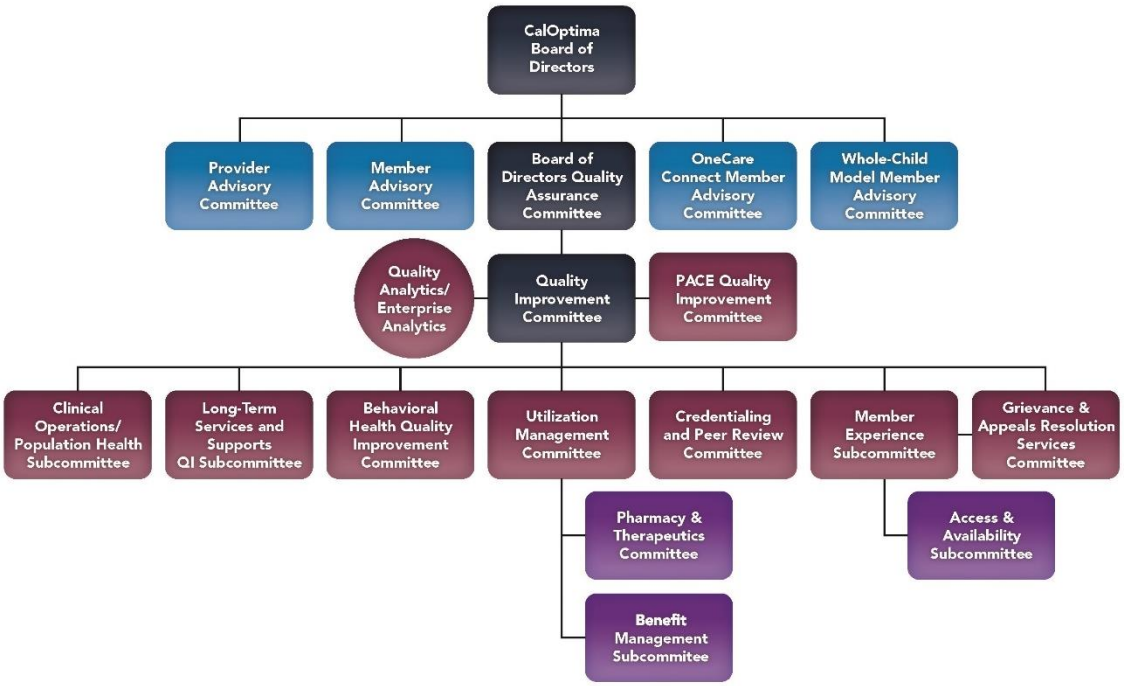
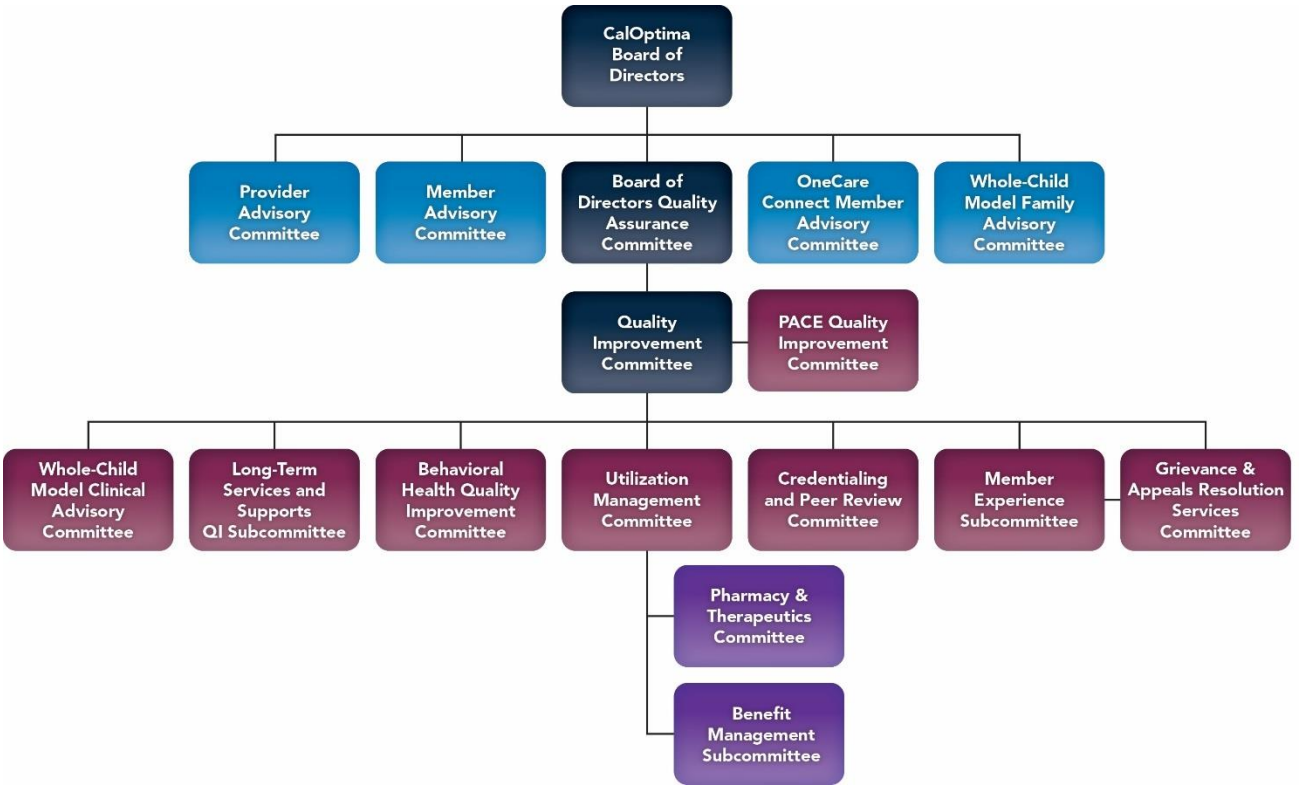
- ~~T~~he percentage ~~of~~ or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

COMMITTEE STRUCTURE





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Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, and MBHOss to identify areas of under or over utilization that may adversely impact member care and is
~~The UMC is~~ responsible for the annual review and approval of medical necessity criteria and protocols, ~~and~~ the UM ~~Program,~~ policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description and~~,~~ Work Plan, and also reviews and approves the Annual UM Program Evaluation. Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM ~~S~~specialist, t~~T~~he ~~D~~director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. ~~Daily o~~Oversight and operating authority of UM activities is delegated to the UMC which reports up through CalOptima's QIC and ultimately to CalOptima's QAC and the Board of

Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the utilization management program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its ~~D~~delegated ~~Health Networks~~HN~~;~~.
- Oversees the UM activities and compliance with federal and state statutes and regulations, ~~and~~as well as contractual and NCQA requirements that govern the utilization management process~~;~~.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UM Work Plan and UM Program Evaluation on an annual basis~~;~~.
- Reviews and analyzes UM Operational and Outcome data; Reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action~~;~~.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects~~;~~.
- Promotes a high level of satisfaction with the ~~Utilization Management~~UM program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives~~;~~.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring; sets appropriate upper and lower thresholds for over/under utilization trend reports.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

Direct Subcommittee Reports:

- Benefit Management Subcommittee (BMSC)
- ~~Pharmacy and Therapeutics Subcommittee (~~P&T~~)~~
-

Departments Reporting Relevant Information on ~~Utilization Manage~~UM~~ment~~ Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- ~~Utilization Management~~UM Workgroup
- ~~Long Term Services and Support~~LTSS
-

- Reports to the ~~Quality Improvement Committee (~~QIC~~)~~ on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

~~UMC Scope~~

- ~~Oversees the UM activities of CalOptima regarding compliance with federal and state statutes and regulations, and contractual and NCQA requirements;~~
- ~~Reviews and approves the UM Program Description on an annual basis;~~ ~~Approves the use of medical necessity criteria;~~
- ~~Reviews and approves the UM Work Plan on an annual basis;~~
- ~~Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects;~~
- ~~Reviews trends and/or utilization patterns presented at UMC and makes recommendations for further action;~~
- ~~Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives;~~
- ~~Communicates significant findings and recommendations related to UM issues to the QIC;~~
- ~~Identifies opportunities where UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations;~~
- ~~Provides feedback to the QIC regarding effectiveness of CalOptima's P4P programs;~~
- ~~Report's findings of UM studies and activities to the QIC;~~ and
- ~~Liaisons with the QIC for ongoing review of quality indicators.~~

UMC Membership

Voting Members:

- ~~Chief Medical Officer (~~CMO~~)~~
- ~~CalOptima~~ Medical Director ~~Utilization Management~~UM
- ~~*Six (6) participating Practitioners from the community~~
- ~~**CalOptima~~ Medical Director Behavioral Health*
- ~~Executive Director Clinical Operations~~
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Six participating practitioners from the community**

~~~~ Behavioral Health ~~P~~practitioner is defined as a medical director, clinical director, or participating practitioner from the organization or delegated provider groups.

**~~*~~ Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists, and administrative ~~P~~practitioners.~~-~~ At least ~~6~~six outside practitioners are assigned to the committee to ensure that at least ~~3~~three are present each meeting as part of the quorum requirements.

~~**Behavioral Health Practitioner is defined as a medical director, clinical director, or participating practitioner from the organization or delegated provider groups.~~

The UMC is supported by:

- Director, ~~Utilization Management~~UM
- Director, Quality Improvement
- Director, Pharmacy

- Manager, Prior Authorization
- Manager, Concurrent Review

~~**UMC Members**~~

~~The UMC actively involves several active network practitioners as available and to the extent that there is not a conflict of interest. CalOptima's UMC is chaired by the UM Medical Director and is comprised of the following voting members:~~

- ~~CMO;~~
- ~~Deputy CMO;~~
- ~~Executive Director, Clinical Operations;~~
- ~~Six (6) participating Practitioners from the community;~~
- ~~CalOptima Medical Director of Behavioral Health;~~
- ~~CalOptima Medical Director of Senior Programs;~~
- ~~CalOptima Medical Director of Quality and Analytics;~~
- ~~CalOptima Medical Director of Prior Authorization;~~
- ~~CalOptima Medical Director of Concurrent Review;~~
- ~~Director, Utilization Management;~~
- ~~Director, Quality Improvement;~~
- ~~Director, Pharmacy;~~
- ~~Manager, Prior Authorization; and~~
- ~~Manager, Concurrent Review~~

~~**Quorum**~~

~~A quorum consists of fifty percent (50%) plus one (1) of the voting members, with at least three (3) non CalOptimanon-CalOptima employees / community participants. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.~~

Benefit Management Subcommittee (BMSC)

The ~~Benefit Management Subcommittee~~BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division (MMCD) All Plan Letters (APLs), and the Medi-Cal Manual.

BMSC Scope

The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.~~; and~~
- ~~Revise~~ Revising and ~~update~~ updating CalOptima's authorization rules.
- ~~Makes~~ Making recommendations regarding the need for prior authorization for specific services~~;~~.
- ~~Clarifies~~ Clarifying financial responsibility of the benefit, when needed.
- ~~Recommends~~ Recommending benefit decisions to the UMC~~; and~~.
- ~~Communicates~~ Communicating benefit changes to staff responsible for implementation.

BMSC Members

The sSubcommittee membership consists of the following:

- Medical Director, Utilization Management- Chairperson;
- Executive Director, Clinical Operations;
- Director, ~~Utilization Management~~UM;
- Director, Claims Management;
- Director, Claims~~; and~~
- Director, Coding Initiatives.

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a qQuarterly basis.

Behavioral Health Quality Improvement Committee (BHQIC)

The purpose of the ~~Behavioral Health Quality Improvement Committee~~BHQIC is to:

- Ensure members receive timely and satisfactory behavioral health care services;.
- Enhance the integration and coordination between physical health and behavioral health care providers;.
- Monitor key areas of service utilization by members and providers.;
- Identify areas of improvement~~; and~~.
- Guide CalOptima towards the vision of bi-directional behavioral health care integration.

BHQIC Scope

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership.
- Oversee the functions of delegated entities;.
- Monitor to ensure that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with regulatory and accrediting agency standards;.
- Ensure that member benefits and services are not underutilized, and that assessment and appropriate interventions are taken to identify inappropriate over utilization;.
- Utilize member and ~~N~~network ~~P~~provider satisfaction study results when implementing quality activities;.
- Maintain compliance with evolving NCQA accreditation standards;.
- Communicate results of clinical and service measures to ~~N~~network ~~P~~providers~~; and~~.
- Document and report all monitoring activities to appropriate committees.

BHQIC Members

The designated Cchairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for reviewing information, reporting findings, and making QI recommendations, and to represents the BHQI Ccommittee at the QIC meetings. The voting members of the BHQIC committee include:

- Chief Medical OfficerCMO/ Deputy Chief Medical Officer;
- Executive Director, Clinical Operations;
- Medical Director, Behavioral Health Integration;
- Director of Behavioral Health IntegrationServices;
- Medical Director, Medical Management;
- Medical Director, Utilization ManagementUM;
- Executive Director, Quality and Analytics;
- Medical Director, Orange County Health Care AgencyOC HCA;
- Medical Director, Managed Behavioral Health Organization;
- Medical Director, Health Network; and
- Medical Director, Regional Center of Orange County.

The Ccommittee may permit participation by other CalOptima staff or outside guests with relevant expertise and experience. The BHQIC meets quarterly at a minimum, or and more frequently as needed.

LTSS Quality Improvement Subcommittee (LTSS QISC)

The LTSS QISC was created to provide a forum for LTSS providers to share best practices, identify challenges and barriers, and identify solutions that are person-centered, maximize available resources and reducing reduce duplicate duplication of services.

The LTSS QISC Purpose

The purpose of the LTSS QISC is:

- Engage stakeholders on strategies for integrating LTSS programs within the managed care delivery system.
- Improve coordination of care for CalOptima members who reside in long-term care facilities and for those who receive Home- and Community-Based Services (HCBS).

The LTSS QISC Responsibilities

The LTSS QISC responsibilities are to:

- Identify barriers to keeping members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent inappropriate admissions.
- Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, MSSP and other HCBS.
- Monitor the important aspects of quality of care, quality of services and patient safety by collecting and analyzing results.
- Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.
- Identify and recommend topics for LTSS provider workshops, educations and trainings.

The LTSS QISC Structure

- The designated cChairman of the LTSS QISC is the Medical Director, Senior Programs, ~~who is responsible for chairing the committee.~~
- ~~T~~and the LTSS QISC ~~includes~~ invites the following participants:
  - Nursing Facility Administrators~~;~~
  - CBAS Administrators~~;~~
  - OC SSA, Deputy Director or Designee~~;~~
  - MSSP, Site Director or Designee~~;~~
  - ~~Chief Medical Officer/Deputy Medical Officer;~~CMO
  - Medical Director, QI and Analytics~~;~~
  - Medical Director, UM~~;~~
  - Executive Director, Clinical Operations~~;~~
  - Executive Director, Quality Analytics~~;~~
  - Manager(s), LTSS~~; and~~
  - Director, LTSS~~.~~

- The LTSS QISC meets at least quarterly, and as needed.

~~**The LTSS QISC meets at least quarterly**~~

INTEGRATION WITH THE QUALITY IMPROVEMENT PROGRAM

The ~~Utilization Management~~UM Program and Work Plan are evaluated and submitted for review and approval annually by ~~both~~ the CalOptima UMC, the QIC and the QAC, with final review and approval by the Board of Directors.

- Utilization data is collected, aggregated and analyzed including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- ~~The QIC reports to the Board QAC.~~
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- ~~The~~The QIC reports to the Board QAC.

CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on ~~Utilization Management Committee~~UMC or who otherwise make decisions on utilization management, quality oversight and activities timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

CONFIDENTIALITY

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, SRGs and Managed Behavioral Health Organizations (MBHOs) hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This ~~A~~agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

INTEGRATION WITH OTHER PROCESSES

The ~~Utilization Management~~UM Program, Case Management Program, Behavioral Health Program, Managed LTSS Programs, ~~Pharmacy & Therapeutics (~~P&T~~) Program~~ Committee, Quality Improvement~~I~~, Credentialing, Compliance, and Audit and Oversight ~~Programs~~ are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to CalOptima's QI department. As case managers perform the functions of UM,

quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review ~~or Credentialing~~ Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified.
In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention~~;~~
- State protective and regulatory services~~;~~
- Women, Infant and Children Services (WIC)~~;~~
- EPSDT Health Check~~; and~~
- ~~Services provided by local public health departments.~~
-

UM Process

The UM process encompasses the following program components: referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination, and second opinions. All approved services must meet ~~be~~ medical~~ly~~ necessity criteria. ~~ary.~~ The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM ~~D~~department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS ~~(Medi-Cal)~~and the Centers for Medicare and Medicaid Services (CMS).~~,~~ ~~a~~ A variety of program documents, regulations, policy letters and all ~~the Center for Medicare and Medicaid Services~~CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit

coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in ~~place, and~~place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the CalOptima Audit and Oversight department via its delegation oversight team for compliance.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality-based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, DMHC, CDA and NCQA at least annually. Recommendations for revisions and improvements are made, as appropriate. The UM Work Plan is based on the findings of the annual program Work Plan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The organization chart and the program Committee's reporting structure accurately reflect CalOptima's Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the Committees Charters.

The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer~~,~~; Medical Director(s) of UM~~,~~; ~~the~~ Executive~~,~~ Director~~,~~ ~~of~~ Clinical Operations~~,~~; ~~the~~ UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the UM Program and UM Work Plan~~, s, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and Work Plans.~~

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the Centers for Medicare and Medicaid Services and the State of California for Medi-Cal, ~~OneCare~~ OC and ~~OneCare Connect~~OCC. Medically necessary means all covered services or supplies that:

- Are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury;
- ~~a~~Are appropriate and needed for the diagnosis or treatment of a member's medical condition; ~~.~~
- ~~a~~Are provided for the diagnosis, direct care, and treatment of the member's medical condition; ~~.~~
- ~~m~~Meet the standards of good medical practice in the local area;~~;~~
- Are consistent with current evidence-based clinical practice guidelines; and ~~and~~.
- A~~a~~re not mainly for the convenience of the member or the doctor.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or other appropriate health care professionals, review and determine all final denial or modification decisions for requested medical and behavioral health care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified Physician or Pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services~~;~~
- Admission Review~~;~~
- Concurrent/Continued Stay Review for selected conditions~~;~~
- Discharge Planning Review~~;~~
- Retrospective Review~~;~~
- Evaluation for potential transplant services for health network members~~;~~
- ~~Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima members;~~

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services~~;~~.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated~~;~~.

- Member characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable
    -
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure, GG.1508, Authorization and Processing of Referrals;.
- Reasons for decisions are clearly documented in the medical management system;.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures;.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services;.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.;
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director or a copy of the specific criteria utilized.

The ~~following~~ information that may be used to make medical necessity determinations ~~including~~includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider

- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

CalOptima's UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, ~~of~~ Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management ~~departments~~ areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima' program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

~~Prior authorization is required for select services such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization List. This list is accessible on the CalOptima website at www.caloptima.org.~~

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on ~~appearing on~~ the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by ~~the health networks~~providers and processed electronically. Some r~~R~~eferrals are auto-adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of- network practitioners ~~as noted on the Prior Authorization Required List~~.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in- network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure, Standing Referral: GG.1112, includes guidance on how members with life-threatening conditions or diseases ~~which~~ that require specialized medical care over a prolonged ~~period of time~~period can request and obtain access to ~~S~~specialists and specialty care centers.

Out-of-Network Providers

If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for

services does not meet the appropriate clinical criteria, the UM Nurse Case Managers and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes a statement to all members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Pharmaceutical Management

The Pharmacy Management Program is overseen by the CMO, and CalOptima's Director, Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by the Pharmacy & TherapeuticsP&T Committee (P&T) and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals, andpharmaceuticals, andpharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The CalOptima P&T Committee is responsible for development of the CalOptima Formulary, which is based on sound clinical evidence, and is reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers.
If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug, and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a Pharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per

month are reviewed by a Clinical Pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

PHARMACY DETERMINATIONS

Medi-Cal

CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima P&T Committee. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima ~~Pharmacist~~ pharmacist or ~~CalOptima~~ Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima ~~P~~pharmacist or ~~CalOptima~~ Medical Director.

CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

~~OneCare/OneCare Connect~~OC/OCC

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Formulary

The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the CalOptima P&T Committee. Final

approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, customer service, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM recommends denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit and Oversight department's policies and procedures.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal

CalOptima's Behavioral Health Integration department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by behavioral health UM staff that consist of Medical Case Managers and Care Managers (BCBA). Determinations are based on criteria from MCG Guidelines, APL, and CalOptima policy (approved by DHCS).

The behavioral health UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a CalOptima Licensed Psychologist or Medical Director.

CalOptima's written notification of behavioral health modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss behavioral health UM denial decisions.

~~OneCare/OneCare Connect~~OC/OCC

CalOptima delegates Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Magellan complies with regulatory timelines and criteria set forth by MCG guidelines, APL's, and CalOptima Policies (approved by CMS).

~~Utilization Review of Supplemental Dental Benefits (OC, OCC)~~

~~Utilization Review of Supplemental Dental Benefits available for OneCare and OneCare Connect Members is delegated to Liberty Dental Denti-Cal. Oversight of the UM process is performed by CalOptima's Audit and Oversight Department to ensure compliance with contractual and regulatory requirements.~~

~~Preventive and Clinical Practice Guidelines (CPG)~~

UM Criteria

~~Clinical Guidelines are developed and implemented via the QIC, and assist in making health care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the P&T Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated Health Networks as they are approved.~~

~~While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.~~

~~UM criteria are nationally recognized, evidence based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.~~

CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least

~~annually, and~~annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

~~uses the following criteria sets for all medical necessity determinations:~~

- ~~-~~Nationally-recognized Evidence Based criteria such as Milliman Care Guidelines (MCG)~~;~~
- Medicare and Medi-Cal Manuals of Criteria~~;~~
- Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines~~;~~
- Medicare Part D: CMS-approved Compendia~~;~~
- National Guideline Clearinghouse~~;~~
- National Comprehensive Cancer Network (NCCN) Guidelines~~;~~
- Transplant Centers of Excellence guidelines~~;~~
- Preventive health guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines)~~;~~
- CalOptima Criteria for outpatient behavioral health services~~,~~
- ~~•~~ CalOptima Policies and Medi-Cal Benefits Guidelines~~, and~~
- ~~•~~
- Beginning July 1, 2019, or such later time as CalOptima assume responsibility for the provision of CCS services for its members, CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to ~~California Children's Services~~CCS and Whole Child Model.

~~Medi-Cal and Medicare Manual of Criteria;National and Local Coverage Determination Guidelines.~~

- ~~•~~
- ~~MCG — Evidence-based nationally recognized criteria;~~
- ~~National Comprehensive Cancer Network (NCCN) Guidelines;~~
- ~~Centers of Excellence Guidelines;~~
- ~~Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association Guidelines;~~
- ~~CalOptima Criteria for outpatient behavioral health services;~~
- ~~CalOptima Medical Policy and Medi-Cal Benefits Guidelines;~~
- ~~National and Local Coverage Determination Guidelines.~~
- ~~National Guideline Clearinghouse~~
- ~~Medicare Part D: CMS-approved Compendia~~

Delegated ~~H~~health ~~N~~networks must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.

Authorization Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	PA Nurse Reviewer**	Medical Director / Physician Reviewer
Chemotherapy – all request types reviewed by ~~Ph D~~	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		~~X~~	X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
~~Dialysis~~	~~MCG / Medi-Cal and Medicare Manuals~~	~~X~~	~~X~~	
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	PA Nurse Reviewer**	Medical Director / Physician Reviewer
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals	~~RCOC Referrals~~	X	
Transplants	DHCS Guidelines/ MCG	~~Referral~~	X	X

* If Medical Necessity criteria is not met, the request is referred to a PA Nurse Reviewer for further review and determination.

** If Medical Necessity criteria is not met, the request is referred to a ~~the~~ Medical Director / Physician Reviewer for further review and determination.

Long-Term ~~Services and Supports~~Support Services Authorization Types

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer
Community- Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Medi-Cal Behavioral Health Services Authorization Types

Authorization Type*	Criteria Utilized	Medical Case Manager ~~Medical Assistant~~	Care Manager (BCBA)	Medical ~~Director /~~ Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal Manual, CalOptima policy	X	~~X~~	X
Behavioral Health Treatment (BHT) services	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed **Psychologist for review and determination.**

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service or certain appeal reviews, the clinical judgment needed for ~~a~~n UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

For the purposes of Behavioral Health review and oversight as a delegated vendor, Magellan ensures there are peer reviewers/clinical consultants. Peer reviewers are behavioral health professionals who are qualified, as determined by Magellan's Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.

New Technology Review

Medi-Cal, ~~OneCare, OneCare Connect~~OC and OCC

CalOptima's P&T Committee and Benefit Management s~~S~~ubcommittee shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting CalOptima's UM ~~department, or~~department or may discuss the UM decision with CalOptima Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director, ~~of~~ Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, ~~of~~ Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, CalOptima's UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.

Provider/Member Communication

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available toll free at **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the web, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The

vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral health and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll-free phone number and asking for the CalOptima Medical Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

UM Sstaff Aaccess to Clinical Expertise

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated ~~SRGs Health Network~~HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

UM staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times. ~~Members requesting a copy of CalOptima's designated record set are not charged for the copy.~~

Sharing Information

CalOptima's UM staff share all clinical and demographic information on individual patients among various ~~divisions~~ areas of the agency (e.g. discharge planning, case management, disease

management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider/Member Communication

CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered;.
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;.

The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines — Medi-Cal (Excludes Pharmacy ~~r~~Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
Routine (Non-Urgent) Pre-Service: Prospective or concurrent service requests where no extension is requested or needed	Approve, ~~M~~modify or ~~D~~deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision but no longer than 14 calendar days following receipt of request. "all information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** ~~—~~(AKA: Deferral) - • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The ~~M~~member or the ~~M~~member's provider may request for an extension, or the ~~P~~plan can provide justification upon request by the State for the need for additional information	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	and how it is in the m~~M~~ember's interest. ▪ The ~~D~~delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the m~~M~~ember notice of denial.		from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the ~~M~~member and ~~P~~prescribing ~~P~~provider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
Expedited Authorization Requests (Pre-Service): No extension requested or needed. —All necessary information received at time of initial request. Requests where a provider indicates, or the Pplan determines that the standard timeframe could seriously jeopardize the me Member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) — Extension needed: ~~Requests where provider indicates, or the Hh complex care management and case management servicesealth Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.~~ ~~Additional clinical information required~~. Extension is allowed ***only*** if Mmember or provider requests the extension or the Pplan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the Mmember.	The Pplan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Pplan asks the Mmember, the Mmember's representative, or provider for the specific information necessary to make the decision. ▪ The Pplan gives the Mmember or Mmember's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Pplan, begins: ○ On the date when the Pplan receives the Mmember's response (even if not all of the information is provided), ***or*** ○ At the end of the time period given to the Mmember to provide the information, if no response is received from the	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination. - **Member:** Within 2 business days of the decision[2] but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[3] (written notification) **Note:** CalOptima shall make reasonable efforts to give the Mmember and Pprescribing Pprovider oral notice of the delay.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	~~M~~member or the ~~M~~member's authorized representative. **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life–threatening care determinations: ▪ ○ ~~o~~ Could seriously jeopardize the life, health or safety of the ~~M~~member or others, due to the ~~M~~member's psychological state, or ○ — In the opinion of a practitioner with knowledge of the ~~M~~member's medical or behavioral condition, would subject the ~~M~~member to adverse health consequences without the care or treatment that is the subject of the request. ○ ▪ The ~~M~~member or the ~~M~~member's provider may request for an extension, or the ~~H~~health ~~P~~plan/ ~~P~~provider ~~G~~group can provide justification upon request by the ~~S~~state for the need for additional information and how it is in the ~~M~~member's interest.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Within 2 working days of making the decision ~~**Practitioner:**~~ ~~Within 2 working days of making the decision~~ ~~**Member:**~~ ~~Within 2 working days of making the decision~~

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	– Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the ~~M~~member's treating provider has been notified of the health plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that ~~M~~member	Within 24 hours of receipt of the request **NOTE:** The p~~P~~lan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the ~~P~~plan previously; ~~T~~the ~~P~~plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The ~~P~~plan has up to 72 hours to make a decision (NCQA UM 5) ○ A response to defer is required within 24 hours for all services that require prior authorization. ○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a ~~M~~member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the ~~P~~plan must notify beneficiaries at least ~~ten (~~10~~)~~ days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision[2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2]
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request.	**Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types:– Written notice within 30 calendar days from receipt of the information necessary to make the determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	Additional Information Received: If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified **Member & Practitioner**: None specified	
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

UM Decision and Notification Timelines – Medicare (Eexcludes Pharmacy Rrequests)

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) –If Nno Eextension Rrequested or nNeeded	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) –If Eextension Rrequested or Nneeded	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny).- Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. -The extension notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Hhealth Pplan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension. -
Expedited Initial Organization Determination –If Eexpedited cCriteria are not met	Promptly decide whether to expedite – determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or –If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. 2. ○ If submitted as expedited but	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. .–The written notice must include: 1. Explain that the Hhealth Pplan will automatically transfer and process the request using the 14-day timeframe for standard determinations;. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination;.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was received for an expedited determination.	3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically~~; and~~. ~~—~~Provide instructions about the expedited grievance process and its timeframes. 4.
Expedited Initial Organization Determination ~~–~~If ~~N~~no ~~E~~extension ~~R~~requested or ~~N~~needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends ~~&~~and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** ○ Oral or written notice must be given to member and provider within 72 hours of receipt of request. ○ Document date and time oral notice is given. ○ If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** ○ When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. ~~○~~ ~~–~~Document date and time of oral notice. ○ If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. ~~:~~ ○
Expedited Initial Organization Determination ~~–~~If ~~E~~extension ~~R~~requested or ~~N~~needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). -Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The ~~H~~health ~~P~~plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals ○ Oral or written notice must be given to member and provider no later than upon

Type of Request	Decision	Notification Timeframe Member and Practitioner
	— When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). ▪ ~~D~~ ▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	expiration of extension. ○ Document date and time oral notice is given. ○ If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials ○ When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. ○ Document date and time of oral notice. ○ — If only written notice is given, it must be received by member and provider no later than upon expiration of extension. ○

UM Decisions and Timeframes for Determinations — Pharmacy for Medi-Cal, OCC & OCC

~~Medi-Cal~~ ~~Clinical Decision Making~~	~~OneCare and OneCare Connect~~ ~~Clinical Decision Making~~

• ~~Performed by CalOptima UM staff for COD-A and CCN members~~
• ~~Performed by Health Network UM staff for HN members~~
  ○ ~~Requests for transplant services for HN members are performed by CalOptima UM staff~~
• ~~Qualified physician review for modifications or denials~~
• ~~Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services~~
• ~~Qualified pharmacist review for pharmacy modifications or denials~~
	• ~~Performed by CalOptima UM staff for CCN members~~
	• ~~Performed by Health Network UM staff for HN members~~
	  ○ ~~For OneCare HN members Medi-Cal "wrap" benefits and requests for out of area services (SRGs only) are performed by CalOptima UM staff.~~
	• ~~Behavioral Health Determinations Performed by Managed Behavioral Health Organization~~
	• ~~Qualified physician review for any modifications or denials~~
	• ~~Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services~~
	• ~~Qualified pharmacists or physician review for pharmaceutical partial approvals or denials~~

Medi-Cal Timeframes for Decision	OneCare and OneCare Connect Timeframes for Decision
Routine: 5 business days from receipt of all medically necessary information to make a determination, not to exceed 14 calendar days from receipt of request **Urgent**: 72 hours from receipt of request **Retrospective**: 30 calendar days from receipt of request	**Routine**: 14 calendar days from receipt of request **Routine Extension Needed**: May extend for an additional 14 days if additional information may result in an approval. • Provider: Within 24 hours of extension decision • Member: Within 24 hours of extension decision **Urgent:** 72 hours **Retrospective:** 30 calendar days from receipt of request

Medi-Cal Timeframes for Notification	OneCare and OneCare Connect Timeframes for Notification (non-Part D)
Routine: Provider: Verbal/ Electronic: within 24 hours of decision Written: within 2 working days of the decision, if verbal previously given Member: Verbal not required Written: (Required only for delay, modification or denial). Within 2 working days of the decision, not to exceed 14 calendar days from the receipt of the request. **Expedited (Urgent):** Provider: Verbal Electronic: within 72 hours from the receipt of the request; must include expedited appeal rights. Written (if verbal notification given): Within 2 working days of the decision Member: Verbal: not required Written: (Required only for delay, modification or denial) Within 2 working days of making the decision.	**Standard (Routine):** Provider: Written notification must be sent within three days of decision. Member: Notified of the decision no later than 2 working days from the decision, not to exceed 14 days from receipt of the request. **Expedited (Urgent):** Provider: Verbal/ Electronic: notification 72 hours from the receipt of the request; must include expedited appeal rights. Written (If verbal notification given): Within 2 working days of the decision Member: Verbal: Within 24 hours of decision Written: Within 2 working days of making the decision

Medi-Cal Timeframes for Notification (cont.)	OneCare and OneCare Connect Timeframes for Notification (non-Part D) (cont.)
Concurrent: Practitioner: Verbal/ Electronic: Within 24 hours of making the decision Written (if verbal notification): Within 2 working days of the decision. Following completion of treatment, an authorization summary is provided within 2 working days. Member: Verbal: Not required. Written: (Required only for delay, modification or denial). Within 2 working days of decision **Retrospective:** Practitioner: Verbal: not required Written: (Required only for modification or denial): Within 30 days of receipt of information necessary to make the determination Member: Verbal: Not required Written: (Required only for modification or denial): Within 30 days of receipt of information necessary to make the determination	**Concurrent:** Practitioner: Verbal/ electronic: Within 24 hours of making the decision Written (if verbal notification): Within 2 working days of the decision. Following completion of treatment, an authorization summary is provided within 2 working days. Member: Verbal: Not required. Written: (Required only for denial). Within 2 working days of decision **Retrospective:** Practitioner: Verbal: Not required Written: (Required only for denial): Within 30 days of receipt of information necessary to make the determination Member: Verbal: Not required Written: (Required only for denial): Within 30 days of receipt of information necessary to make the determination Notice requirement: CMS "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination

Medi-Cal Pharmaceutical — Decision Making	OneCare and OneCare Connect Pharmaceutical — Decision Making
• Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals •	• Processed by CalOptima Pharmacy Management department ~~or Pharmacy Benefits Manager~~ • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals •

Medi-Cal Pharmacy Timeframes for Determinations	OneCare and OneCare Connect Pharmacy Timeframes for Determinations (Part D):
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed:** Within 5 working days of receiving needed information, but no longer than 14 calendar days **Expedited (Urgent) Preservice:** Within 24 hours a decision to approve, modify, deny or defer is required. **Expedited (Urgent) Preservice, Extension Needed:** Within 72 hours of the initial request **Concurrent:** A deferral must be made within 24 hours if indicated. Approval, modification or denial within 72 hours. **Post-Service/Retrospective:** Within 30 days of receipt	• Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days

Medi-Cal Pharmacy — Timeframes for Notification	OneCare and OneCare Connect Pharmacy — Timeframes for Notification (Part D)
Routine (Non-Urgent): Pre-Service Extension Needed: Provider: Electronic/written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request. Member: Written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request. **Expedited Authorization (Pre-Service):** Notification of Denial or Modification: Provider: Electronic/written: Within 2 business days of making the decision. Member: Written: Within 2 business days of making the decision. **Expedited (Urgent) Preservice, Extension Needed:** Provider: Electronic/written: Within 2 business days of the decision Member: Written: Within 2 business days of the decision **Concurrent:** Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 24 hours of making the decision. **Post Service/ Retrospective Review:** Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of —receipt of request.	Authorization Request Type: **For expedited requests**: Written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. **For standard requests**: Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. **For retrospective requests:** Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.

~~Medi-Cal~~ ~~Denial Letter/Member Notification~~	~~OneCare and OneCare Connect~~ ~~Denial Letter/Member Notification~~
~~State mandated "Notice of Action"~~	~~CMS mandated "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination~~

Emergency Services

Emergency room services are available 24 hours/day, 7 days/week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered ~~inpatient and outpatient services~~ when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a ~~P~~plan network practitioner, or ~~P~~plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as ~~previously stated.~~follows:

Authorization for Post-Stabilization Services

A Hospital must submit a Prior Authorization Request for Post-Stabilization Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined

to have reached medical stability, but requires additional, Medically Necessary inpatient covered services that are related to the Emergency Medical Condition, and provided to maintain, improve or resolve the Member's stabilized medical condition.

CalOptima or a Health Network shall approve or deny the Prior Authorization Request for Post-Stabilization Services within ~~thirty (~~30~~)~~ minutes of receipt of the telephone call from the Hospital for Medi-Cal members and within ~~sixty (~~60~~)~~ minutes of receipt of the telephone call from the hospital for OneCare or OneCare Connect members.~~-~~ If CalOptima or the H~~ealth N~~etwork~~ does not respond within the prescribed time frame, Medically Necessary services are considered approved.

Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required time frames, except as related to any claim filing time frames. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services
For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima ~~within~~ at least ~~five (~~5~~)~~ days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for ~~emergent~~ emergency or urgent care services~~. Facilities are required to notify CalOptima of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services require authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.~~

UM Routine/Standard Prior Authorization Services
CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within ~~five (~~5~~)~~ business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request.~~ A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. CalOptima makes a determination for urgent concurrent, expedited continued stay, post stabilization review or in cases for ongoing ambulatory care or if the lack of treatment may result in an emergency visit or emergency admission within 24 hours of receipt of the request for services. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.~~

Retrospective Review
Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, UM or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted ~~as follows per~~in accordance with CalOptima Policy and Procedure GG.1508 Authorization and Processing of Referrals.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request. ~~The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.~~

Admission/Concurrent Review Process

Facilities are required to notify CalOptima of all inpatient admissions within ~~one (~~1~~)~~ business day following the admission. ~~-~~The admission/concurrent review process assesses the clinical status of the member~~,~~ ~~and~~ verifies the need for continued hospitalization~~,~~ ~~and~~ facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed~~,~~
- Validating the diagnosis~~;~~
- Assessment of the clinical status of the member to determine special requirements to
- facilitate a safe discharge to another level of care~~;~~
- Additional days/service/procedures proposed~~, and~~
- Reasons for extension of the treatment or service~~.~~

~~Post-stabilization services requires authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as described above.~~

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management ~~, disease management,~~ or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members,

either in the Emergency Room or inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:

- Established estimated length of stay criteria.
- Medical necessity criteria to establish appropriate level of care.
- Member psychosocial needs impacting ongoing care.
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care.
- Facilitation of transfer of members from non-contracted facilities to facilities with a contracted hospitalist team.

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:

- Early identification of ~~CalOptima Direct (~~COD~~)~~ members
- Process for notification of hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care ~~P~~plan development and implementation
- Discharge ~~P~~planning

The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient ~~admission, and~~admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.~~;~~
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.~~;~~
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.~~;~~
- Communication to attending physician and member regarding covered benefits, to reduce the

possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.;

- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge pPlanning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in the Referral/Authorization Processing Policy and Procedure. The written notification is easily understandable and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

GRIEVANCE PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OneCare or OneCare Connect members wish to exercise their right to review ~~of~~ a UM decision to deny, delay, ~~terminate~~ or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's GARS. The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Policy ~~and Procedure~~ HH.1102: CalOptima Member Complaint and CalOptima Policy GG.1510: Appeal Process.~~Grievance and Appeals Resolution Services.~~ This process includes:

- Collection of data.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Resolution of operational or systems issues.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the ~~initial~~ appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination~~; however, the initial reviewer may participate in the appeal process if new or additional information is submitted~~.
The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues ~~is~~ are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, ~~or~~ member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily

function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in ~~as~~ an expeditious ~~a~~ manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature~~,~~ and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member~~,~~ or could jeopardize the member's ability to regain maximum functionality.

~~Fair~~ State Hearing (Medi-Cal Line of Business Only)

CalOptima Medi-Cal members have the right to request a ~~Fair~~ State Hearing from the California Department of Social Services ~~at any time during the appeals process,~~ after exhausting the appeal process. ~~or within 90 days of an adverse decision.~~ A member may file a request for a ~~Fair~~ State Hearing within 120 days from the Notice of Appeal Resolution. ~~and a request for an appeal at the same time.~~ CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State ~~Fair~~ Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution ~~resolution letter~~ sent to the member or the member's representative.

Independent Medical Review

OneCare and OneCare Connect members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). ~~T~~CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. ~~OneCare~~ CalOptima is notified when a request is made by a member or member representative. ~~OneCare~~ CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and ~~OneCare~~ CalOptima of the outcome of their review. If the decision is overturned, ~~OneCare~~ CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions (PPCs)

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals~~, and~~.

2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

LONG-TERM SERVICES AND SUPPORTS

Long-Term Care

The Long-Term Care case management program includes authorizations for the following facilities:

- ~~s~~Skilled nursing~~,~~
- ~~i~~Intermediate care, sub-acute care~~,~~
- ~~I~~intermediate care~~–~~, developmentally disabled~~,~~
- ~~I~~intermediate care~~–~~, developmentally disabled~~—~~ ~~–~~ habilitative~~, and~~
- ~~i~~Intermediate care~~—~~, developmentally disabled~~—~~ ~~–~~ nursing~~.~~

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. An on-site visit is scheduled to assess patient's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system. Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, ~~facility based~~facility-based program offering day time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP

CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals

who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to: senior center programs~~,~~; case management~~,~~; money management and counseling~~,~~; respite~~,~~; housing assistance~~,~~; assistive devices~~,~~; legal services~~,~~; transportation~~,~~; nutrition services~~,~~; home health care~~,~~; meals~~,~~; personal care assistance with hygiene~~,~~; personal safety; and activities of daily living.

~~IHSS~~

~~CalOptima is responsible for member referral to the IHSS program (which is operated by the County of Orange) for individuals who may qualify for services. The program provides services to those members who are disabled, blind, or 65 years of age or older and are unable to live safely at home without help who meet the financial need requirement. Services are provided by a caretaker that the member hires. The County determines eligibility under the program. It also determines the number of hours that an individual can receive services. Under an MOU with the county, CalOptima works collaboratively to ensure that referrals are being made.~~

Transitions of Care (TOC)

Transitions of Care (TOC) is a ~~4 week~~ patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides ~~OneCare~~OC and ~~OneCare Connect~~OCC ~~patients~~members discharged from Fountain Valley Regional Hospital (or caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential ~~a~~ of a ~~possible~~ readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: ~~Patient~~ Member is knowledgeable about indications that their condition is worsening and how to respond~~:~~.
- **Medication Self-Management**: ~~Patient~~ Member is knowledgeable about medications and has a medication management system~~:~~.
- **Patient-Centered Health Record**: ~~Patient~~ Member understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings~~:~~.
- **Physician Follow-Up**: ~~Patient~~ Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other healthcare delivery organizations and community resources, as applicable. -

For further details of the structure, process, staffing, and overall program management please refer to the ~~2018~~ 2019 Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by CalOptima's Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The CalOptima Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence~~, or CMS Center(s) of Excellence for OneCare,~~ as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program, ~~and reports to the UMC to oversee the accessibility, timeliness and quality of the transplant process across networks.~~

Coordination of Care.

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases ~~which~~ that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and underutilization, and/or changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed Days
- Admits per 1000
- ALOS
- Readmission Rates
- ~~Used/Unused Authorizations~~
- ~~Inter-rater Reliability for all licensed staff utilizing clinical review criteria~~
- ~~Grievances — Member per 1000 per Year~~
- ~~Appeals — Member per 1000 per Year~~
- Overturn Rates — Provider per 1000 per Year
- ~~Satisfaction with Primary Care Access~~
- ~~Provider Satisfaction~~
- ~~Member Satisfaction~~
- HEDIS rates for selected measures ~~/Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~
-
-

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director~~, of U~~~~tilization M~~~~anagement~~ evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation

and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may ~~include, but~~include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM ~~process, and~~process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

2019 Utilization Management Program

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

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2019 UM Program Description

- Defines CalOptima's structure and process for review of health care services, treatment and supplies
- Explains how services are reviewed in an effective, timely manner
- Includes the assignment of appropriate individuals for review
- Outlines monitoring processes to evaluate the effectiveness of the program and identify opportunities for improvement

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2019 UM Program Description Revisions

- Aligned program descriptions and committee references with the Quality Management Program and approved committee charter updates.
- Updated program to reflect the transition of California Children's Services program to the Whole Child Model program
- Updated description of responsibilities for various key positions
- Modified reference to CalOptima's health networks to reflect changes in participating networks since 2018

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action

Recommend approval of the 2019 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of December 31st, 2018, CalOptima PACE had 299 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

Discussion

PACE organizations are required to have a written Quality Assessment and Performance Improvement (QAPI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QAPI Plan reflects the full range of services furnished by CalOpima PACE. The goal of the QAPI Plan is to improve future performance through effective improvement activities driven by identifying key, objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

The 2019 CalOptima PACE QAPI Plan is based on CalOptima's first five full years of data collection, review and analysis with specific data driven goals and objectives. The work plan elements were developed based on the opportunities for quality improvement that were revealed in the 2018 CalOptima PACE QAPI Plan Evaluation. For the 2019 QAPI work plan, five new elements were added, two elements were retired, and three elements were bundled into one element. The added elements are focused on reducing falls, increasing participant satisfaction with meals, increasing the inquiry to enrollment conversion, monitoring participants on high dosages of opioids and identifying a

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family member who can make decisions in emergency situations. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommend action to approve the 2019 CalOptima PACE QAPI Plan does not have a fiscal impact. Administrative expenses to implement the 2019 PACE QAPI Plan are included in the Board-approved Fiscal Year 2018-19 Consolidated Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a Quality Assessment and Performance Improvement (QAPI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QAPI plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR §460.132(a) and (b), the PACE organization leadership presents their QAPI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

Concurrence

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

Attachments

1. Proposed 2019 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan and QAPI Work Plan
2. PowerPoint Presentation to the Board of Directors' Quality Assurance Committee: 2019 PACE QAPI Description and Work Plan

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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CALOPTIMA PACE

QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN

20198

Quality Improvement Subcommittee Chairperson:

~~Richard Helmer~~David Ramirez, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, M.D. **Date**

Board of Directors Chairperson:

Paul Yost, M.D. **Date**

Introduction

The Quality Assessment Performance Improvement Plan (QAPI) at CalOptima's Program of ~~All Inclusive~~All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous quality improvement for all the PACE organizations' services. ~~-~~It is designed and organized to support the mission, values, and goals of CalOptima PACE.

Overview

- The goal~~s~~ of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). ~~-~~As CalOptima's governing body, the Board of Directors has the final authority to review and~~,~~ approve ~~and, if necessary, revise~~ the QAPI Plan annually, and direct the PACE Medical Director to make revisions to the QAPI Plan, as necessary and appropriate. (See Appendix A).~~-~~ It is comprised of both the PACE QAPI Program Description and specific goals and objectives described in the PACE QAPI Work Plan. (See Appendix B).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. ~~-~~The PACE QI Coordinator will ensure timely collection and completeness of data.
- The CalOptima PQIC~~PACE QAPI Committee~~ will complete an annual evaluation of the approved QAPI Plan. ~~-~~This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QAPI Plan to the goals and objectives for the following year.

~~Goals~~

- ~~To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes~~
- ~~To coordinate all QAPI activities into a well-integrated system that oversees quality of care services~~
- ~~To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care~~
- ~~To ensure that all levels of care are consistent with professionally recognized standards of practice~~
- ~~To assure compliance with regulatory requirements of all responsible agencies.~~
- ~~To promote continuing education and training of staff, practitioners, administration and the executive board~~
- ~~To analyze data and studies for outcome patterns and trends~~
- ~~To annually assess the effectiveness of the QAPI Plan and enhance the program by finding opportunities to improve the CalOptima PACE QAPI Plan~~

~~Objectives~~Goals

- Improve the quality of health care for participants.
  - Ensure all QAPI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
  - Ensure the QAPI program ~~that~~ involves all providers of care within the PACE program.
  - ~~Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).~~
  - Implement population health management techniques, such as immunizations, for specific participant populations~~, such as immunizations~~.
  - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
  - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) in order to identify areas needing of quality improvement.
  -
  - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the state administering agencies (SAA) which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 98~~0~~% for the appropriate participant population ~~that is appropriate~~.
  - Communicate relevant ~~all~~ QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
  - Share r~~R~~esults of QAPI-identified benchmarks ~~are shared~~ with staff and contracted providers at least annually.
  -
  - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. ~~-~~Professional standards of CalOptima PACE ~~S~~staff will be measured against those outlined by their respective licensing agency~~y~~ies in the State of California (i.e. ~~The~~ State Board of Nursing of California).
  - ~~To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes~~
  - ~~To coordinate all QAPI activities into a well integrated system that oversees quality of care services~~
  - ~~To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care~~
  - E~~To e~~nsure that all levels of care are consistent with professionally recognized standards of practice.
  - A~~To a~~ssure compliance with regulatory requirements of all responsible agencies.
- ~~To promote continuing education and training of staff, practitioners, administration and the executive board~~

-
- Improve ~~on~~ the participant~~tient~~ experience.
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of patient experience.
  - Identify and implement ways to better engage participants in the PACE experience, i.e., menu selection~~,~~ and ~~PACE Member Advisory Committee (~~PMAC~~)~~.
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) which honors members' wishes as well as advance directive rights..
- Ensure the ~~A~~appropriate ~~U~~use of ~~R~~resources.
  - Review and analyze utilization data regularly, including hospital admissions, hospital readmissions, ~~ER~~Emergency Room visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
  - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
  - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs)~~s~~.
  - ~~o~~ Ensure high levels of coordination and communication between ~~the~~ inpatient facilities, nursing facilit~~y~~ies and ~~the~~ PACE ~~primary care physicians~~PCPs.
  -
  - ~~o~~ Review and analyze clinic medical records to ensure appropriate documentation and coding.
  - ~~o Ensure appropriate use of resources~~
  - ~~o Review and analyze utilization data regularly including hospital admissions, hospital readmissions, ER visits, and hospital 30-day all-cause readmission.~~
  - ~~o~~
  - ~~o Provide oversight of contracted services~~
  - ~~o Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.~~
  - ~~o Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.~~
  - ~~o Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing basis.~~
  - ~~o Monitor staff and contractors to ensure that appropriate standards of care are met.~~
  - ~~o~~
  - ~~o Communication of Quality and Process Improvement Activities and Outcomes~~
  - ~~o Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, and the Board of Directors.~~
  - ~~o Results of QAPI identified benchmarks are shared with staff and contracted providers at least annually.~~

-
- Ensure the ~~S~~safety of ~~C~~clinical ~~C~~care
  - Reduce potential risks to safety and health of PACE participants through ongoing r~~R~~isk m~~M~~anagement.
  - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
  - ~~Monitor, analyze and report the aggregated data elements required by CMS via the Health Plan Management System in order to identify areas needing of quality improvement.~~
  - Monitor, report and perform a Root Cause Analysis on all participant-involved events~~,~~ resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
  - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
- Ensure appropriate access and availability.
  - ~~Continuously m~~Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
  - Continue to develop the network of Alternate Care Setting sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure (See Appendix A for Organizational Chart)
CalOptima Board of Directors provides oversight and direction to the CalOptima PACE Organization. ~~-~~The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. ~~-~~The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the quality improvement (QI) programs at CalOptima, including ~~. This includes~~ the CalOptima PACE QAPI Program, to the CalOptima Board of Director~~'~~s' Quality Assurance Committee (QAC), which performs the functions of the Quality Improvement Committee (QIC) described in CalOptima's State and Federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The CalOptima Board of Director~~'~~s' QAC is a subcommittee of the Board, and consists of currently active Board members. ~~-~~The CalOptima Board of Director's QAC reviews the quality and utilization data that are discussed during the PACE Quality Improvement Committee (PQIC) reports. ~~-~~The CalOptima Board of Director's QAC provides progress reports, reviews the annual PACE QAPI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

CalOptima PACE Quality Improvement Committee (PQIC)

Purpose

This committee provides oversight for the overall administrative and clinical operations of ~~the~~ CalOptima ~~organization~~PACE. ~~-~~The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. Twice a quarter, ~~-~~the PQIC will review all QAPI ~~Plan~~ initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. ~~-~~The PQIC may create Ad Hoc Focus Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. ~~-~~It will also discuss Unusual Quality Incidents~~Level One data and Level Two data and incidents~~.~~-~~ Potential areas for improvement will be identified through analysis of the data and through ~~Level Two~~ root cause analysis. ~~-~~This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director~~'~~s' QAC, who will then report up to the Board.~~-~~ The PACE Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence.~~-~~ The PACE Director or the PACE QI Manager ~~A Coordinator~~ may report up to the CalOptima Board of Director~~'~~s' QAC if the PACE Medical Director is not available.

Membership

Membership shall be ~~comprise~~comprised of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager~~, PACE Clinical Medical Director~~, PACE QI ~~A~~ Manager~~, the~~ PACE ~~and the~~ QI ~~A~~ Coordinator, and PACE Intake/Enrollment Manager. ~~-~~At least four regular members shall constitute a quorum. ~~-~~The PACE Medical Director will act as the standing c~~C~~hair of the committee. See Appendix C for QI Committee Minutes Template.

CalOptima PACE Focused Review Committees

Purpose

These committees will be formed to respond to or to proactively address specific quality issues ~~which~~ that rise to the level of warranting further study and action. ~~-~~Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to ~~-~~include at least two of the following positions and/or functions: PACE Medical Director~~, PACE Clinical Medical Director~~, PACE QI~~A~~ Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI~~A~~ Coordinator, and PACE Intake/Enrollment ~~Coordinator~~ Manager or direct care staff.~~-~~ The Committee will be chaired by the PACE Medical Director~~, PACE Clinical Medical Director~~, ~~-~~PACE Director or PACE QI~~A~~ Manager. ~~-~~The chair will report on activities and results to the PQIC. ~~-~~The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC. ~~-~~This c~~C~~ommittee will be responsible for managing all peer review activities performed by independent reviewers related to adverse outcomes.

CalOptima PACE Member Advisory Committee (PMAC)

Purpose
This committee provides advice to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. -A member of the PMAC shall report its activities to ~~both the PQIC and~~ the CalOptima Board of Directors'~~,~~ QAC, which then will be reported to the Board. -The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. -Participants and representatives of participants shall constitute a majority of membership. -The committee will be comprised of at least seven members. -At least four regular members shall constitute a quorum. -The PACE Program Director will act as the standing c~~C~~hair and will facilitate for the committee. -The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

Quality and Performance Improvement Activities, Outcomes and Reporting

Quality ~~I~~indicators and ~~O~~opportunities for i~~I~~mprovement
Routine quality indicators appropriate to the CalOptima PACE population are identified on analysis and trending of data related to the care and services provided at PACE. -Other indicators and opportunities for performance improvement are identified through:

- Utilization of s~~S~~ervices
    - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
        - Hospital Bed Days
        - ER Visits
        - 30-Day All-Cause Readmissions
        - Participants residing in Long-~~-~~Term Care
    - Data analysis will allow for analyzing both overutilization and ~~under utilization~~underutilization for areas of quality improvement.
- Participant and ~~C~~caregiver ~~S~~satisfaction
    - The organization shall survey the participants and their caregivers on at least an annual basis. -Additionally, the organization~~we~~ will ~~continue to~~ look for other opportunities for feedback in order to improve quality of services.
    - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
    - The ~~PACE Member Adviosory~~Advisory ~~Committee~~PMAC shall provide direct ~~feeback~~feedback on satisfaction to both the PACE leadership staff and the CalOptima Board of Directors~~,~~' ~~Quality Assuarnace~~Assurance ~~Committee~~QAC.
- Outcome m~~M~~easures f~~F~~rom the QAPI W~~w~~ork P~~p~~lan elements ~~as well as the~~and ~~elininically~~clinically ~~relavant~~relevant HPMS data. This will include:

- ~~This will include t~~The CMS mandated immunization elements.
- Healthcare Effectiveness Data and Information Set (HEDIS) metrics ~~relavent~~relevant to the PACE population including:
  - Comprehensive Diabetes Care (CDC)
  - Care for Older Adults: Advanced Care Planning
  - Potentially Harmful Drug-Disease ~~Interations~~Interactions in the Elderly (DDE)
  - Medication ~~Reconcilliation~~Reconciliation Post Discharge (MRP)
  - ~~Opioids at High Dosage (UOD)~~
  -
- ~~Annual Medication Review~~

Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments may be used. ~~-~~Standardized, evidenced~~-~~based assessments will be used whenever available.

-

- Effectiveness and safety of staff-provided and contract-provided services.
  - This will be measured by participants~~'~~' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
  - All clinical and certain non-clinical positions have competency profiles specific to their positions.
  - CalOptima PACE staff will monitor providers by methods such as review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews.
  - Unannounced visits to inpatient provider sites will be made by CalOptima PACE staff as necessary.
- Non-clinical areas
  - The PACE PQIC has oversight to all activities offered by PACE.
  - Member ~~G~~grievances will be forwarded to the QI~~A~~ Coordinator and QI Manager for tracking, trending and data gathering. ~~-~~These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. ~~-~~Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed.~~-~~ Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
  - Member a~~A~~ppeals will be forwarded to the QI~~A~~ Coordinator and QI Manager for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. ~~If the PACE Director determines that the appeal is for clinical services, it will be forwarded to the PACE Medical Director for review. If the PACE Directorcor or PACE Medical Director disagrees with decision made by the IDT, they will approve the service and communicate this decision to IDT. If the PACE Director or PACE Medical Director agees with IDT's decision, T~~the case will then be ~~forwared~~forwarded to a third party with the appropriate licensure for review. ~~-~~The third~~-~~party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the ~~Interdisciplinary Team~~IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.

- Transportation services will continue to be monitored through monthly metrics and ~~,~~ grievance trending. ~~, and a transportation incident log.~~ The monthly report generated by the transportation vendor will be ~~reviewed~~reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. ~~-~~The PACE QI department will validate the transportation data by periodically comparing the raw GPS data and unannounced ride along data against the reports submitted~~-~~.
- Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima ~~PACE Member Advisory Committee~~PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.
- ~~o~~ Plans of correction on problems noted will be implemented by center staff, ~~and~~ reviewed by the PACE Program Director, PACE Medical Director or the PACE ~~QA~~ QI Manager, and ~~will be~~ presented to the PQIC.
-

~~o~~ The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

-

Priority setting for performance improvement initiatives is based on:

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver~~,~~ or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume~~,~~ or high frequency events.
- Relevance to the mission and values of CalOptima PACE.

External ~~M~~monitoring and ~~R~~reporting

CalOptima PACE will report both aggregate and individual-level data to CMS and ~~State Administering Agencies~~SAA to allow them to monitor CalOptima's PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events) ~~Level One and Level Two Reporting~~, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. ~~-~~Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of ~~the Health Plan Management System (~~HPMS~~)~~. ~~-~~The following data is ~~Level One events are~~ reported to CMS via the ~~Health Plan Management System (~~HPMS~~)~~ on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents~~Burns~~
- Medication Errors
- Immunizations
- Enrollment Data~~/Disenrollment~~
- Denials of Prospective Enrollees
- ~~•~~ Falls without Injury

-
- ER Visits~~Kennedy Terminal Ulcer~~
-

Unusual q~~Q~~uality ~~I~~incidents:~~Level Two Reporting Indicators~~

- When unusual incidents reach specified thresholds, CalOptima PACE must notify CMS on a quarterly basis through ~~the Health Plan Management System (~~HPMS~~)~~. ~~-~~ CalOptima PACE must ~~and the State Administering Agency in the required timetables,~~ complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and DHCS ~~agencies~~ as well as internally at the PACE QIC. ~~-~~The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:~~Level Two Events are:~~
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure ~~ulcer~~ injuries acquired while enrolled in the PACE Program.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - Any elopement.
    - Adverse ~~D~~drug ~~R~~reactions
    - Foodborne o~~O~~utbreak
    - Burns 2nd ~~D~~degree or higher
- Health Outcomes Survey-Modified (HOS-M)
    - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other ~~E~~external ~~R~~reporting ~~R~~requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC).

Corrective ~~A~~action ~~P~~plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each ~~corrective plan~~CAP will include an explanation of the problem, the individual who is responsible for implementing the ~~corrective plan~~CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- ~~Corrective Action Plans~~CAPs from contracted providers will be requested by the QI~~A~~ Manager or ~~other~~another member of the PQIC, as appropriate.

Urgent ~~C~~corrective ~~M~~measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the CalOptima PACE Medical Director and the CalOptima PACE Director.
- The QI~~A~~ Manager or QI~~A~~ Coordinator will consult with relevant CalOptima PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

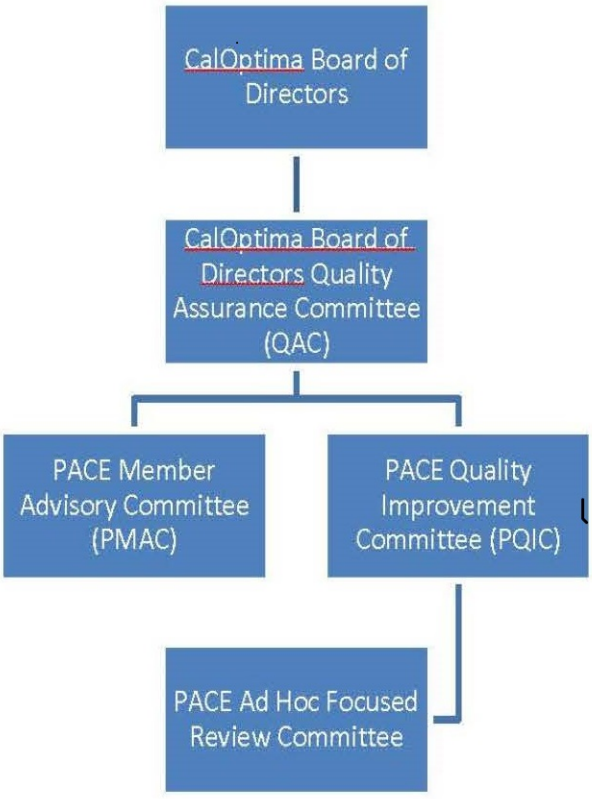
Re-~~E~~evaluation and ~~F~~follow-up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - ~~-~~Feasibility of implementation
    -
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. ~~-~~A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Annual ~~R~~review of PACE QAPI Plan

- The PACE QAPI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QAPI Work Plan.
- The CalOptima Board of Directors will review~~, revise~~ and approve the CalOptima PACE QAPI Plan, and direct the PACE Medical Director to make revisions to the QAPI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

Appendix A: 2019~~8~~ CalOptima PACE QAPI Program Reporting Structure



Appendix B

Proposed 2019 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan								
QAPI Item#	**Goal**	**Description**	**Objective**	**Sub-Objective**	**Activity**	**Reporting Frequency**	**Target completion**	**Responsible Person**
QAPI19.01	**Improve the Quality of Care for Participants**	**2018 PACE QAPI Plan and Work Plan Annual Evaluation**	2018 PACE QAPI Plan will be evaluated by March 1st, 2019	N/A	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2019	PACE Medical Director
QAPI19.02	**Improve the Quality of Care for Participants**	**2019 PACE QAPI Plan and Work Plan Annual Oversight**	PACE QAPI Plan and Work Plan will be reviewed and updated by March 1st, 2019	N/A	QAPI and QAPI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2019	PACE Medical Director
QAPI19.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	>/= 90% of eligible participants will have their annual influenza vaccination by December 31st, 2019	N/A	Improve compliance with influenza immunization recommendations	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	>/= 90% of eligible participants will have had their pneumococcal vaccination by December 31st, 2019	N/A	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.05	**Improve the Quality of Care for Participants**	**Infection Control**	In 2019, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	N/A	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.06	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Advance Directive Planning**	>/=95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2019	N/A	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2019	PACE Center Manager
QAPI9.07	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Advance Directive Planning**	>/=90% of participants who a completed POLST will have the designated family member who will make decisions in emergency situations identified and documented on the POLST by December 31st, 2019	N/A	Increase the number of PACE participants who have a designated emergency, family decision maker documented on the POLST.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.08	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Functional Status Assessment**	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	N/A	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.09	**Improve the Quality of Care for Participants**	**Comprehensive Diabetes Care (CDC)**	100% of CDC Sub Objectives will be met in 2019	>80.12% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director
				> 83.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019	
				>98.38% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019	
QAPI19.10	**Ensure the Safety of Clinical Care**	**Reduce the Rate of Day Center Falls**	Decrease the rate of participate falls occurring at the PACE day centers (ACS and Garden Grove PACE) by 10% (<6.65 Falls per 1000 member months) in 2019	N/A	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.11	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents**	<36.13% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director
QAPI19.12	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs**	<3.85% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director
QAPI19.13	**Ensure the Safety of Clinical Care**	**Decrease the Use of Opioids at High Dosage (UOD)**	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2019	N/A	The PACE QI Department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2019	PACE Clinical Medical Director
QAPI19.14	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	>/=90% of participants will have their medications reconciled within 30 days of hospital discharge in 2019	N/A	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2019	PACE Pharmacist

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QAPI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QAPI19.15	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	>/= 80% of specialty care authorizations will be scheduled within 10 days in 2019	N/A	Appointments for specialty care will be scheduled within 10 days to improve access to specialty care for initial consultations	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.16	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	< 2,760 hospital days per 1000 per year (10% decrease from 2018)	N/A	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director
QAPI19.17	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	< 878 emergency room visits per 1000 per year (10% decrease from 2018)	N/A	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director
QAPI19.18	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<15% 30-day all cause readmission (July 2018 CalPACE average)	N/A	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2019	PACE Medical Director
QAPI19.19	**Ensure Appropriate Use of Resources**	**Long Term Care Placement**	<3% of members (July 2018 CalPACE average) will reside in long term care	N/A	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Center Manager
QAPI19.20	**Improve Participant Experience**	**Enrollments/Disenrollments**	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment in 2019 by 10% (<27 disenrollments/K/Y)	N/A	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager
QAPI19.21	**Improve Participant Experience**	**Enrollments/Disenrollments**	Increase the Inquiry to enrollment conversion rate to 7% in 2019 (Baseline of 5% in the last 6 months of 2018)	N/A	Review and analyze the inquiry to enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager
QAPI19.22	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2019	N/A	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2019	PACE Center Manager
QAPI19.23	**Improve Participant Experience**	**Transportation**	>/= 90% of all transportation rides will be on-time in 2019	N/A	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	Quarterly	12/31/2019	PACE Center Manager
QAPI19.24	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	>/= 64% on Satisfaction with Meals summary score (2018 CalPACE average) on the 2019 PACE Satisfaction Survey	N/A	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.25	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	>/=88% on the Overall Satisfaction Weighted Average (2018 CalPACE Average) on the 2019 PACE Satisfaction Survey	N/A	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2019	PACE Director

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Appendix C: PACE QAPI Committee Meeting Minutes Template

PACE Quality Improvement Committee Meeting Minutes Date Time: Place: PACE conference Room 109		
Meeting Attendees: PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and the PACE Intake/Enrollment Manager.		
Meeting Notes Taker: QA Coordinator		
Topic	Presentation/Discussion	Recommendation/Action
Roll Call and Introduction		
Review and Approval of Last PQIC Meeting Minutes		
Old Business:		
New Business:		
Level II Issues		
HPMS Data Analysis		
Standing Agenda Item		
Clinical Logs and Updates		
Operational Logs and Updates		
Site Logs and Updates		
PMAC Update Report		

2019 PACE Quality Assurance Performance Improvement (QAPI) Plan

Board of Directors' Quality Assurance Committee Meeting

February 20, 2019

Miles Masatsugu, MD

Medical Director

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2019 Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations

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2018 PACE QAPI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience

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2019 QAPI New/Updated Work Plan Elements

- Comprehensive Diabetes Care (CDC) Bundled
  - Annual Diabetic Eye Exams
  - Nephropathy Monitoring
  - Blood Pressure Control (<140/90)
- Use of Opioids at High Dosage (UOD)
- Reduce the Rate of Day Center Falls
- Increase Participant Satisfaction with Meals
- Care for Older Adults (COA): Advanced Care Planning
- Increase Inquiry to Enrollment Conversion

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Recommended Action

- Recommend approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment Performance Improvement (QAPI) Plan

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Extending and Authorizing Allocations/Reallocations of Spending Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality Analytics & Population Health Management, (714) 246-8400

Recommended Actions

1. Authorize extension of the timeline for previously-approved spending of Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds to expand the child and adolescent component of the Shape Your Life (SYL) weight management program for CalOptima Medi-Cal members until the funds have been exhausted; and
2. Authorize the funds allocated for member interventions ($150,000) to support program awareness and outreach efforts, continued costs for program expansion, and the Department of Health Care Services (DHCS)-approved member and provider incentive program.

Background

In the United States, the percentage of children and adolescents affected by obesity has more than tripled since the 1970s. Data from 2015-2016 show that nearly 1 in 5 school age children and young people (6 to 19 years) in the United States has obesity. Childhood obesity has immediate and long-term effects on physical, social, and emotional health. Children with obesity are at a higher risk of having other chronic health conditions and diseases (ex. asthma, sleep apnea, type 2 diabetes, etc.) that influence physical health. Children with obesity are bullied and teased more than their normal weight peers and are more likely to suffer from social isolation, depression, and lower self-esteem. The California Department for Public Health Advocacy reports 38 percent of fifth, seventh, and ninth-graders in California are overweight or obese, compared to 33 percent in 2014. The cities with the highest levels of overweight youth are Anaheim (43.5percent), Santa Ana (46.5percent) and Stanton (51.8percent) cities which also have the highest rates of poverty, according to publichealthacvocacy.org.

CalOptima has been participating in the Intergovernmental Transfer (IGT) funds program since July 1, 2010. Each IGT must meet federal and state requirements and each transaction is approved in advance by the Department of Health Care Services (DHCS) and the Center for Medicare and Medicaid Services (CMS). Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members. Revenue must be used to finance improvements in services for Medi-Cal beneficiaries. The Health Education and Disease Management (HE/DM) department received $500,000f from IGT 1 for the purpose of creating programs for high risk children. These funds were received in fiscal year 12-13; however, the department did not obtain board approval to act on these funds until October 6, 2016. After a lengthy Request for Proposal (RFP), the department identified vendor support for expansion efforts and contracts were awarded in the fourth quarter of 2017.

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Discussion

In 2014, staff completed a comprehensive evaluation of CalOptima's SYL program and identified many opportunities for improvement, including revising the program's structured weight management interventions for children due to the interventions' high costs, low member penetration and limited geographical access. As a result, staff redesigned the child and adolescent evidenced-based core curriculum for our community, group-based weight management interventions, refined risk stratification and rebranded our entire obesity program "Shape Your Life." The program currently provides health education materials to all its members and has outreached to all CalOptima primary care providers (PCPs) to share the evidenced-based treatment recommendations, as well as tools to aid in the office-based treatment of childhood and adult obesity.

In support of staff efforts, the Board allocated $500,000 of IGT 1 Funds for high risk children programs at its March 6, 2014, meeting. Of these allocated funds, approximately $250K have been expended to date on staffing and member/provider incentives; however, because health education group classes are a covered Medi-Cal benefit, these are not an appropriate use for IGT funds (i.e., IGT 2010-11 IGT dollars must be spent to provide enhanced benefits for existing Medi-Cal beneficiaries, not for Medi-Cal covered benefits). For this reason, staff proposes to use the $150,000 allocated for member interventions to expand awareness of the SYL program and set up costs to continue county wide expansion efforts until funds are exhausted.

Program / Awareness and Outreach Efforts:

In the first six months of program implementation in 2018, SYL classes were expanded to 10 sites throughout the county through community partnership. Approximately 850 members enrolled in classes, and 66% either reduced or maintained their BMI. CalOptima paid $25,000 in member/provider incentives during this time period.

To further expand awareness of the SYL program considering these favorable 2018 results, CalOptima staff seeks to strengthen its member communication strategies through public broadcasting television (PBS KIDS SOCAL). According to Nielsen NPOWER data sources, in the16-17 season, PBS Kids was available in 95% of U.S. households, providing kids access to what may be their only source of educational TV. The report also indicates PBS also reaches more children ages 2-8 from low-income families than any children's cable network. CalOptima would like to expand program awareness with messaging that will:

- Deliver useful health promotion and prevention messaging, specifically on the topic of healthy eating and physical fitness
- Promote healthy behaviors among members (e.g. annual physician visits, immunization calendar and flu awareness)
- Grow awareness of CalOptima brand and programs
- Improve clinical care outcomes

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Incentives:
Continue with DHCS-approved incentive program to members and providers. CalOptima incentive program is as follows:
Member

- Complete 6 group classes
- Attend a follow-up visit with their PCP
- $50 gift card for post-program office visit

Provider

- Provider follow-up appointment with member
- Complete incentive form
  - ICD-10 codes – Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) highly encouraged
- $75 for post-program office visit and reassessment (paid quarterly).

Program Administrative Costs:
Continue to support program expansion expenses including:

- Distribution of Shape Your Life newsletter
- Expand community partnership to cover more geographic areas based on member needs
- Support licensing costs to expand curriculum to additional sites
- Provide teaching aids to support improved member outcomes (food models, fitness technology products, etc.)

Fiscal Impact
The recommended action to approve the allocation of $150,000 from IGT 1 to support program marketing outreach efforts, continued costs for program expansion, and the DHCS approved member and provider incentive program has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
Childhood obesity is a growing epidemic that affects more than 48,000 children enrolled in CalOptima's Medi-Cal program. Although health plans are not the only stakeholder in this national epidemic, CalOptima recognizes that it plays a critical role in combating this important issue.

SYL program components address environmental and cultural practices that support healthier eating and increased daily activity. These interventions can assist children in achieving and maintaining appropriate BMI levels, and prevent complications such as hyperlipidemia, hypertension, diabetes, and other chronic conditions associated with obesity. The extension of IGT funds is recommended to continue program implementation and expansion countywide. A comprehensive evaluation will be conducted 16-24 months post program implementation. This evaluation will inform long-term program components and costs for future operating budgets.

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

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Attachments

1. Shape Your Life Program Update – Executive Summary
2. Power Point Presentation to the Board of Directors' Quality Assurance Committee: Shape Your Life
3. Board Action dated October 6, 2016, Consider Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions
    a. Board Action dated March 6, 2014, Approve Final Expenditure Plan for Use of FY 2010–11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011–12 IGT Funds; Authorize the Chief Executive Officer to Initiate Required Process for FY 2012–13 IGT Funds and Execute the Standard Required Application Documents

/s/ Michael Schrader — *2/27/2019*

Authorized Signature — **Date**

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Board of Directors Meeting
March 7, 2019

Shape Your Life Program Update – Executive Summary

Shape Your Life Intergovernmental Transfer (IGT) Status Update:

- Completed a comprehensive assessment of our obesity program
- Redesigned our entire obesity program
  - Rebranded the program "Shape Your Life"
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Interactive nutrition education, physical activity and parent seminars
  - Family-centered teaching
  - Refined our evidence-based outcome metrics for our obesity interventions
  - Includes member and provider incentives for program completion
- Expansion
  - Group classes are available in seven cities throughout the county
- Shape Your Life Program Eligibility
  - Ages 5–18
  - BMI ≥85th percentile
  - Medi-Cal eligible
- Shape Your Life has received over 845 incoming program referrals.
  - Sixty-six percent of members have reduced their BMI
  - Fifty-three percent of referred members have attended at least one group class
  - Only 15 percent of referred members have refused services or dropped
  - One hundred-member incentives processed
- Program Opportunities
  - Maintain consistent messaging to members
  - Continue to expand access
  - Identify program sites that promote a positive family-based learning environment
  - Improved oversight of vendor program materials
- Proposed Next Steps
  - Request extension of the timeline for previously approved spending of Rate Year 2010-11 IGT 1 Funds to continue expansion for SYL until funds are exhausted
  - Request the use of remaining funds (approximately $250K) to support program outreach efforts, continued costs for program expansion, and the DHCS approved member and provider incentive program.
  - Consider the challenges of leveraging IGT funding to sustain the Shape Your Life Program, staff plans to transition the program operations, interventions, and incentives through the 2019 -20 budgeting process.

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Shape Your Life Update

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Pshyra Jones
Director, Health Education and Disease Management

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Shape Your Life (SYL) Overview

- Program Eligibility Requirements
  - Ages 5–18
  - BMI ≥ 85th percentile
  - Medi-Cal eligible
- Program Design
  - Group classes
  - Nutrition education
  - Physical activity component
  - Family-centered (parent or close family member encouraged to participate in each class)
  - Up to 12 group classes per year

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SYL Program Goals

- Program Goals
  - Increase youth member access to weight management program(s)
  - Increase doctor-patient relationships regarding healthy weight and nutrition and physical activity counseling
  - Increase member nutrition and physical activity knowledge and behaviors.

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Evaluation

- Program Performance Measures/Evaluation
  - Pre/post BMI
  - Pre/post survey
  - Member feedback
  - Number of member incentive forms received
  - Monitor WCC HEDIS rates

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SYL Services

- SYL Providers
  - Latino Health Access
  - Dr. Riba's Health Club
  - CalOptima hosts classes at community sites
- Locations
  - Expanded to nine sites
  - Anticipate additional sites will be added

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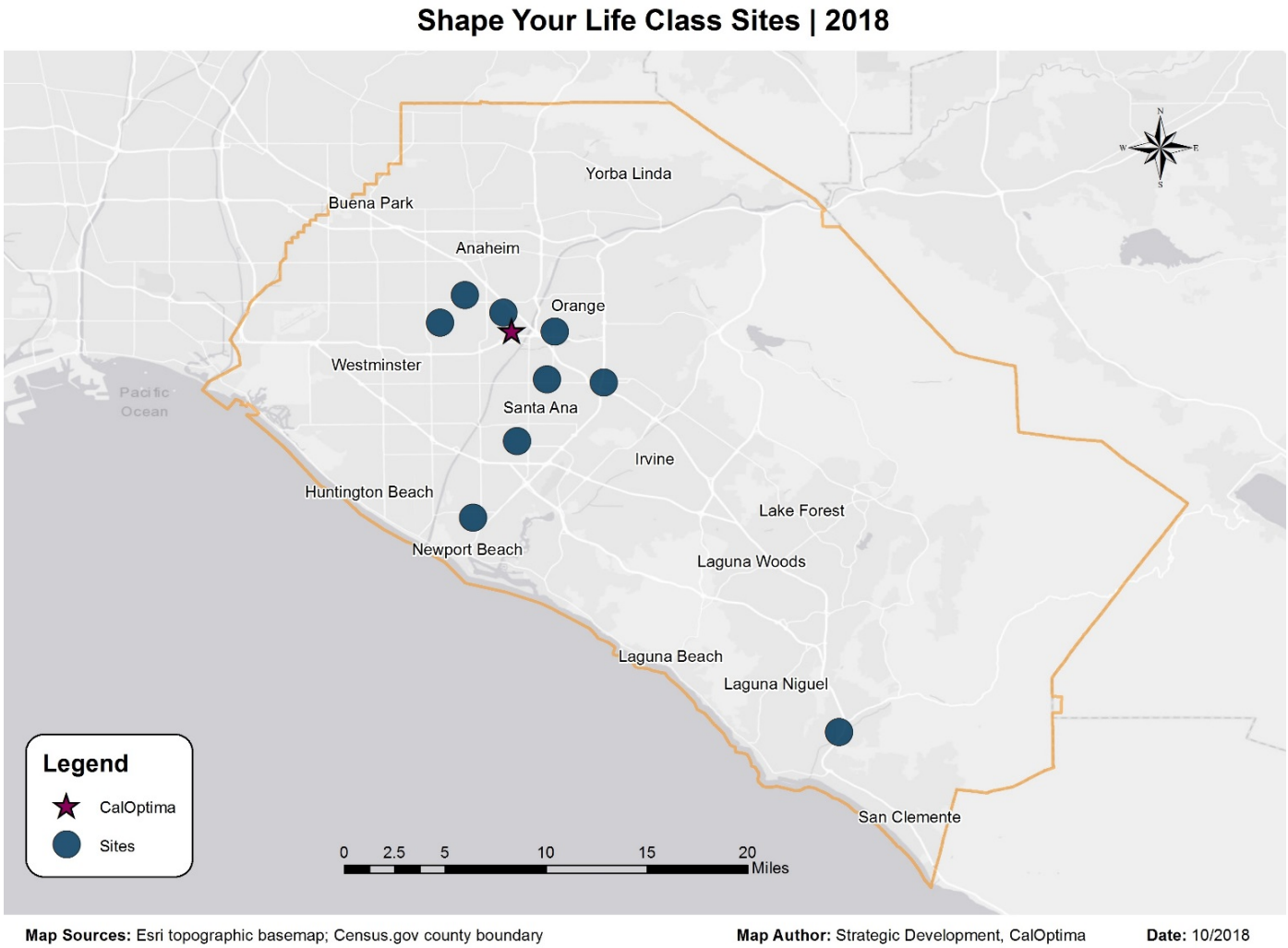
Site Map Locations



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Curriculums

- CalOptima licensed the Kids N Fitness (KNF) curriculum through Children's Hospital Los Angeles
  - Evidence-based program
  - Interactive nutrition education, physical activity and parent seminars
  - Family-centered
- Contract vendors are required to follow specific educational components including:
  - Nutrition education – MyPlate/Food Groups, Portion Control, Food Label Reading, Real vs. Processed Foods, Special Occasions and Dining Out, Healthy Fats, Fiber, Sugar and a market tour, if applicable.
  - Physical activity each class

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Incentives

- Member
  - Complete six group classes
  - Attend a follow-up visit with their PCP
  - $50 gift card
- Provider
  - Provide follow-up appointment with member
  - Completed incentive form
    - ICD-10 codes — Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) highly encouraged
  - Establish and maintain doctor-patient relationship around healthy weight
  - $75 paid quarterly

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Progress to Date

- 848 Referrals
  - 66 percent of members have reduced their BMI
  - 53 percent of referred members have attended at least one group class
  - Only 15 percent of referred members have refused service or dropped
- 100 member incentives processed
- 44 unique provider incentives

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Member Feedback

"We prefer the group setting because we feel less alone."

"We especially like how information is shared with the whole family."

"I (parent) am happy with the classes and like that I can always ask questions and see my daughters are more motivated to eat healthy."

Mother said "I like that my daughter likes the physical activity portion of the class."

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Future Program Opportunities

- Ensuring CalOptima, vendors and PCPs provide consistent messaging to members
- Expand access
- Program sites that promote a positive family-based learning environment
- Improved oversight of vendor program materials

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Shape Your Life IGT Status Update

- Completed a comprehensive assessment of our obesity program
- Redesigned our entire obesity program
  - Rebranded the program “Shape Your Life”
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Refined our evidence-based outcome metrics for our obesity interventions
- Expansion
  - Group classes available in seven cities throughout the county

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Proposed Next Steps

- Request Board authorization for the following:
  - Authorize extension of the timeline for previously approved spending of Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds to expand the child and adolescent component of the Shape Your Life (SYL) weight management program for CalOptima Medi-Cal members until funds have been exhausted; and
  - Authorize the funds allocated for member interventions ($150,000) to support program awareness and outreach efforts, continued costs for program expansion, and the Department of Health Care Services (DHCS) approved member and provider incentive program.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 6, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Consider Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions

Contact

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

Recommended Actions

Authorize:

1. The expenditure of $500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life weight management program for CalOptima Medi-Cal members, which includes, subject to regulatory approval as applicable, member and provider incentives; and
2. The Chief Executive Officer to contract with the vendor(s) selected through an RFP process to provide group-based child and adolescent Shape Your Life program interventions.

Background

Childhood obesity is a growing national epidemic that has more than doubled in children and quadrupled in adolescents in the past 30 years. Overweight and obesity in childhood are known to have significant impact on both physical and psychosocial heath. In 2014, an average of 33% of Orange County students in 5th, 7th, and 9th grades were overweight or obese, compared to 38% statewide. In 2011-2012, 32% of Orange County adults were overweight, in addition to23% identified as obese. Weight status has worsened in Orange County, decreasing from 50% of adults with a healthy weight in 2001 to only 43% in 2011-2012.

Discussion

CalOptima's takes a population management approach towards addressing obesity. Clinical practice guidelines serve as the foundation of the program. These guidelines provide direction for medically-based prevention and treatment protocols within the program. The child and adolescent component of the Shape Your Life program has adopted the clinical practice guidelines entitled "Prevention, Assessment and Treatment of Childhood Obesity: Recommendations from the AMA Expert Committee on Childhood Obesity, June 2007". The main tenet of these guidelines is that a staged approach should be used in the treatment of childhood obesity. This incremental approach begins with health education and moves to structured weight management programs.

Staff has completed a comprehensive evaluation of CalOptima's program and identified many opportunities for improvement, including revising the program's structured weight management interventions for children due to the interventions' high costs, low member penetration and limited geographical access. As a result, staff has redesigned the child and adolescent evidenced-based core

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curriculum for our community, group-based weight management interventions, refined our risk stratification and rebranded our entire obesity program "Shape Your Life." The program currently provides health education materials to all its members and has outreached to all CalOptima primary care physicians (PCPs) to share the evidenced-based treatment recommendations, as well as tools to aid in the office-based treatment of childhood and adult obesity.

The Board allocated $500,000 of IGT 1 funds for high risk children programs at its March 6, 2014, meeting. Of these allocated funds, none have been expended to date. Staff believes these funds are best used to expand the child and adolescent components of the redesigned Shape Your Life program.

Staff proposes to use $150,000 on the group-based weight management childhood obesity interventions, $100,000 for member and provider incentives and up to $250,000 over two years to hire new staff to manage this expansion.

Child and Adolescent Group-Based Interventions: $150,000
For the proposed child and adolescent group-based weight management interventions, staff plans to use the RFP process to find and contract with vendors who can provide these services countywide to our child and adolescent Medi-Cal members. The proposed intervention will be 6-8 group-based visits with nutritional, exercise and healthy habit components.

Incentives: $100,000
A proposed distribution approach for the member and provider incentives are presented below. However, actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participant engagement. Member incentive goals will be established by CalOptima. The goals will be based on completing 6-8 group-based visits, completing a pre and post-program PCP assessment and behavior modification achievements as measured by a validated questionnaire. Provide incentives will be established by CalOptima and will be based on program referrals, pre-intervention program assessments and post-intervention assessments.

Member
- $50 for achievement of program process and outcome goals.
- $25 for post-program office visit.

Provider
- $25 for program referral and member assessment.
- $50 for post-program office visit and reassessment.

Staffing: $250,000
Staff proposes the use of up to $250,000 over two years to hire one new project manager that will help in the expansion of the child and adolescent components of the Shape Your Life program. As proposed, the staff duties will include:
1. Evaluating the vendors who respond to the RFP
2. Developing rates for the community, group-based child and adolescent weight management interventions

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3. Providing technical assistance to vendors across the county as needed
4. Developing, managing and evaluating the child and adolescent "Shape Your Life" member and provider incentives
5. Continuously evaluate the vendors, interventions and the incentive programs

At the conclusion of the two years, staff will transition the remaining ongoing duties of the project manager to budgeted staff positions.

Fiscal Impact

The recommended action to authorize use of $500,000 in currently available IGT 1 funds to expand CalOptima's Shape Your Life program is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Childhood obesity is a growing epidemic that affects more than 48,000 children enrolled in CalOptima's Medi-Cal program. Although health plans are not the only stakeholder in this national epidemic, CalOptima recognizes that it plays a critical role in combating this important issue.

Early intervention can assist children in achieving and maintaining appropriate BMI levels. These interventions may prevent complications such as hyperlipidemia, hypertension, diabetes, and other chronic conditions associated with obesity. The IGT funds will be used to expand the newly redesigned child and adolescent components of the CalOptima Shape Your Life program with a focus on evidence-based interventions and outcomes.

Concurrence

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

Attachments

1. Power Point Presentation, Shape Your Life Expansion
2. Board Action dated March 6, 2014, Approve Final Expenditure Plan for Use of FY 2010-11 IGT Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT Funds; Authorize the CEO to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

/s/ Michael Schrader — *09/29/2016*
Authorized Signature — **Date**

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“Shape Your Life” Expansion

Board of Directors Meeting

October 6, 2016

Dr. Miles Masatsugu, Medical Director

Pshyra Jones, Director, Health Education & Disease Management

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Roadmap

- Completed a comprehensive assessment of our obesity programs
- Redesigned our entire obesity program
  - Rebranded the program “Shape Your Life”
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Refined our evidence-based outcome metrics for our obesity interventions
- Expansion
- Evaluation and further refinement

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Assessment Findings

- Evidence **is not yet conclusive** on the long term benefits of intensive short term interventions.
- However, evidence-based recommendations on the prevention and treatment of childhood obesity have been made and endorsed by the CDC, AAP and AMA
- Limited provider understanding of evidence-based recommendations
- Providers and members alike would like to know what resources exist in the community and what is offered through CalOptima
- Access is an issue for our members due to limited intervention sites and lack of knowledge of the interventions offered by CalOptima by both its providers and members.

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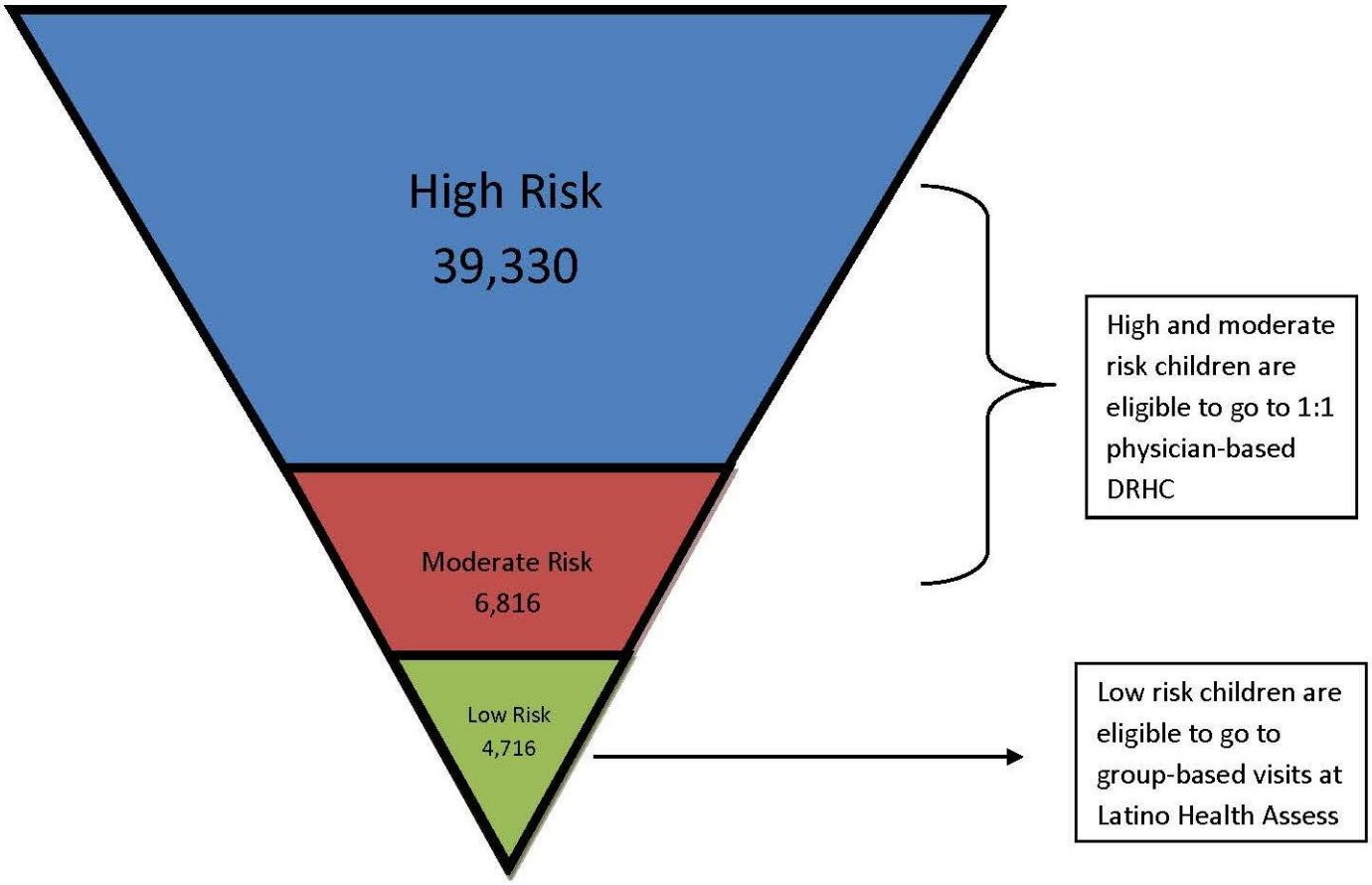
Assessment Findings: Risk Stratification Data Upside Down



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Assessment Findings: Penetration Low and Costs High

		2012-2013	2013-2014	% Increase Year Over Year
Dr. Riba's Health Club	Members	361	666	84%
Medium and High Risk	Visits	1,165	2,325	99.6%
Members	Costs	$130,020	$263,200	102.4%
	Cost per Member	$364.20	$395.13	7.8%
		2012-2013	2013-2014	% Increase
Latino Health Access	Members	100	115	15%
Low Risk	Visits	764	843	10.3%
Members	Costs	$76,472	$85,788	12.1%
	Costs per Member	$764.72	$745.98	-2.5%

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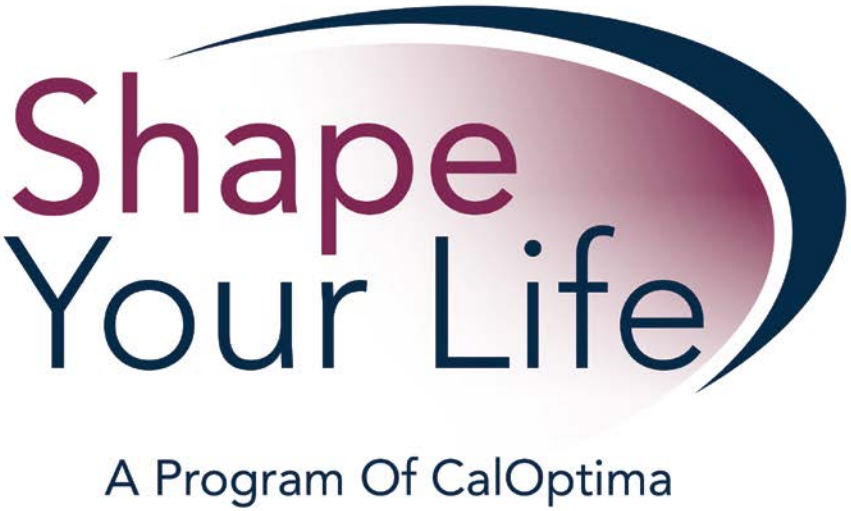
Rebranded Obesity Program



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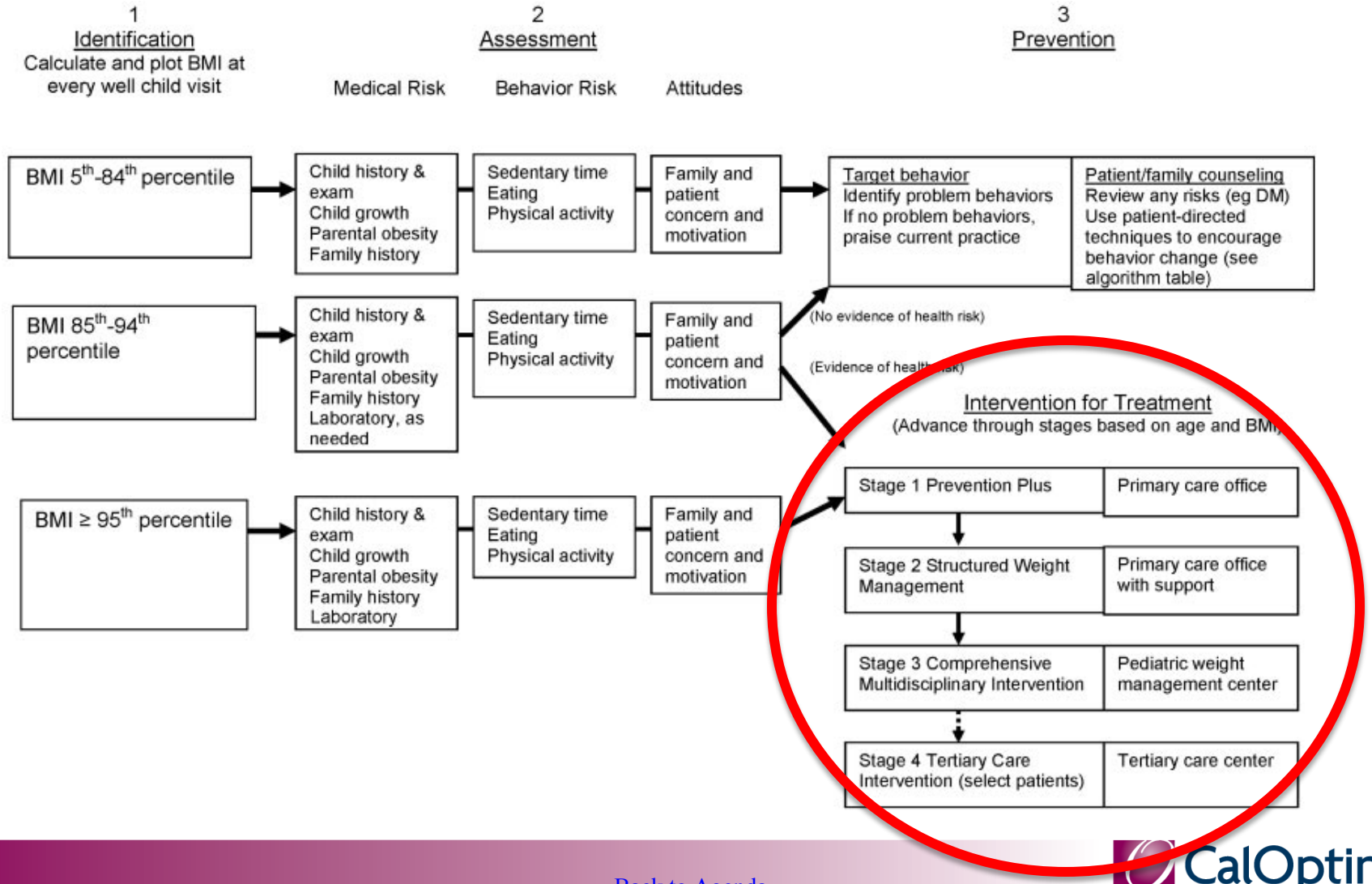
Adopted the Expert Committee Recommendations for the Assessment, Prevention, and Treatment of Childhood Obesity by Childhood Obesity Action Network (COAN) Evidenced-Based Recommendations



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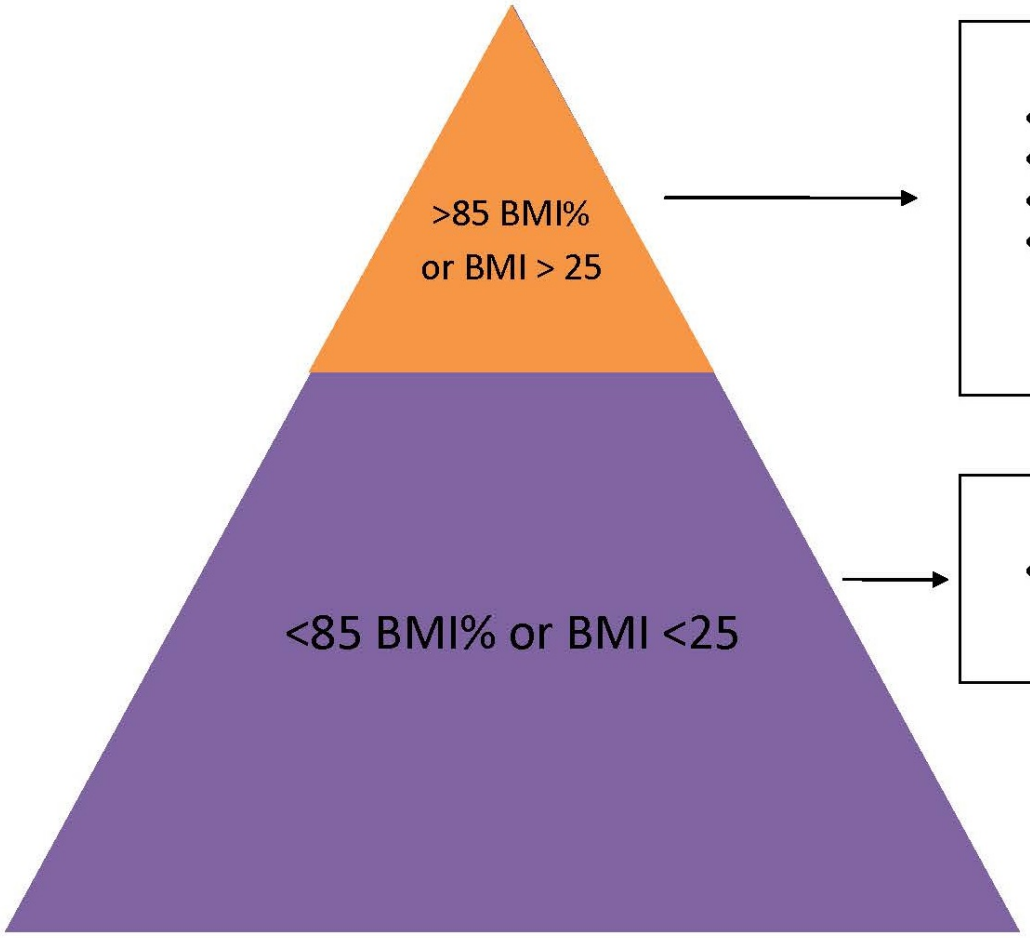
Refined New Risk Stratification



Structured Weight Management

- w/PCP
- Group-based interventions
- Member and Provider Incentives
- Telephonic counseling from CalOptima Health Education Department

Prevention

- Regular newsletters & mailed educational material

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Redesigned Interventions (Implemented)

- Entire Population
  - Healthy Alert
    - Quarterly newsletter w/healthy recipes, tips for parents, teens and children, informed about other services for eligible members
- Group-Based Interventions
  - Assessing member readiness for behavior modification prior to authorization
  - Streamlined referral process
  - Supportive tools and local resources mailed to members to support group-based education intervention model
  - Evaluated existing vendor contracts

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Redesigned Interventions (Not Implemented)

- Member incentives to improve children's participation in group-based interventions and reaching outcome goals
- Provider incentives to improve the assessments, referrals and post-program reassessments of overweight and obese children
- Expand the group-based educational intervention for children countywide

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Proposed Next Steps

- Request Board authorization to expend the $500,000 in allocated IGT funds
- Request for Proposal (RFP) to find vendors who can provide the group-based intervention
- Hire project manager
- Develop Member and Provider Incentives
- Contract with vendors and expand intervention countywide
- Ongoing evaluation of interventions and incentive programs

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Project Manager Duties

- Evaluate the vendors who respond to the RFP
- Provide technical assistance to vendors as needed
- Develop, manage and evaluate the child and adolescent “Shape Your Life” member and provider incentives
- Develop, manage and evaluate the child and adolescent “Shape Your Life” group-based interventions

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Proposed Member and Provider Incentives

Member

- $50 for achievement of program process and outcome goals*
- $25 for post-program office visit*

Provider

- $25 for program referral and member assessment*
- $50 for post-program office visit and reassessment*

*Actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participation engagement

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Proposed IGT Expenditures to Expand “Shape Your Life”

- Use up to $250,000 to add a new staff member for up to two years to implement and manage the program expansion
- $100,000 to support member & provider incentives
- $150,000 to pay new vendors for group-based intervention services

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Recommended Board Action

- Recommend Board of Directors' authorize the expenditure of $500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life program for CalOptima Medi-Cal members.
- Recommend authorizing the CEO to contract with the vendors selected through the RFP process to provide the group-based child and adolescent Shape Your Life program interventions.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

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Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

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1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

2/28/2014 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to Grievances and Appeals, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), and Annual Policy Review

Contact

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

Recommended Actions

Authorize modifications of CalOptima's existing Policies and Procedures for the Grievance and Appeals process to be in compliance with Regulatory requirements and Medicaid Final Rule as follows:

1. HH.1102: CalOptima Member Complaint
2. HH.1103: CalOptima Health Network Member Complaint
3. HH.1108: State Hearing Process
4. GG.1510: Appeal Process for Decisions Regarding Care and Services
5. GG.1814: Appeal Process for Long Term Care Facility

Background

Periodically, CalOptima modifies existing Policies and Procedures to implement modified laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated and subject to peer review. New and modified Policy and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, or programs are established. Most recently, the following has impacted CalOptima's Policies and Procedures:

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and CHIP Managed Care Final Rule [Medicaid Managed Care (CMS-2390-F)], which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to the Medicaid and CHIP managed care regulations in more than a decade. These regulations are sometimes referred to in aggregate as the "Mega Reg".

The Department of Health Care Services (DHCS) has provided guidance to incorporate requirements of the Final Rule into Managed Care Plans (MCPs). On June 1, 2017, the CalOptima Board of Directors approved an amendment to CalOptima's contract with DHCS to include Final Rule requirements.

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Discussion

The following Grievance and Appeals policies have been updated and are being presented for review and approval:

1. ***HH.1102: CalOptima Member Complaint*** defines the process by which CalOptima addresses and resolves Grievances from a Member or a Member's Authorized Representative, in accordance with applicable statutory, regulatory, and contractual requirements. The title of this policy is being updated to *Member Grievanc*e based on the new delineated separation between a grievance and an appeal previously referred to as a complaint. The policy is also modified to allow a provider to file a grievance on Member's behalf with Member consent. In addition, expedited grievance requirements were added. In the event that resolution is not reached within 30 calendar days, the Member shall be notified of the status and a statement was included in the policy to state that a resolution shall not exceed 14 calendar days following a status letter on a grievance. In addition, an appeal process specific to non-coverage determinations has been added to the policy.
2. ***HH.1103: CalOptima Health Network Member Complaint*** is for applicable health network(s) and defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in a Health Network, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department. This title of this policy is being updated to CalOptima Health Network Member Grievance and Appeals Process to be in line with the Final Rule distinction between grievances and appeals. The policy is modified to allow a provider to file a grievance on Member's behalf with Member consent. Expedited grievance requirements were added to this policy. Included a clause that allows a Member to request a State Hearing if the Health Network fails to send a resolution notice within 30 calendar days. In addition, the previous provisions of the policy allowing for a 14-day extension to the response deadline has been removed. Last, it was added that the Health Network will process the Appeal whether a signed written confirmation is received from the Member or not.
3. ***HH.1108: State Hearing Process*** defines CalOptima's process, role and responsibilities in ensuring a Member's right to access the State Hearing process. The policy is modified to allow a provider to file a State Hearing on Member's behalf with Member consent. The State Hearing processes were divided in sections for clarity, including the expedited hearing process. The policy is also modified to include specific language about authorizing or providing the service within 72 hours if the decision is wholly or partially in favor of the Member.
4. ***GG.1510: Appeal Process for Decisions Regarding Care and Services*** defines the process by which CalOptima addresses and resolves Utilization Management (UM) appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit. The title of this policy is being updated to *Appeal Process* since it includes all UM appeals. The policy is also modified to allow a provider to file an appeal on Member's behalf with Member consent. Clarification was added to this policy that the UM Appeal process is separate from a Complaint, State Hearing or Provider Complaint process. References to a 14-day extension were removed. The

policy has been updated to clarify that a Member may be represented by anyone, including a legal representative.

5. ***GG.1814: Appeals Process for Long Term Care Facility*** defines the process by which a Long-Term Care (LTC) Facility provider may Appeal a CalOptima post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, or OneCare Connect Member. This policy is being submitted for annual review and approval. Only grammatical changes were made.

Fiscal Impact

The recommended action to authorize modifications to existing Grievance and Appeals policies and procedures to ensure compliance with regulatory requirements and the Medicaid Final Rule is not anticipated to have a material fiscal impact to CalOptima.

Rationale for Recommendation

To ensure that CalOptima's Grievance and Appeals policies and procedures are updated to meet the requirements of the Final Rule, approval of modifications is recommended.

Concurrence

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

Attachments

Revised CalOptima Policies, redlined and clean copies:
1. HH.1102: CalOptima Member Complaint
2. HH.1103: CalOptima Health Network Member Complaint
3. HH.1108: State Hearing Process
4. GG.1510: Appeal Process for Decisions Regarding Care and Services
5. GG.1814: Appeal Process for Long Term Care Facility

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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Policy #:	HH.1102
Title:	~~CalOptima~~ **Member** ~~Complaint~~**Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1996
~~Last~~ Revised Date:	~~07/01/17~~TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Grievances from a Member or a Member's Authorized Representative, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall establish and maintain a Grievance Process pursuant to which a Member, or a Member's Authorized Representative~~.~~, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance for review and Resolution.

B. CalOptima's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

~~C.~~D. CalOptima shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

~~D.~~E. CalOptima shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance, or may manage a Grievance under the supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

F. CalOptima shall process expedited requests timely in instances where a Provider indicates, or CalOptima determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

~~E.~~G. CalOptima shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance~~.~~ and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

~~F.~~H. CalOptima shall refer all medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review.

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~~G.~~I. CalOptima shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that ~~the Member~~he or she filed a Grievance~~, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations~~.

~~H. CalOptima, a Health Network, Provider, or Practitioner shall not discriminate against a Member in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.~~

~~I.~~J. CalOptima and a Health Network shall inform a Member of their right to file a Grievance through CalOptima at any time ~~that caused the Member's~~to express dissatisfaction~~,~~ about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this policy~~.~~.

a. A Member's Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

~~J.~~K. CalOptima and a Health Network shall inform a Member of their right to file an Appeal ~~within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that delayed, denied, deferred, or modified a request for services. CalOptima shall process an Appeal,~~ in accordance with CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~.

~~K.~~L. CalOptima and a Health Network shall inform a Member, during the ~~Complaint~~Grievance Process, of their right to request a State Hearing after the Appeal ~~Process~~process, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: Member Appeal Process ~~for Decisions Regarding Care and Services~~.

~~L.~~M. CalOptima shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. ~~In the case of a Grievance subject to an expedited review,~~ CalOptima and a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

~~M.~~N. CalOptima shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or the Member's Authorized Representative ~~at no cost~~, or Provider acting on behalf of the Member and with the Member's written consent. CalOptima shall provide records at no cost.

~~N.~~O. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance ~~process~~Process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

~~O.~~P. CalOptima and a Health Network shall inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

~~P.~~Q. CalOptima shall process Exempt Grievances ~~s~~ in accordance with CalOptima Policy DD.2013: Exempt Grievance Process.

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III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

2. CalOptima shall provide complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances, and shall triage Member calls and route Grievances to GARS via its electronic system.

B. Grievance Process

1. A Member, or a Member's Authorized Representative~~-~~, or Provider acting on behalf of the Member and with the Member's written consent, may file a Grievance:

   a. With CalOptima's Customer Service Department, by telephone, or in person; or

   b. With CalOptima GARS, by facsimile, in writing, or through the CalOptima website at www.caloptima.org.

   c. CalOptima shall provide language assistance, by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. CalOptima will process the Grievance whether or not a signed written confirmation is received from the Member.

2. GARS shall:

   a. Date stamp and document the substance of the Grievance in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of ~~-~~Grievance~~(~~, including but not limited to the following categories: quality of care, quality of service, access to care, and other~~)~~, based on the Grievance~~, assign~~. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

   d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Grievance.

   e. Refer all Grievances related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

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f. Review and immediately process all Grievances ~~of an imminent and serious threat to~~ that may seriously jeopardize the Member's life or health ~~of a Member, including, but not limited to, severe pain or potential loss of life, limb,~~ or ~~major bodily~~ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited ~~review~~ Grievance as required in the CalOptima contract with Department of Health Care Services (DHCS).

g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Grievance.

h. Send the Member a Grievance Resolution Letter within thirty (30) calendar days after receipt of the Grievance.

i. ~~In~~For a standard Grievance, in the event the Resolution is not reached in thirty (30) days, notify the Member in writing of the status of the Grievance and provide an estimated completion date of Resolution, which shall not exceed fourteen (14) calendar days.

j. Translate Grievance ~~Resolution Letters~~correspondence into Threshold Languages, and offer oral interpretation for ~~a~~ Grievance ~~Resolution Letter~~correspondence for all other languages; and

~~j.~~k. Provide an interpreter, or auxiliary aide, for assistance in the Grievance Process.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. Summary of the Member's Grievance;

b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

c. When possible, the outcome of the review;

d. Alternative resources or references, when applicable; and

e. The Member's right to Appeal, as appropriate.

6. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member ~~end date~~ and save the electronic file.

C. Non-Coverage Appeals

1. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of

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Grievance is considered a non-coverage appeal and is separate from the appeal process in CalOptima Policy GG.1510: Appeal Process.

2. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may file the non-coverage appeal with CalOptima's Customer Service Department by telephone or in person; or with GARS via facsimile, in writing or through the CalOptima Website at www.caloptima.org.

3. CalOptima shall provide language assistance by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

   a. Date stamp and document the substance of the Non-Coverage Appeal into its electronic system, verifying demographics and network affiliation;

   b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the non-coverage appeal;

   d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Complaint;

   e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Chief CMO or their Designee and any action deemed necessary under the quality review process;

   f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

   g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance.

      i. CalOptima shall translate Grievance Resolution Letters into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter, written in English, for all other languages.

      ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Direct - Administrative, and for access to out-of-network Providers or change of Health Networks, the resolution letter shall include:

         1) Summary of the Member's Non-Coverage Appeal;

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2) Description of actions taken to review the request;

3) Date and name of position of staff involved in the review;

4) Date of the issuance of the decision.

6. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity (ies), decision and any action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

E. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Grievance Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Grievances in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

F. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Grievance, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Grievance Resolution Letters and Notice of Appeal Resolution letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. On a quarterly basis, CalOptima shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

4. CalOptima shall submit a report of aggregated Grievance data, as required, to DHCS.

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5. CalOptima shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

6. CalOptima shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

7. CalOptima shall establish and maintain a system of aging of Grievances that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgement Letter
B. Grievance Resolution Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy DD.2013: Exempt Grievance Process
D. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
F. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
G. CalOptima Policy HH.1108: State Hearings Process and Procedures
H. CalOptima Policy HH.1109: Complaint Decision Matrix
~~I. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations~~
~~J.~~I. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
~~K.~~J. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
K. Title 22, California Code of Regulations (C.C.R.), §53858
L. Title 22, California Code of Regulations (C.C.R.), §53858 (e)(4)
~~L.~~M. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
N. Title 42, Code of Federal Regulations (C.F.R.), §438.3(u)
O. Title 42, Code of Federal Regulations (C.F.R.), §§438.402, 406, 408, and 416

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services
C. 06/29/15: Department of Health Care Services

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VII. BOARD ACTION(S)

~~Not Applicable~~
None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	06/01/1996	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2004	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2011	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2013	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	02/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal

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Revised	TBD	HH.1102	Member Grievance	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an ~~Adverse~~Aadverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Authorized Representative	~~Has the meaning given such term in Section 164.502(g) 45 CFR 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.~~For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
~~Complaint~~	~~For the purposes of this policy, the same as a Grievance.~~
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance.
Grievance Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An ~~oral or written~~ expression of dissatisfaction ~~with~~about any ~~aspect of the CalOptima program,~~matter other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

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Term	Definition
In-Home Supportive Services (IHSS)	Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code Section 14186.1(c)(1).
Long Term Care	Care provided in a skilled nursing facility and sub-acute care services.
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 Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Multipurpose Senior Service Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted grievance.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).

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Policy #:	HH.1102
Title:	**Member Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1996
Revised Date:	TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Grievances from a Member or a Member's Authorized Representative, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall establish and maintain a Grievance Process pursuant to which a Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance for review and Resolution.

B. CalOptima's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

D. CalOptima shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

E. CalOptima shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance, or may manage a Grievance under the supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

F. CalOptima shall process expedited requests timely in instances where a Provider indicates, or CalOptima determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

G. CalOptima shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

H. CalOptima shall refer all medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review.

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I. CalOptima shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that he or she filed a Grievance.

J. CalOptima and a Health Network shall inform a Member of their right to file a Grievance through CalOptima at any time to express dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this policy.

   a. A Member's Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

K. CalOptima and a Health Network shall inform a Member of their right to file an Appeal in accordance with CalOptima Policy GG.1510: Appeal Process.

L. CalOptima and a Health Network shall inform a Member, during the Grievance Process, of their right to request a State Hearing after the Appeal process, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: Member Appeal Process.

M. CalOptima shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima and a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

N. CalOptima shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or the Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent. CalOptima shall provide records at no cost.

O. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

P. CalOptima and a Health Network shall inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

Q. CalOptima shall process Exempt Grievances in accordance with CalOptima Policy DD.2013: Exempt Grievance Process.

III. PROCEDURE

A. Assistance to Members

   1. CalOptima and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

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2. CalOptima shall provide complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances, and shall triage Member calls and route Grievances to GARS via its electronic system.

B. Grievance Process

1. A Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent**,** may file a Grievance:

   a. With CalOptima's Customer Service Department, by telephone, or in person; or

   b. With CalOptima GARS, by facsimile, in writing, or through the CalOptima website at www.caloptima.org.

   c. CalOptima shall provide language assistance, by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. CalOptima will process the Grievance whether or not a signed written confirmation is received from the Member.

2. GARS shall:

   a. Date stamp and document the substance of the Grievance in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of Grievance, including but not limited to the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

   d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Grievance.

   e. Refer all Grievances related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

   f. Review and immediately process all Grievances that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited Grievance as required in the CalOptima contract with Department of Health Care Services (DHCS).

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g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Grievance.

h. Send the Member a Grievance Resolution Letter within thirty (30) calendar days after receipt of the Grievance.

i. For a standard Grievance, in the event the Resolution is not reached in thirty (30) days, notify the Member in writing of the status of the Grievance and provide an estimated completion date of Resolution, which shall not exceed fourteen (14) calendar days.

j. Translate Grievance correspondence into Threshold Languages, and offer oral interpretation for Grievance correspondence for all other languages; and

k. Provide an interpreter, or auxiliary aide, for assistance in the Grievance Process.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. Summary of the Member's Grievance;

b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

c. When possible, the outcome of the review;

d. Alternative resources or references, when applicable; and

e. The Member's right to Appeal, as appropriate.

6. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

C. Non-Coverage Appeals

1. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of Grievance is considered a non-coverage appeal and is separate from the appeal process in CalOptima Policy GG.1510: Appeal Process.

2. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may file the non-coverage appeal with CalOptima's Customer Service Department by telephone or in person; or with GARS via facsimile, in writing or through the CalOptima Website at www.caloptima.org.

3. CalOptima shall provide language assistance by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

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4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

    a. Date stamp and document the substance of the Non-Coverage Appeal into its electronic system, verifying demographics and network affiliation;

    b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

    c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the non-coverage appeal;

    d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Complaint;

    e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Chief CMO or their Designee and any action deemed necessary under the quality review process;

    f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

    g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance.

        i. CalOptima shall translate Grievance Resolution Letters into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter, written in English, for all other languages.

        ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Direct - Administrative, and for access to out-of-network Providers or change of Health Networks, the resolution letter shall include:

            1) Summary of the Member's Non-Coverage Appeal;

            2) Description of actions taken to review the request;

            3) Date and name of position of staff involved in the review;

            4) Date of the issuance of the decision.

6. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

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7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity (ies), decision and any action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

E. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Grievance Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Grievances in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

F. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Grievance, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Grievance Resolution Letters and Notice of Appeal Resolution letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. On a quarterly basis, CalOptima shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

4. CalOptima shall submit a report of aggregated Grievance data, as required, to DHCS.

5. CalOptima shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

6. CalOptima shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

7. CalOptima shall establish and maintain a system of aging of Grievances that are pending and unresolved for thirty (30) calendar days or more.

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IV. ATTACHMENT(S)

A. Acknowledgement Letter
B. Grievance Resolution Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy DD.2013: Exempt Grievance Process
D. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E. CalOptima Policy GG.1510: Appeal Process
F. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
G. CalOptima Policy HH.1108: State Hearings Process and Procedures
H. CalOptima Policy HH.1109: Complaint Decision Matrix
I. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
J. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
K. Title 22, California Code of Regulations (C.C.R.), §53858
L. Title 22, California Code of Regulations (C.C.R.), §53858 (e)(4)
M. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
N. Title 42, Code of Federal Regulations (C.F.R.), §438.3(u)
O. Title 42, Code of Federal Regulations (C.F.R.), §§438.402, 406, 408, and 416

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services
C. 06/29/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1996	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1102	CalOptima Member Complaint	Medi-Cal
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Action	Date	Policy	Policy Title	Program(s)
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Revised	01/01/2007	HH.1102	CalOptima Member Complaint	Medi-Cal
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Revised	07/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	TBD	HH.1102	Member Grievance	Medi-Cal

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IX. GLOSSARY

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Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Aadverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
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Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
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Long Term Care	Care provided in a skilled nursing facility and sub-acute care services.
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Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Multipurpose Senior Service Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home.
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Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted grievance.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

<DATE>

<FIRST AND LAST NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MR/MS LAST NAME>:

This letter is in response to your complaint filed on <insert the date filed> about <insert the member's issue(s) or concern(s)>. Thank you for taking the time to share your concerns with us. We are sorry for any trouble this may have caused you.

In your complaint, you stated <insert the member's statement>.

<STANDARD GRIEVANCE> Grievance and Appeals Resolution Services reviewed your complaint <summary of your investigation, outcomes, referrals, alternative resources or references when applicable including name(s) of person(s) contacted, department, medical group & any outcomes that are relevant to member not subject to peer review protection>.

<QUALITY OF CARE INSERT: Also, I have referred your concerns to CalOptima's Quality Improvement (QI) department to review the health care you received. The reason for this review is to decide if the health care provided meets the professional standards in the community. You will receive an acknowledgment letter from the QI department explaining the review process. The review process normally takes 120 days to complete. If the standards have been met, no further action is needed. If not, CalOptima will take the correct action necessary. California law does not let us share the details of this review.

CalOptima will take all required actions to solve your concerns. All member concerns, including those that could be related to quality of care, fraud and abuse, quality of service, or access problems are taken very seriously. We monitor these issues to look for ways to improve our program and prevent future problems. It is our goal to provide access to quality care and services to our members.

Your input is important to us and we are here to help you with your health care needs. If you have questions or concerns about this letter, please call me at **1-714-<PHONE NUMBER>.**

For future assistance or questions about your benefits, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at www.caloptima.org.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

Policy #:	HH.1103
Title:	~~CalOptima~~ **Health Network Member ~~Complaint~~ Grievance and ~~and &~~ Appeal Process~~Process~~**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/01/1996
~~Last~~ Revision Date:	~~07/01/17~~T BD

I. PURPOSE

This policy defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in the Health Network, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

II. POLICY

A. CalOptima may authorize a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network.

B. If CalOptima authorizes a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network:

1. The Health Network shall establish and maintain a Grievance and Appeals Process pursuant to which a Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution.

2. The Grievances and Appeals Process shall address the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with applicable statutory, regulatory, and contractual requirements.

3. The Health Network shall ensure prompt review and investigation of a Grievance or Appeal by management or supervisory staff responsible for the services or operations that are the subject of the Grievances or Appeals.

4. The Health Network shall ensure that the person making the final decision ~~on~~for the ~~Grievance or~~ proposed resolution of an Appeal ~~did not participate~~has neither participated in any prior ~~decision(s)~~decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

a. An Appeal of a denial based on lack of Medical Necessity;

b. A Grievance regarding denial of an expedited resolution of an Appeal; and

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~~4.~~c. Any Grievance or Appeal involving clinical issues.

5. The Health Network shall immediately refer all medical quality of care issues to the Health Network's Medical Director or Designee for review.

6. The Health Network shall ensure that there is no discrimination against a Member on the grounds that the Member filed a Grievance or Appeal.

7. The Health Network shall ensure that its Members are informed of their right to Appeal a Health Network Utilization Management (UM) decision by filing a UM Appeal with the Health Network within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that denied, delayed, or modified a request for services.

8. The Member has the right to request an Appeal in the event that a Health Network fails to issue a NABD/NOA within the required ~~timeframe;~~time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

C. The Health Network shall inform a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of his or her right to file a Grievance at any time regarding an incident or issue that caused the Member's dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) through CalOptima or the Health Network, in accordance with the provisions of this policy.

D. The Health Network shall inform a Member ~~or~~, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, during the Appeal Process, of his or her right to request a State Hearing after the Appeal Process has been exhausted or ~~should have been exhausted~~if the Health Network fails to send a resolution notice with thirty (30) calendar days of the Appeal being filed with the Health Network , and of his or her right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. The Health Network shall give a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance. ~~In case of a Grievance subject to an expedited review,~~ or Appeal. CalOptima and the Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.

F. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by the Member ~~or~~, his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, at no cost.

G. The Health Network shall assist a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs as provided for in Section III.A.6.a of this Policy.

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H. The Health Network shall inform a Member of his or her right to file a Grievance with CalOptima, the Health Network, or the Secretary of Health and Human Services regarding violations of the Member's privacy rights, in accordance with CalOptima Policy HH.~~3020~~3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

I. The Health Network shall not discriminate or retaliate against any Member, a Member's Authorized Representative, or a Provider on grounds that such Member filed a Grievance or Appeal~~, in accordance with CalOptima Policy HH.3012: Non-Retaliation on Reporting Violations~~.

III. PROCEDURE

A. A Health Network authorized to manage Grievances and Appeals for Members enrolled in that Health Network pursuant to Section II.B. of this policy, shall maintain a Grievance and Appeal Process as follows:

1. Filing a Grievance or Appeal

a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, by telephone, in person, facsimile, or in writing.

b. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.

c. Assistance to Members

i. The Health Network shall make the complaint forms and procedures for filing a Grievance or Appeal available to facilities that provide services to Members.

ii. The Health Network shall promptly provide the complaint forms and procedures to a Member upon request.

iii. The Health Network Member Services staff shall assist a Member with respect to the filing of a Grievance or Appeal.

iv. The Health Network shall provide a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with Limited English Proficiency (LEP), disabilities, or cultural needs.

2. Acknowledgment of a Grievance or Appeal

a. Except as otherwise provided in Section III.A.4 of this policy, a Health Network shall send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance or Appeal indicating receipt of the Grievance or Appeal, the date of receipt of the Grievance or Appeal, identifying a Grievance Resolution staff person whom the Member may contact regarding the Grievance or Appeal and the estimated completion date of resolution.

b. In instances of an oral Appeal request (excluding expedited Appeals) made by the ~~member~~Member, CalOptima shall send a written confirmation of the oral Appeal for ~~member's~~Member's signature.

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i. The date of the oral Appeal establishes the filing date for the Appeal.

ii. ~~In~~The Health Network will process the ~~event that CalOptima does~~Appeal whether or not ~~receive~~ a signed written~~, signed~~ Appeal confirmation is received from the Member~~, CalOptima shall neither dismiss nor delay resolution of the Appeal~~ Appeal.

c. A written confirmation does not apply to an oral grievance request.

~~c.~~d. If CalOptima receives a Member's Grievance or Appeal for a Health Network that manages Grievances or Appeals, CalOptima shall forward the Grievance or Appeal immediately to the Health Network Complaint staff for investigation and resolution.

3. Investigation and Resolution of a Grievance or Appeal

a. The Health Network Complaint staff shall promptly consult with the Health Network department responsible for the services or operations that are the subject of the Grievance or Appeal.

b. The Health Network Complaint staff shall review the factual findings, proposed resolution, and any other relevant information, and shall issue a Grievance Resolution Letter or Notice of Appeal Resolution to respond to the Grievance or Appeal.

c. The Health Network shall send the Member a Grievance Resolution Letter or Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of the Grievance or Appeal, except as otherwise provided in Section III.A.4 of this policy.

d. The Grievance Resolution Letter ~~or Notice of Appeal Resolution~~ shall describe the Grievance ~~or Appeal~~, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. Summary of the Member's ~~Grievances or Appeals~~Grievance;

ii. The investigation made in the review process, including any referrals to the Quality Improvement Department for a quality of care review;

iii. When possible, the outcome of the review;

iv. Alternative resources or references, when applicable;

e. The Notice of Appeal Resolution shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

~~v.~~ The ~~The Member's right to Appeal, as appropriate; and~~

~~vi. The State Hearing process and Aid Paid Pending, as appropriate.~~

i. results of the resolution and the date it was completed;

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ii. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

iii. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

iv. Alternative resources or references, when applicable;

v. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

~~e.~~f. The Health Network shall translate the Grievance Resolution Letter or Notice of Appeal Resolution into threshold languages and offer oral interpretation for a Grievance Resolution Letter or Notice of Appeal Resolution for all other languages upon request.

~~f.~~g. The Health Network shall take ~~immediate~~ action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

4. Expedited UM Appeal or Grievances

a. If the Health Network receives a Grievance or Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall process such Grievance or Appeals an Expedited UM Appeal or Grievance:

i. Upon receipt of the expedited review Appeal or Grievance information, the Health Network Chief Medical Officer (CMO), or his or her Designee, shall conduct a medical review.

ii. The Health Network shall utilize specialist consultants, as appropriate.

iii. The Health Network shall notify the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

iv. The Health Network shall make a decision on the Expedited UM Appeal or Grievance request as quickly as the medical condition requires, but no later than seventy-two (72) hours after the Expedited UM Appeal or Grievance request is made to the Health Network. The Health Network shall provide verbal notice of the resolution of the expedited review to the Member.

v. The Health Network shall notify the Member or the Member's Authorized Representative, and all involved Providers of the Expedited UM Appeal or Grievance decision by facsimile or verbal communication within seventy-two (72) hours after receiving the Expedited UM Appeal or Grievance. The Health Network shall provide a written notice within one (1) business day after a verbal notice.

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b. The Health Network shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal or Grievance decision.

~~5. Extension of Timeframes~~

~~a. A Health Network shall extend the resolution timeframes for either standard or expedited Appeals by up to fourteen (14) calendar days if any of the following two (2) conditions apply:~~

~~i. The Member requests the extension;~~

~~ii. The Health Network demonstrates to the satisfaction of the DHCS upon request, that there is a need for additional information and how the delay is in the Member's best interest.~~

~~b. For any extension not requested by the Member, the Health Network is required to provide the Member with written notice of the reason for the delay.~~

~~i. The Health Network shall make reasonable efforts to provide the Member with oral notice of the extension.~~

~~ii. The Health Network shall provide written notice of the extension within two (2) calendar days and notify the Member of the right to file a Grievance if the beneficiary disagrees with the extension.~~

~~iii. The Health Network shall resolve the Appeal as expeditiously as the Member's health condition requires but not beyond the initial fourteen (14) calendar day extension.~~

~~iv. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.~~

~~6.~~5. In addition to any rights set forth in this policy, a Member shall also have the right to:

a. Request the Health Network to provide an interpreter or auxiliary aide for assistance in the Grievance or Appeal Process, or to provide translation of Grievance or Appeal correspondence.

b. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

i. The Health Network shall notify a Member of this right annually, and in every Acknowledgement and resolution letter.

ii. A Member may request a State Hearing within one hundred and twenty (120) calendar days after the Notice of Appeal Resolution.

iii. To request a State Hearing, a Member may:

a) Write to: Department of Social Services
State Hearings Division

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P. O. Box 944243, M.S. 19-37
Sacramento, CA 95814;

b) Call: (800) 952-5253, or for TDD only, (800) 952-8349;

c) Facsimile: 1-916-651-5210, or 916-651-2789; or

d) Present him or herself to the Department of Social Services at:

744 P Street
Sacramento, CA 95814

d. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.

e. Upon notice from CalOptima that a Member filed for a State Hearing, a Health Network shall grant Aid Paid Pending, if applicable, until the State Hearing occurs, or a decision is rendered, in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures and GG.1510: Appeal Process for Decisions Regarding Care and Services.

f. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

~~7.~~6. Responsible Staff

a. The Health Network shall designate a manager with authority to require corrective actions to be responsible for receiving Grievance or Appeal, issuing Grievance or Appeal decisions, and reporting to CalOptima.

b. The CalOptima Director of GARS or Designee shall have primary responsibility for the oversight of the Health Network Grievance and Appeal Process, including referring any non-compliance to the CalOptima Compliance Department for review and action, if needed.

c. CalOptima's Chief Operating Officer shall have primary responsibility for:

i. Maintenance of the Grievance or Appeal Process;

ii. Review of the operations; and

iii. Review of any emerging patterns of Grievance or Appeal in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

~~8.~~7. Notices, Records, and Reports

a. Notice of Grievance or Appeal Procedures

i. Upon enrollment, and annually thereafter, the Health Network shall inform a Member, in writing, of the locations for filing a Grievance or Appeal, telephone numbers where a Complaint may be submitted, and related procedures regarding the Member Grievance or Appeal Process.

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ii. The Health Network shall provide these notices in each of the Threshold Languages, as required by CalOptima.

b. Records

i. The Health Network shall maintain written records of each Grievance or Appeal, including at least the following information:

a) Date of receipt;

b) Member's name;

c) Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

(i) Untimely assignments to providers;

(ii) Issues related to cultural and linguistic sensitivity;

(iii) Difficulty accessing specialists; and

(iv) Grievances related to out-of-network requests.

d) Names of Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the Grievance or Appeal; and

e) Disposition.

ii. The Health Network shall maintain the written records of each Grievance or Appeal, including the date of receipt, Member's name, description of the problem, names of the Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

c. Reporting Requirements

i. The Health Network shall send to CalOptima GARS:

a) A copy of the Grievance or Appeal, and

b) A copy of the Acknowledgement Letter, Grievance Resolution Letter, Notice of Appeal Resolution letter, and all supporting documentation that was used in investigation of the Grievance or Appeal upon request by CalOptima.

ii. The Health Network shall submit aggregate and detailed Grievance or Appeal data, in the format required by CalOptima to CalOptima's GARS Department on a quarterly basis, as outlined in the Health Network Reporting Due Date Matrix.

B. If CalOptima determines that a Health Network has failed to comply with the requirements of this policy, CalOptima may take appropriate action including, but not limited to, taking steps to resolve

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a Member's Grievance or Appeal, implementing a decision, de-delegation of or Grievance and Appeal management for its assigned Members, or imposing corrective action or sanctions against the Health Network, in accordance with CalOptima Policies HH.~~2002~~2002Δ: Sanctions and HH.~~2005~~2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Grievance Resolution Letter
C. Notice of Appeal Resolution (Uphold)
D. Notice of Appeal Resolution (Overturn)
E. Health Network Reporting Due Date Matrix

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Policy HH.1108: State Hearing Process and Procedures
E. CalOptima Policy HH.~~2002~~2002Δ: Sanctions
F. CalOptima Policy HH.~~2005~~2005Δ: Corrective Action Plan
~~G. CalOptima Policy HH.3012: Non-Retaliation on Reporting Violations~~
~~H.~~G. CalOptima Policy ~~HH.3020~~3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
~~I.~~H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~J.~~I. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c),(g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
~~K.~~J. Title 22, California Code of Regulations (C.C.R.), §53858
K. Title 42, Code of Federal Regulations (C.F.R.), §§438.406 (b)(3) and 438.420(a),(b), and (c)

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

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

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VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	06/1996	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/1997	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2000	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2001	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	04/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	03/01/2014	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1103	CalOptima Health Network Member Complaint & Appeal	Medi-Cal
Revised	02/07/2019	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	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.
Authorized Representative	~~Has the meaning given such term in Section 164.502(g) 45 CFR 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.~~. For the purpose of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an appeal or grievance.
~~Complaint~~	~~For the purposes of this policy, the same as a Grievance.~~
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance or Appeal.
Grievance and Appeals Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances and Appeals.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	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.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

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Term	Definition
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Working Days	Shall mean state of California working day(s), defined in 8 CCR §330 as Monday through Fridays but not including Saturday, Sunday or State Holidays.

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Policy #:	HH.1103
Title:	**Health Network Member Grievance and Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1996
Revision Date:	TBD

I. PURPOSE

This policy defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in the Health Network, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

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3. The Health Network shall ensure prompt review and investigation of a Grievance or Appeal by management or supervisory staff responsible for the services or operations that are the subject of the Grievances or Appeals.

4. The Health Network shall ensure that the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

   a. An Appeal of a denial based on lack of Medical Necessity;

   b. A Grievance regarding denial of an expedited resolution of an Appeal; and

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8. The Member has the right to request an Appeal in the event that a Health Network fails to issue a NABD/NOA within the required time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

C. The Health Network shall inform a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of his or her right to file a Grievance at any time regarding an incident or issue that caused the Member's dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) through CalOptima or the Health Network, in accordance with the provisions of this policy.

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E. The Health Network shall give a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance or Appeal. CalOptima and the Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.

F. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by the Member, his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, at no cost.

G. The Health Network shall assist a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs as provided for in Section III.A.6.a of this Policy.

H. The Health Network shall inform a Member of his or her right to file a Grievance with CalOptima, the Health Network, or the Secretary of Health and Human Services regarding violations of the

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Member's privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

I. The Health Network shall not discriminate or retaliate against any Member, a Member's Authorized Representative, or a Provider on grounds that such Member filed a Grievance or Appeal.

III. PROCEDURE

A. A Health Network authorized to manage Grievances and Appeals for Members enrolled in that Health Network pursuant to Section II.B. of this policy, shall maintain a Grievance and Appeal Process as follows:

1. Filing a Grievance or Appeal

a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, by telephone, in person, facsimile, or in writing.

b. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.

c. Assistance to Members

i. The Health Network shall make the complaint forms and procedures for filing a Grievance or Appeal available to facilities that provide services to Members.

ii. The Health Network shall promptly provide the complaint forms and procedures to a Member upon request.

iii. The Health Network Member Services staff shall assist a Member with respect to the filing of a Grievance or Appeal.

iv. The Health Network shall provide a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with Limited English Proficiency (LEP), disabilities, or cultural needs.

2. Acknowledgment of a Grievance or Appeal

a. Except as otherwise provided in Section III.A.4 of this policy, a Health Network shall send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance or Appeal indicating receipt of the Grievance or Appeal, the date of receipt of the Grievance or Appeal, identifying a Grievance Resolution staff person whom the Member may contact regarding the Grievance or Appeal and the estimated completion date of resolution.

b. In instances of an oral Appeal request (excluding expedited Appeals) made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.

i. The date of the oral Appeal establishes the filing date for the Appeal.

ii. The Health Network will process the Appeal whether or not a signed written Appeal confirmation is received from the Member Appeal.

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c. A written confirmation does not apply to an oral grievance request.

d. If CalOptima receives a Member's Grievance or Appeal for a Health Network that manages Grievances or Appeals, CalOptima shall forward the Grievance or Appeal immediately to the Health Network Complaint staff for investigation and resolution.

3. Investigation and Resolution of a Grievance or Appeal

a. The Health Network Complaint staff shall promptly consult with the Health Network department responsible for the services or operations that are the subject of the Grievance or Appeal.

b. The Health Network Complaint staff shall review the factual findings, proposed resolution, and any other relevant information, and shall issue a Grievance Resolution Letter or Notice of Appeal Resolution to respond to the Grievance or Appeal.

c. The Health Network shall send the Member a Grievance Resolution Letter or Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of the Grievance or Appeal, except as otherwise provided in Section III.A.4 of this policy.

d. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. Summary of the Member's Grievance;

ii. The investigation made in the review process, including any referrals to the Quality Improvement Department for a quality of care review;

iii. When possible, the outcome of the review;

iv. Alternative resources or references, when applicable;

e. The Notice of Appeal Resolution shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. The results of the resolution and the date it was completed;

ii. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

iii. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

iv. Alternative resources or references, when applicable;

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v. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

f. The Health Network shall translate the Grievance Resolution Letter or Notice of Appeal Resolution into threshold languages and offer oral interpretation for a Grievance Resolution Letter or Notice of Appeal Resolution for all other languages upon request.

g. The Health Network shall take action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

4. Expedited UM Appeal or Grievances

a. If the Health Network receives a Grievance or Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall process such Grievance or Appeals an Expedited UM Appeal or Grievance:

i. Upon receipt of the expedited review Appeal or Grievance information, the Health Network Chief Medical Officer (CMO), or his or her Designee, shall conduct a medical review.

ii. The Health Network shall utilize specialist consultants, as appropriate.

iii. The Health Network shall notify the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

iv. The Health Network shall make a decision on the Expedited UM Appeal or Grievance request as quickly as the medical condition requires, but no later than seventy-two (72) hours after the Expedited UM Appeal or Grievance request is made to the Health Network. The Health Network shall provide verbal notice of the resolution of the expedited review to the Member.

v. The Health Network shall notify the Member or the Member's Authorized Representative, and all involved Providers of the Expedited UM Appeal or Grievance decision by facsimile or verbal communication within seventy-two (72) hours after receiving the Expedited UM Appeal or Grievance. The Health Network shall provide a written notice within one (1) business day after a verbal notice.

b. The Health Network shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal or Grievance decision.

5. In addition to any rights set forth in this policy, a Member shall also have the right to:

a. Request the Health Network to provide an interpreter or auxiliary aide for assistance in the Grievance or Appeal Process, or to provide translation of Grievance or Appeal correspondence.

b. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

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i. The Health Network shall notify a Member of this right annually, and in every Acknowledgement and resolution letter.

ii. A Member may request a State Hearing within one hundred and twenty (120) calendar days after the Notice of Appeal Resolution.

iii. To request a State Hearing, a Member may:

a) Write to: Department of Social Services
State Hearings Division
P. O. Box 944243, M.S. 19-37
Sacramento, CA 95814;

b) Call: (800) 952-5253, or for TDD only, (800) 952-8349;

c) Facsimile: 1-916-651-5210, or 916-651-2789; or

d) Present him or herself to the Department of Social Services at:

744 P Street
Sacramento, CA 95814

d. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.

e. Upon notice from CalOptima that a Member filed for a State Hearing, a Health Network shall grant Aid Paid Pending, if applicable, until the State Hearing occurs, or a decision is rendered, in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures and GG.1510: Appeal Process for Decisions Regarding Care and Services.

f. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

6. Responsible Staff

a. The Health Network shall designate a manager with authority to require corrective actions to be responsible for receiving Grievance or Appeal, issuing Grievance or Appeal decisions, and reporting to CalOptima.

b. The CalOptima Director of GARS or Designee shall have primary responsibility for the oversight of the Health Network Grievance and Appeal Process, including referring any non-compliance to the CalOptima Compliance Department for review and action, if needed.

c. CalOptima's Chief Operating Officer shall have primary responsibility for:

i. Maintenance of the Grievance or Appeal Process;

ii. Review of the operations; and

iii. Review of any emerging patterns of Grievance or Appeal in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

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7. Notices, Records, and Reports

   a. Notice of Grievance or Appeal Procedures

      i. Upon enrollment, and annually thereafter, the Health Network shall inform a Member, in writing, of the locations for filing a Grievance or Appeal, telephone numbers where a Complaint may be submitted, and related procedures regarding the Member Grievance or Appeal Process.

      ii. The Health Network shall provide these notices in each of the Threshold Languages, as required by CalOptima.

   b. Records

      i. The Health Network shall maintain written records of each Grievance or Appeal, including at least the following information:

         a) Date of receipt;

         b) Member's name;

         c) Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

            (i) Untimely assignments to providers;

            (ii) Issues related to cultural and linguistic sensitivity;

            (iii) Difficulty accessing specialists; and

            (iv) Grievances related to out-of-network requests.

         d) Names of Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the Grievance or Appeal; and

         e) Disposition.

      ii. The Health Network shall maintain the written records of each Grievance or Appeal, including the date of receipt, Member's name, description of the problem, names of the Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

   c. Reporting Requirements

      i. The Health Network shall send to CalOptima GARS:

         a) A copy of the Grievance or Appeal, and

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b) A copy of the Acknowledgement Letter, Grievance Resolution Letter, Notice of Appeal Resolution letter, and all supporting documentation that was used in investigation of the Grievance or Appeal upon request by CalOptima.

ii. The Health Network shall submit aggregate and detailed Grievance or Appeal data, in the format required by CalOptima to CalOptima's GARS Department on a quarterly basis, as outlined in the Health Network Reporting Due Date Matrix.

B. If CalOptima determines that a Health Network has failed to comply with the requirements of this policy, CalOptima may take appropriate action including, but not limited to, taking steps to resolve a Member's Grievance or Appeal, implementing a decision, de-delegation of or Grievance and Appeal management for its assigned Members, or imposing corrective action or sanctions against the Health Network, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Grievance Resolution Letter
C. Notice of Appeal Resolution (Uphold)
D. Notice of Appeal Resolution (Overturn)
E. Health Network Reporting Due Date Matrix

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Policy HH.1108: State Hearing Process and Procedures
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
G. CalOptima Policy HH.CalOptima Policy 3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
I. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c),(g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
J. Title 22, California Code of Regulations (C.C.R.), §53858
K. Title 42, Code of Federal Regulations (C.F.R.), §§438.406 (b)(3) and 438.420(a),(b), and (c)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/1996	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/1997	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2000	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2001	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	04/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	03/01/2014	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1103	CalOptima Health Network Member Complaint & Appeal	Medi-Cal
Revised	02/07/2019	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	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.
Authorized Representative	. For the purpose of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an appeal or grievance.
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance or Appeal.
Grievance and Appeals Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances and Appeals.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	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.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Working Days	Shall mean state of California working day(s), defined in 8 CCR §330 as Monday through Fridays but not including Saturday, Sunday or State Holidays.

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

<DATE>

<FIRST AND LAST NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MR/MS LAST NAME>:

This letter is in response to your complaint filed on <insert the date filed> about <insert the member's issue(s) or concern(s)>. Thank you for taking the time to share your concerns with us. We are sorry for any trouble this may have caused you.

In your complaint, you stated <insert the member's statement>.

<STANDARD GRIEVANCE> Grievance and Appeals Resolution Services reviewed your complaint <summary of your investigation, outcomes, referrals, alternative resources or references when applicable including name(s) of person(s) contacted, department, medical group & any outcomes that are relevant to member not subject to peer review protection>.

<QUALITY OF CARE INSERT: Also, I have referred your concerns to CalOptima's Quality Improvement (QI) department to review the health care you received. The reason for this review is to decide if the health care provided meets the professional standards in the community. You will receive an acknowledgment letter from the QI department explaining the review process. The review process normally takes 120 days to complete. If the standards have been met, no further action is needed. If not, CalOptima will take the correct action necessary. California law does not let us share the details of this review.

CalOptima will take all required actions to solve your concerns. All member concerns, including those that could be related to quality of care, fraud and abuse, quality of service, or access problems are taken very seriously. We monitor these issues to look for ways to improve our program and prevent future problems. It is our goal to provide access to quality care and services to our members.

Your input is important to us and we are here to help you with your health care needs. If you have questions or concerns about this letter, please call me at **1-714-<PHONE NUMBER>.**

For future assistance or questions about your benefits, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at www.caloptima.org.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

[CalOptima logo]

"Uphold"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf]* appealed the *[denial, delay, modification, or termination]* of *[Service requested]*.

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you need help reading this letter or have any questions, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff

who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

[CalOptima logo]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf],* appealed the *[denial, delay, modification, or termination]* of *[Service requested].*

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision].*

[CalOptima] has 72 hours to approve or provide you the service.

Your request has been approved *[under authorization number <#> from <date> to <date> with <provider> or payment has been made].* On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

If you need help reading this letter or have any questions, please call, *[Grievance and Appeals Resolution Services Staff Name],* at *[telephone number].*

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

Timely and Appropriate Submission Grid

Year: 2018
Release: 2
Release Date: 1/2/18

Per CalOptima policy HH.2003, *Health Network Reporting* , Health Networks and Delegated Entities (as defined in the policy) are responsible for the submission of reports to CalOptima as specified in their Contract, the Report Binder/Timely and Appropriate Submission Grid, and/or CalOptima's policies and procedures.

Health Networks and Delegated Entities shall submit reports in the time, manner, and file format specified in this Timely and Appropriate Submission Grid, which includes the report frequency, naming convention and FTP folder.

Health Network and Delegated Entity reports shall be considered timely and appropriate when submitted by the due date, on the current template, and completed correctly. Failure to submit reports as specified may result in corrective action in accordance with CalOptima policies HH.2002, *Sanctions* , and HH.2005, *Corrective Action Plan* .

If the due date of a report, other than Model of Care (MOC) reports, falls on a weekend or holiday, the report is due the following business day by 2 pm. If the due date of a MOC report falls on a weekend or holiday, the report is due the prior business day by 5 pm.

For Health Network and Delegate Entity reporting requirements, please see the following worksheets:
"Report Grid": Lists the reporting requirements, including report frequency, naming convention and FTP folder
"Change Log": Lists any recent changes made to reporting requirements

Should you have any questions about reporting requirements, please contact healthnetworkdepartment@caloptima.org.

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Timely and Appropriate Submission Grid

Year: 2018
Release: 2
Release Date: 1/2/18

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Claims XML Universe	Health Networks are required to report a complete Claims Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All	x		x	x	x	x
Claims Universe Case Files	Health Networks are required to submit monthly Claims Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	All	x		x	x	x	x
Credentialing Universe Monthly Case Files	Health Networks are required to submit Credentialing Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	All	x			x	x	x
Credentialing Annual Universe	Health Networks are required to report an annual Credentialing universe of all currently contracted providers at the time the report is run.	Audit and Oversight	**Annually** **January 15**	2_AORPT_QIRPT_**HN_YYYY**_CRED	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	x
Expedited Initial Organization Determination Log (OneCare & OneCare Connect)	Health Networks are required to report Expedited Initial Organization Determination requests for reporting and auditing. CalOptima will review the log weekly to monitor processing compliance and will notify the Health Network if there are any discrepancies or concerns.	Audit and Oversight	**Weekly** **Every Friday between 12:00-2:00 p.m.**	1_AORPT _**HN**_EIOD_**MMDDYYYY**_LB	HN = Health network # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Excel	OneCare, OneCare Connect	x			x	x	
NOMNC Log (OneCare & OneCare Connect)	Health Networks are required to report monthly NOMNC for reporting and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Word	OneCare, OneCare Connect	x			x		

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REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
NOMNC Files (OneCare & OneCare Connect)	Health Networks are required to submit monthly NOMNC files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	OneCare, OneCare Connect	x			x		
PDR XML Universe	Health Networks are required to report a complete PDR Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All	x		x	x	x	x
PDR Universe Case Files	Health Networks are required to submit monthly PDR Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare	hn_reporting	PDF	All	x		x	x	x	x
UM XML Universe	Health Networks are required to report a complete UM Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_UM_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All	x			x	x	x
UM Universe Case Files	Health Networks are required to submit monthly UM Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	All	x			x	x	x
HN Dashboard	Health Network performance results to support compilation of monthly Health Network Dashboard (deliverable to Audit and Oversight Committee)	Audit and Oversight	**Monthly** **15th of each month**	2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	
Provider Directory Universe	Health Networks are required to report a complete Provider Directory Universe for quarterly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the files selected on a quarterly basis.	Audit and Oversight	**Quarterly** **January 10, April 10, July 10, October 10**	1_AORPT_**HN_MMYYYY**_PD	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	
DHCS APL 17-005 Data Certification Statement	Per DHCS APL 17-005, Health Networks and delegates are required to certify that data submitted to CalOptima monthly is accurate, complete, and truthful.	Audit and Oversight	**January 2018 only**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	Medi-Cal	x		x	x		x
Customer Service Call Log Universe	Health Networks are required to submit monthly Customer Service call logs for auditing.	Audit and Oversight	**Quarterly** **January 7, April 7, July 7, October 7**	MC: 1_AORPT_**HN**_ODAG-14_CS_MC_**MMYYYY** OC: 1_AORPT_**HN**_ODAG-14_CS_OC_**MMYYYY** OCC: 1_AORPT_**HN**_MMP-SARAG-12_CS_DB_**MMYYYY**	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	

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Credentialing Monthly Universe	Health Networks are required to report a complete Credentialing Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight and Quality Improvement	**Monthly** **2nd of every month**	2_AORPT_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	All	x		x	x	x	x
Mental Health Continuity of Care (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org	YYYY= 4 digit year	Secure email	Excel	Kaiser						x
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	Kaiser						x
Mental Health Referrals (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	Kaiser						x
BHT Reporting Template - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **28 days after the end of each quarter**	CalOptima.BHT.Mar.2016 Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	Kaiser						x
Mental Health Continuity of Care (Medi-Cal) - Magellan	MCE DHCS Reporting	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_MC_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	
Mental Health Referrals (Medi-Cal) - Magellan	MCE DHCS Reporting	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_MC_Referrals	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	
BHT Reporting Template - Magellan	MCE DHCS Reporting	Behavioral Health	**Quarterly** **28 days after the end of each quarter (Q1 2018 only)**	1_BHRPT_**HN_MMYYYY**_DHCS_BHT_TEMPLATE	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	
DHCS Monthly Reporting - Magellan	DHCS report	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_DHCS_Monthly	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal					x	
DHCS Provider Report - Magellan	DHCS report	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_DHCS_Provider	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	PDF	Medi-Cal					x	
MH Provider Supplemental Directory	Used to populate CalOptima's online and print provider directories.	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_Supplemental_Provider_Directory CalOpt_Monthly_Provider_Supplemental_Directory_MMDDYYYY	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	Email to Kenny Chhuor, Natalie Zavala, Edwin Poon	Excel	All					x	
Claims Lag With Member Months - Magellan	Claims lag with member months	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_M13	HN = Health network reporting # MM = 2 digit month YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	

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Case Management Program Description	The case management program description is the description of the PMG and HN annual Case Management programs. It is a required submission as part of audit and oversight activities to ensure the respective case management programs are adhering to the standards required by our various governing agencies – CMS or DMHC – or for NCQA accreditation. The essential components of the case management program are specifically addressed in MA.6009 – Care Management and Coordination Process and GG.1301-Complex Case Management Process.	Case Mgmt	**Annually** **February 15th**	1_CMRPT_**HN**_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	Kaiser						x
Case Management Log	This log is required as a part of oversight activities for maintenance of NCQA accreditation and is for the Medi-Cal and OneCare Connect population only. Through the log, case management referral activities are tracked based on data and referral sources as are members in the various levels of care management from Complex to Service Coordination. "Add on" services are also noted	Case Mgmt	**Monthly** **15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal, OneCare Connect	x					x
Birth Outcomes	Birth Outcomes reporting	Case Mgmt	**Quarterly** **January 30, April 30, July 30, October 30**	1_CMRPT_**HN_QTYYYY**_BOC	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Continuity of Care (OneCare Connect)	Continuity of Care reporting for OneCare Connect members	Case Mgmt	**Weekly** **Every Tuesday by 10 am for the prior week's activity**	1_CMRPT_**HN_MMDDYYYY**_COCDB	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting	Excel	OneCare Connect	x				x	
OneCare Connect Care Transition Log	As part of the program monitoring of OneCare Connect (OCC), the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) require CalOptima to report on transitions of member care.	Case Mgmt	**Monthly** **15th of the month**	1_CMRPT_**HN_MMYYYY**_Transitions	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	OneCare Connect	x				x	
OneCare Connect Care Transition Supporting Documentation	Supporting documentation for each transition of member care as reported in the OneCare Connect Care Transitions Log.	Case Mgmt	**Monthly** **15th of the month** **Ongoing, per process**	**HN_CIN**_Transition_**MMDDYYYY**	HN = Health network reporting # CIN = Member CIN MM = 2 digit month DD - 2 digit day YYYY= 4 digit year **MMDDYYYY is date of**	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x				x	
Interdisciplinary Care Team (ICT) Bundle (OneCare)	Individual bundles with ICT minutes and ICP	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBER CIN**_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY = 4 digit year	OneCare/RevisedMOC/Inbound	PDF	OneCare	x					
Pediatric Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Individual bundles with ICT minutes and ICP	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	Medi-Cal	x					
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Individual bundles with ICT minutes and ICP	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	Medi-Cal	x					

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Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Individual bundles with ICT minutes and ICP.	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY = 4 digit year	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x					
LTC Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Individual bundles with ICT minutes and ICP.	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY = 4 digit year	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x					
MOC Tracking Log (OneCare)	Report with OneCare PCC assignments and Care Management Levels	Case Mgmt (MOC)	**Monthly** **6th of the month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file	OneCare	x					
MOC SPD Tracking Log (Medi-Cal)	Report with indicated SPD member PCC assignments and Care Management Levels	Case Mgmt (MOC)	**Monthly** **6th of the month**	**HN**271**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	Medi-Cal	x					
MOC Tracking Log (OneCare Connect)	Report with OneCare Connect PCC assignments and Care Management Levels	Case Mgmt (MOC)	**Monthly** **6th of the month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	Pipe delimited text file	OneCare Connect	x					
Organ Transplant	Report of members with organ transplant	Case Mgmt	**Monthly** **15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser						x
Network Staff Legend File	Report PCC and other care coordinator staff names, training status, manager and percentage of time working on Medi-Cal, OneCare and OneCare Connect	Case Mgmt (MOC)	**Monthly** **6th of every month**	**HN**429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Text File	All	x					
Implementation Audit (SPD)	Networks submit documentation of implementation, hospitalization key event, and non-hospitalization key event.	Case Mgmt	**Monthly** **4th Thursday**	**HN_Member CIN**_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	MediCal/RevisedMOC/Inbound	PDF	Medi-Cal	x					
Implementation Audit (OneCare)	Networks submit documentation of implementation, hospitalization key event, and non-hospitalization key event.	Case Mgmt	**Monthly** **4th Thursday**	**HN_Member CIN**_OC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OC/RevisedMOC/Inbound	PDF	OneCare	x					
Implementation Audit (OneCare Connect)	Networks submit documentation of implementation, hospitalization key event, and non-hospitalization key event.	Case Mgmt	**Monthly** **4th Thursday**	**HN_Member CIN**_OCC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x					

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Claims Third Party Liability	Networks report their potential TPL data to CalOptima and we submit to DHCS	Claims	**Monthly** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	Medi-Cal	x					x
Claims Third Party Liability (OneCare Connect)	Networks report their potential TPL data to CalOptima and we submit to DHCS	Claims	**Monthly** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	OneCare Connect	x			x		
Claims Timeliness Reports (Medi-Cal)	Health Networks shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision2. Financial Audit Reports Paragraph B. 2).	Compliance	**Monthly** **15th of every month** **Quarterly** **January 30, April 30, July 30, October 30**	1_HNRPT_**HN_MMYYYY**_MTRMC (Monthly) 1_HNRPT_**HN_QTYYYY**_MTRMC (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Provider Disputes (Medi-Cal)	Health networks are required to report quarterly Provider Dispute Resolution data. CalOptima compiles the data and reports to Regulatory affairs.	Compliance	**Quarterly** **January 30, April 30, July 30, October 30**	1_HNRPT_**HN_QTYYYY**_PDMC	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Call Center Statistics	Per the Medicare Marketing Guidelines, Call Center Requirements includes: • Limit average hold time to two (2) minutes. The average hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. • Answer eighty (80) percent of incoming calls within thirty (30) seconds • Limit the disconnect rate of all incoming calls to five (5) percent Health Networks must report: • Calls by Language • Abandonment Rate • Average Speed of Answer, Average Length of Call, Number of Auth/Referral Calls, Number of Claims Calls, Number of Member Cost Calls	Customer Service	**Quarterly** **January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	All	x		x	x	x	x
DHCS NMT/NEMT Report - Kaiser	Kaiser to submit the DHCS Non-Medical Tranportation (NMT)/Non-Emergency Medical Transportation (NEMT) reporting template. Each report is due 90 calendar days after the end of each month.	Customer Service	**Monthly** **27th of every month**	2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY**	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser						x
Annual Audited Financial Statements	Annual audited financial statements of the organization (PHC and SRG only).	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	All	x				x	
IBNR Documentation	Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims, and supporting documentation for the IBNR calculation. Can be included in Annual Audited Financial Statements, or submitted as a separate report.	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	All	x					

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Medical Loss Ratio	Reporting of the Health Network Medical Loss Ratio. Medi-Cal Expansion reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template.	Finance	**Interim: January - June due August 15.** **Interim: January - December due February 15.** **Final: Annual submission of all 12 months due June 30.**	1_FINRPT_**HN_SemiAnnualYYYY**_MLR 1_FINRPT_**HN_AnnualYYYY**_MLR 1_FINRPT_**HN_FinalYYYY**_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	Medi-Cal, OneCare Connect	x				x	x
Risk Bearing Organization (RBO) Report	Quarterly and annual financial data submitted by networks to DMHC (PHC and SRG only).	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly submissions due:** **February 15, May 15, August 15, November 15**	1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	All	x				x	
Total Business Reports	Quarterly unaudited financial statements of the PHC and SRG organization including balance sheet, income statement, statement of cash flows and related disclosures (PHC and SRG only).	Finance	**Quarterly submissions due:** **February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	All	x				x	
Member All Grievance Log	DHCS: Quarterly log containing details of each case included in the Member All Grievances Summary	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_GrievLog	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Member All Grievances Summary	DHCS: Quarterly report of grievances and appeals closed within the quarter; tracking volume and types of cases	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_AllMbr	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Member CBAS Summary	DHCS: Quarterly report of grievances related to Community Based Adult Services closed within the quarter	GARS	**Quarterly** **January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_CBAS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
DHCS Quarterly Report	Quarterly report of grievances and appeals received within the quarter; tracks grievance types	GARS	**Quarterly** **January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Member SPD Grievances Summary	DHCS: Quarterly report of grievances and appeals closed within the quarter, filed by SPD members; tracking volume and types of cases (subset of Member All Grievances Summary)	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_SPD	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Disease Management Evaluation	The organization must identify a minimum of two chronic condition for which it has implemented a DM program. The conditions should be relevant to the organization s population (including high-risk pregnancy); however, primary prevention may not be included as a disease management condition. The components of the DM program should meet the	Health Education and Disease Management	**Annually** **1st Quarter**	1_DMRPT_04_Annual**YYYY**_DM	YYYY= 4 digit year	hn_reporting	Excel or Word or PDF	Kaiser						x
Health Education Calendar		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser						x
Health Education Individual Encounters		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	Kaiser						x

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Health Education Other Encounters		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	Kaiser						x
Hep C Pharmacy Data File		IS	**Monthly** **15th of every month**	04269**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	Incoming	Text File	Kaiser						x
CBAS Report		Long Term Support Services	**Monthly** **20th of every month**	KaiserPermanente_PRD_HCBShighind_CalOptima_**yyyymm**.txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text File	Kaiser						x
Health Network Newly Contracted Provider Training Report	Health Networks shall initiate, provide, and complete all educational training to all Provider s within ten (10) working days from the Provider s placement on active status. Health Networks shall obtain a signed acknowledgment	HNR	**Quarterly** **January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	All	x			x	x	x
Utlization Report - ASH	American Speciality Health/ASH report monthly fitness center/gym utilization data.	HNR	**Monthly**	Send via email to healthnetworkdepartment@caloptima.org		Secure email	Excel	ASH		x				
Out of Network Requests	Health Networks report out-of-network requests from all enrolled members and approvals by specialty type.	Quality Analytics	**Quarterly** **January 25, April 25, July 25, October 25**	1_MDMRPT_**HN_QTYYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Access and Availability Report	Annual analysis of data to measure performance against standards for access. Report must also include BH access standards.	Quality Analytics	**Annually** **February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	Kaiser						x
QI Program	Health Networks shall develop an annual quality improvement report and submit to CalOptima for review.	Quality Improvement	**Annually** **February 15th**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x		x	x	x	x
QI Evaluation (Previous Year)	Health Networks shall perform an annual evaluation of their quality improvement work plan/program and submit to CalOptima for review.	Quality Improvement	**Annually** **February 15th**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x		x	x	x	x
QI Work Plan Current Year (Initial)	Health Networks must develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	Quality Improvement	**Annually** **February 15th (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All	x		x	x		x
QI Work Plan (ICE)	Health Networks must report progress towards quality improvement program goals semi-annually.	Quality Improvement	**Semi-Annually** **February 15th and August 15th**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All	x		x	x	x	x
Authorization Utilization Report	Health Networks report open authorizations, if a claim was received and the date the claim was paid (if applicable).	Quality Improvement	**Quarterly** **Q3 2016 - February 15** **Q4 2016 - May 15** **Q1 2017 - August 15** **Q2 2017 - November 15**	1_QIRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal	x					
UM Program	Health Networks shall develop a utilization management program description and submit to CalOptima for review.	Utilization Management	**Annually** **February 15th**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x			x		x

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their utilization management work plan/program and submit to CalOptima for review.	Utilization Management	**Annually** **February 15th**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x			x		x
UM Work Plan Current Year (Initial)	Health Networks must develop an annual utilization management work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	Utilization Management	**Annually** **February 15th (for new year)**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	All	x			x	x	x
UM Work Plan (ICE)	Health Networks must report progress towards utilization management program goals semi-annually.	Utilization Management	**Semi-Annually** **February 15th and August 15**	2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All	x			x	x	x
UM Committee Meeting Minutes	Health Networks must keep record of utilization management committee meetings through minutes	Utilization Management	**Semi- Annually** **February 15th and August 15th**	2_UMRPT_AORPT_**HN**_SemiAnnuall**YYYY**_Minutes	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x			x	x	x
Dental Anesthesia Report	The Department of Health Care Services (DHCS) now requires reporting of dental general anesthesia services. The health networks will report quarterly the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability.	Utilization Management	**Quarterly** **15th after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Nurse Advice Line Call Log	Each week on Monday, the health networks will submit the completed Nurse Advice Line Call Log for the previous week s activity	Utilization Management	**Weekly** **Every Monday for the previous weeks activity**	1_NARPT_**HN_MMDDYYYY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD = 2 digit day Use date of submission	hn_reporting	Excel	OneCare, OneCare Connect	x					

Timely and Appropriate Submission Grid Change Log - 2018

Report Name	Release Number	Date of Release	Change	HN/Del Impact? (Change to Template, Frequency, FTP Folder)
UM Program	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_AnnualYYYY_UMP" to "2_UMRPT_AORPT_HN_AnnualYYYY_UMP"	Yes
UM Evaluation (Previous Year)	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_AnnualYYYY_UME" to "2_UMRPT_AORPT_HN_AnnualYYYY_UME"	Yes
UM Work Plan Current Year (Initial)	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_AnnualYYYY_UMCY" to "2_UMRPT_AORPT_HN_AnnualYYYY_UMCY"	Yes
UM Work Plan (ICE)	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_SemiAnnualYYYY_UMCY" to "2_UMRPT_AORPT_HN_SemiAnnualYYYY_UMCY"	Yes
UM Committee Meeting Minutes	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_SemiAnnuallYYYY_Minutes" to "2_UMRPT_AORPT_HN_SemiAnnuallYYYY_Minutes"	Yes
Credentialing Annual Universe	1	12/4/2017	Description changed to clarify the universe must include "all currently contracted providers at the time the report is run."	No
Customer Service Call Log Universe	1	12/4/2017	Report Frequency changed from Monthly to Quarterly	No - Announced on 11/7/17
Call Center Statistics	1	12/4/2017	Template changed to add Submitter Name, correct threshold languages for each LOB	Yes
Health Network Newly Contracted Provider Training Report	1	12/4/2017	Monitoring Department changed from "PN" to "HNR"	No
Medical Loss Ratio	1	12/4/2017	Report Frequency of Interim Report changed from "Waived" to "January - June due August 15" Naming Convention changed to add Interim Report	Yes
Utlization Report - ASH	1	12/4/2017	New report (American Specialty Health/ASH only)	No - Implemented in 2017
HN Dashboard	1	12/4/2017	Template changed to add Transportation Calls (announced 10/9/17) Naming Convention changed from "1_HMRPT_HN_MMYYYY_Dashboard" to "2_HMRPT_CSRPT_HN_MMYYYY_Dashboard"	Yes
OneCare Connect Care Transition Log	1	12/4/2017	Template changed to update column headers	No - Announced 7/3/17
Implementation Audit Bundles	1	12/4/2017	Newly added to grid	No - Announced in 2016
DHCS NMT/NEMT Report - Kaiser	1	12/4/2017	New report (Kaiser only)	Yes
Beacon Reports	1	12/4/2017	Removed all Beacon reports	No
Magellan Reports	1	12/4/2017	Added final submission date for Magellan Medi-Cal reports	Yes (Magellan only)
Provider Directory Universe	2	1/2/2018	Report Frequency corrected from the 7th to the 10th Template changed to add "Contact Information" and "Medical Group Affiliation" fields Instructions updated to reflect template changes	Yes
Medical Loss Ratio	2	1/2/2018	Report Frequency and Naming Convention corrected to include interim report.	No - Existing requirement
Nurse Advice Line Call Log	2	1/2/2018	Line of Business changed from "All" to "OneCare, OneCare Connect"	Yes
QI Work Plan (ICE)	3		Updated ICE template	No - Announced 1/29/18
UM Work Plan (ICE)	3		Updated ICE template	No - Announced 1/29/18

Back to Agenda

Report Name	Release Number	Date of Release	Change	HN/Del Impact? (Change to Template, Frequency, FTP Folder)

Back to Agenda

Policy #:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	~~11/1999~~11/01/1999
~~Last Review Date:~~	~~07/01/17~~02/07/19
~~Last~~ Revis~~ion~~ed Date:	~~07/01/17~~TBD

I. PURPOSE

This policy defines CalOptima's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member ~~seeking to appeal denials, limitations~~, or ~~modifications to Covered Services by CalOptima~~a Member's Authorized Representative or ~~its Health Networks may do so through~~Provider acting on behalf of the ~~Appeal Process established by CalOptima.~~Member and with his or her written consent, has the right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and or not acted upon with reasonable promptness. Once the CalOptima-level Appeal Process has been exhausted ~~or should have been exhausted,~~ a Member may request a State Hearing.

B. CalOptima is not involved in the Medi-Cal eligibility process, and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima shall participate in State Hearings that address medical service denials to Members.

C. CalOptima shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State Hearing. CalOptima shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including both regulations and evidence, which might be favorable to the Member's case.

D. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the Notice of Appeal Resolution or Appeal resolution timeframe has exhausted.

E. CalOptima shall not unlawfully discriminate against a Member for requesting a State Hearing.

F. The parties to a State Hearing include CalOptima, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a

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deceased Member's estate. CalOptima shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

G. When appropriate, CalOptima shall grant Aid Paid Pending, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, until a State Hearing decision is rendered.

H. The DSS will adopt a hearing decision within three (3) working days of the date of the request (for Expedited Hearing only).

~~H.~~I. The DSS will adopt a hearing decision within ninety (90) calendar days after the earliest filing date, unless the Member waives the normal timeline for a decision to be rendered.

~~I.~~J. CalOptima shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

~~J.~~K. CalOptima shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of service.

III. PROCEDURE

A. CalOptima shall communicate the Appeal Process and the Member's statutory right to a State Hearing, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, to a Member in writing. This disclosure shall be included in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member Handbook Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Customer Service Department, by telephone, as requested by the Member.

~~B. To request a State Hearing, a Member may:~~

B. A Member, or a Member's Authorized Representative or Provider acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) by:

1. Write to:

   Department of Social Services
   State Hearings Division
   P. O. Box 944243, M.S. 9-17-37
   Sacramento, CA 94244;

2. Call 1-800-952-5253 or, for TDD only, 1-800-952-8349;
   Facsimile 1-916-651-5210 or 916-651-2789; or

3. Present him or herself to the Department of Social Services at:

   744 P Street
   Sacramento, CA 95814

C. State Hearing Process

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1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate) or Provider (with a completed – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Grievance and Appeals Resolution Services (GARS).

2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

~~C.~~a. CalOptima shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

~~D.~~3. CalOptima GARS shall be responsible for the administrative coordination of CalOptima's responsibilities in the State Hearing process.

D. State Hearing Postponement, Withdrawal and No-show Process:

~~E.~~1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date, at the discretion of the DSS State Hearing Support Section (SHSS), or by the hearing judge on the hearing date. Good cause is established if:

~~1.~~a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

~~2.~~b. CalOptima does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing, or modifies the position statement.

2. ~~A Member~~A Member, Member's Authorized Representative, or Provider, on behalf of the Member with

~~F.~~ the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima of his or her intent to withdraw the hearing request, CalOptima shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

~~G.~~3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

E. CalOptima's Pre Hearing Process:

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~~H.~~1. A CalOptima representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

~~I.~~2. If a CalOptima representative concludes CalOptima's action was correct, the CalOptima representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will attempt to raise at the hearing and provide information that may be of assistance to the Member as described in Section II.C. of this policy.

~~J.~~3. CalOptima GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

~~K.~~4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to the DHCS Ombudsman Office, the DSS AAD, the County Hearing Unit and the Member by certified mail at least two (2) business days prior to the hearing date.

~~L.~~6. A Member and the Authorized Representative and/or Provider may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. ~~With~~In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima shall deliver directly to the designated/appropriate DSS Administrative Law Judge (ALJ) all information and documents that either support, or that CalOptima considered in connection with, the action that is the subject of the expedited State Hearing. This includes, but is not limited to~~, copies~~:

a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA~~), plus any~~).

b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

~~M.~~c. One (1) or more CalOptima or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

F. State Hearing Phase

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~~N.~~1. During the State Hearing process, CalOptima or a Health Network ~~must~~ shall authorize or provide the disputed ~~Covered Services~~services promptly, and as expeditiously as the Member's health condition requires~~.~~, but no later than seventy-two (72) hours from the date CalOptima received the decision, if the Covered Services are not furnished while the ~~appeal~~Appeal is pending and CalOptima or a Health Network ~~reverses a decision to deny, limit, or delay Covered Services~~from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

~~O.~~2. At the hearing, CalOptima will be responsible for the presentation of CalOptima's case. The presentation shall include:

~~1.~~a. Summary of the written position statement;

~~2.~~b. Examining witnesses;

~~3.~~c. Cross-examining the Member and the Member's witnesses;

~~4.~~d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

~~5.~~e. Having the case record available at the hearing.

~~P.~~f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

G. Hearing Decision(s)

~~Q.~~1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to both the Member and CalOptima, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

~~R.~~ A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy.

~~S.~~2. Upon receipt of the hearing decision, CalOptima or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

~~1.~~3. If the decision is made wholly or partially in favor of the Member, CalOptima shall submit a ~~———~~compliance report to the AAD, using the County Report of Compliance form, when requested ~~———~~by AAD or DSS.

~~2.~~ If the decision is made wholly or partially in favor of the Member, CalOptima or a Health Network shall authorize or provide the disputed ~~services~~Services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours if the Covered Services are not furnished while the Appeal is pending and CalOptima or a Health Network from the date ~~of~~ it receives notice reversing the determination.

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4. ~~If the decision~~ CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

~~3.~~5. If the decision is decided in favor of CalOptima, in cases in which Aid Paid Pending was requested, CalOptima shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

~~T.~~6. CalOptima's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

~~U.~~7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a compliance issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

~~V.~~8. CalOptima shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

IV. ATTACHMENT(S)

A. Withdrawal of Request for State Fair Hearing
B. County Report of Compliance
C. Notice of Appeal Resolution

V. REFERENCES

A. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
B. California Welfare and Institutions Code, §10950 through 10967
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy DD.2005: Member Handbook Requirements
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510 Appeal Process for Decisions Regarding Care and Services
~~F.~~G. CalOptima Policy HH.1102: CalOptima Member Complaint
~~G.~~H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~H.~~I. Title 22, California Code of Regulations (C.C.R.), §50951 through 50955
~~I.~~J. Title 42, Code of Federal Regulations (C.F.R.), §§ 438.404(b)(3), 438.404(c)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 06/10/15: Department of Health Care Services
C. 01/05/10: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

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~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	11/1999	AA.1203	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2013	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	TBD	HH.1108	State Hearing Process and Procedures	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination (NABD)	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a aa Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	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.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or California Department of Social Services pursuant to Regulation Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Compliance Issue	An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.
Compliance Related Issues	Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Grievance	An oral or written expression of dissatisfaction about any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice Adverse Benefit Determination (NABD)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Action (NOA)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.

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Term	Definition
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overtu;rned or upheld.
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.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

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Policy #:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	11/01/1999
Revised Date:	TBD

I. PURPOSE

This policy defines CalOptima's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member, or a Member's Authorized Representative or Provider acting on behalf of the Member and with his or her written consent, has the right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and or not acted upon with reasonable promptness. Once the CalOptima-level Appeal Process has been exhausted a Member may request a State Hearing.

B. CalOptima is not involved in the Medi-Cal eligibility process, and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima shall participate in State Hearings that address medical service denials to Members.

C. CalOptima shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State Hearing. CalOptima shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including both regulations and evidence, which might be favorable to the Member's case.

D. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the Notice of Appeal Resolution or Appeal resolution timeframe has exhausted.

E. CalOptima shall not unlawfully discriminate against a Member for requesting a State Hearing.

F. The parties to a State Hearing include CalOptima, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a deceased Member's estate. CalOptima shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

G. When appropriate, CalOptima shall grant Aid Paid Pending, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, until a State Hearing decision is rendered.

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H. The DSS will adopt a hearing decision within three (3) working days of the date of the request (for Expedited Hearing only).

I. The DSS will adopt a hearing decision within ninety (90) calendar days after the earliest filing date, unless the Member waives the normal timeline for a decision to be rendered.

J. CalOptima shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

K. CalOptima shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of service.

III. PROCEDURE

A. CalOptima shall communicate the Appeal Process and the Member's statutory right to a State Hearing, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, to a Member in writing. This disclosure shall be included in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member Handbook Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Customer Service Department, by telephone, as requested by the Member.

B. A Member, or a Member's Authorized Representative or Provider acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) by:

1. Write to:

   Department of Social Services
   State Hearings Division
   P. O. Box 944243, M.S. 9-17-37
   Sacramento, CA 94244;

2. Call 1-800-952-5253 or, for TDD only, 1-800-952-8349;
   Facsimile 1-916-651-5210 or 916-651-2789; or

3. Present him or herself to the Department of Social Services at:

   744 P Street
   Sacramento, CA 95814

C. State Hearing Process

1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate) or Provider (with a completed – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Grievance and Appeals Resolution Services (GARS).

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2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

    a. CalOptima shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

3. CalOptima GARS shall be responsible for the administrative coordination of CalOptima's responsibilities in the State Hearing process.

D. State Hearing Postponement, Withdrawal and No-show Process:

1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date, at the discretion of the DSS State Hearing Support Section (SHSS), or by the hearing judge on the hearing date. Good cause is established if:

    a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

    b. CalOptima does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing, or modifies the position statement.

2. A Member, Member's Authorized Representative, or Provider, on behalf of the Member with the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima of his or her intent to withdraw the hearing request, CalOptima shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

E. CalOptima's Pre Hearing Process:

1. A CalOptima representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

2. If a CalOptima representative concludes CalOptima's action was correct, the CalOptima representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will attempt to raise at the hearing and provide information that may be of assistance to the Member as described in Section II.C. of this policy.

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3. CalOptima GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to the DHCS Ombudsman Office, the DSS AAD, the County Hearing Unit and the Member by certified mail at least two (2) business days prior to the hearing date.

6. A Member and the Authorized Representative and/or Provider may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima shall deliver directly to the designated/appropriate DSS Administrative Law Judge (ALJ) all information and documents that either support, or that CalOptima considered in connection with, the action that is the subject of the expedited State Hearing. This includes, but is not limited to:

   a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA).

   b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

   c. One (1) or more CalOptima or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

F. State Hearing Phase

1. During the State Hearing process, CalOptima or a Health Network shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date CalOptima received the decision, if the Covered Services are not furnished while the Appeal is pending and CalOptima or a Health Network from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

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2. At the hearing, CalOptima will be responsible for the presentation of CalOptima's case. The presentation shall include:

    a. Summary of the written position statement;

    b. Examining witnesses;

    c. Cross-examining the Member and the Member's witnesses;

    d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

    e. Having the case record available at the hearing.

    f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

G. Hearing Decision(s)

1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to both the Member and CalOptima, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

2. A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy. Upon receipt of the hearing decision, CalOptima or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

3. If the decision is made wholly or partially in favor of the Member, CalOptima shall submit a compliance report to the AAD, using the County Report of Compliance form, when requested by AAD or DSS.

4. If the decision is made wholly or partially in favor of the Member, CalOptima or a Health Network shall authorize or provide the disputed Services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours if the Covered Services are not furnished while the Appeal is pending and CalOptima or a Health Network from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

5. If the decision is decided in favor of CalOptima, in cases in which Aid Paid Pending was requested, CalOptima shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

6. CalOptima's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a

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compliance issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

8. CalOptima shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

IV. ATTACHMENT(S)

A. Withdrawal of Request for State Fair Hearing
B. County Report of Compliance
C. Notice of Appeal Resolution

V. REFERENCES

A. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
B. California Welfare and Institutions Code, §10950 through 10967
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy DD.2005: Member Handbook Requirements
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510 Appeal Process for Decisions Regarding Care and Services
G. CalOptima Policy HH.1102: CalOptima Member Complaint
H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
I. Title 22, California Code of Regulations (C.C.R.), §50951 through 50955
J. Title 42, Code of Federal Regulations (C.F.R.), §§ 438.404(b)(3), 438.404(c)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 06/10/15: Department of Health Care Services
C. 01/05/10: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/1999	AA.1203	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2013	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	TBD	HH.1108	State Hearing Process and Procedures	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination (NABD)	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a aa Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	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.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or California Department of Social Services pursuant to Regulation Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Compliance Issue	An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.
Compliance Related Issues	Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Grievance	An oral or written expression of dissatisfaction about any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice Adverse Benefit Determination (NABD)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Action (NOA)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.

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Term	Definition
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overtu;rned or upheld.
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.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

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☐ **WITHDRAWAL** ☐ **CONDITIONAL WITHDRAWALS**

OF
REQUEST FOR HEARING

Case Name: _____ County Case No: _____

State Hearing No: _____ Filing Date: _____

County: _____ Hearing Date: _____

Hearing Time: _____

I, _____, the undersigned do hereby:

☐ Withdraw my request for a state hearing before the State Department of Social Services. I understand that by withdrawing my request, I lose my right to a hearing on that request. I also understand that by withdrawing my request for hearing, aid which has been paid because of the request will stop without further notice. I may, however, file a new hearing request raising the identical issue provided that the new request is timely per Manual of Policies and Procedures Section 22-009.

☐ Conditionally withdraw my request for a state hearing before the State Department of Social Services. I understand that by conditionally withdrawing my request for hearing, aid which has been paid because of the hearing request will stop without further notice. I understand that the county will issue a redetermination notice within 30 days and that I must request a hearing within **90 DAYS** of the county's notice if I am not satisfied with the county's reconsideration of my case. Upon such renewal, I shall have the same rights I would have had if I had not signed this conditional withdrawal.

NOTE: A conditional withdrawal must provide that the actions of both parties will be completed within 30 days.

The reasons for or conditions of this withdrawal are: _____

_____

_____

_____

_____

_____

Signed

_____
(County Representative) (Date)

_____
(County Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

Signed

_____
(Claimant) (Date)

_____
(Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

NOTE: A Conditional Withdrawal must also be signed by a County Representative or it is invalid.

DPA 315 (7/99)

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COUNTY REPORT OF COMPLIANCE TRANSMITTAL

Due within 30 days of receipt of decision

COUNTY	DATE

NAME ADDRESS *(if changed)*	STATE HEARING #	ADOPT DATE	COMPLIANCE NOTIFICATION DATE	EFFECTIVE DATE	CODE(S) OR BRIEF STATEMENT

I certify that the above compliance information is true and correct to the best of my knowledge.

NAME	PHONE NUMBER	DATE

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COMPLIANCE CODE OPTIONS

- Use program code (letter) for each program in which a compliance action is required.
- Use one or more action codes (number) for each program code.

PROGRAM CODES:

A. AFDC

B. FS

C. Medi-Cal

D. IHSS

E. AFDC/FC

F. OTHER: List Program

ACTION CODES:

1. Action rescinded –Benefits determined & issued as eligible.
2. Action rescinded – Benefits not determined or issued due to lack of information. Admin Close.
3. Entitlement received as aid pending, (APP).
4. No eligibility for retroactive benefits found.
5. O/P or O/I reduced / cancelled as ordered.
6. Retro benefits reduced or not issued due to balancing against existing O/P, O/I.
7. SOC changed as ordered.
8. County has offered assistance to the claimant in obtaining reimbursement for any Medi-Cal covered expenses incurred.
9. Delayed Compliance (Brief explanation) Wait for followup transmittal.
10. OTHER: (Brief explanation)

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Reading Level 5.6, Powers, Sumner, Kearl (Gunning Fog), April 27, 2017 JH
Reviewed by VC 5-3-17
Reviewed by MKC 5-4-17
Revised Readability Level 5.6 Powers, Sumner, Kearl (Gunning Fog) by MKC on 5-4-17

"Uphold"

NOTICE OF APPEAL RESOLUTION
About Your Adverse Benefit Determination

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name-Optional]
[Address]
[City, State Zip]

Identification Number

RE: [service requested]

You [or Name of requesting provider or authorized representative on your behalf,] [have or has] appealed the [denial, delay, modification, or termination] of [service requested].

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on [date] and has decided to uphold the decision. This request is denied because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

On [Date] at [Time] you were contacted and informed of the decision; or a message was left informing you of the decision; or a message was left asking for a call back>.

You may request copies of all documents and records related to this decision free of charge. If you would like to obtain a copy of the actual benefit terms, guidelines, procedures, or other criteria on which the decision was based, please call [Grievance Resolution Services Staff Name] at [telephone number].

If you need help reading this letter or have any questions, please call, [Grievance Resolution Services Staff Name], at [telephone number].

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where to go to get help, including free legal help. You are encouraged to submit written comments, documents, or any other information relevant to your appeal. The enclosure also tells you the deadlines for pursuing an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" is available to assist you with any questions you may have with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us toll free at 1-888-587-8088.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

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Policy #:	GG.1510
Title:	**Appeal Process ~~for Decisions Regarding Care and Services~~**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
~~Last Review Date:~~	~~07/01/17~~
~~Last~~ Revised Date:	~~07/01/17~~TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves ~~pre-service, post-service, expedited and external~~ Utilization Management (UM) ~~Appeals, in accordance with applicable statutory, regulatory, and contractual requirements~~appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima shall establish and maintain an Appeal Process pursuant to ~~which a~~applicable statutory, regulatory and contractual requirements.

~~A.~~B. A Member, or a Member's Authorized Representative ~~may submit~~, or Provider acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal ~~for review and Resolution~~in the timeframes set forth in this policy.

~~B.~~C. CalOptima's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

~~C.~~D. CalOptima shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section III.G.1 of this Policy.

~~D.~~E. CalOptima shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

~~E.~~ CalOptima shall ~~ensure that the person making the final decision on the Appeal did not participate in any decisions related to the Appeal.~~

F. ~~CalOptima shall~~ refer all ~~Grievances~~Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

G. CalOptima and a Health Network shall inform a Member, during the Appeal Process, of their right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures~~,~~ and GG.1507: Notification Requirements for Covered

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Services Requiring Prior Authorization~~, and GG.1510: Appeal Process for Decisions Regarding Care and Services~~.

H. Neither CalOptima ~~and a Health Network~~, nor any of its Health Networks, Practitioners, or other Providers shall ~~not~~ discriminate ~~or retaliate~~ against ~~any~~a Member~~-~~, a Member's Authorized Representative, or a Provider on the grounds that ~~such Member~~he or she filed an Appeal~~, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations~~.

~~J.~~I. ~~A Provider or a Member shall have the right to Appeal the UM decision. Upon receipt of a~~A Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) sent by CalOptima or a Health Network notifying a Provider or a Member of a CalOptima or Health Network UM decision to delay, deny, modify, or recommend an alternative option to a requested service~~. The UM Appeal shall be a separate process from the Provider Complaint, Member Complaint, Member State Fair Hearing, or claims resubmission processes as specified in CalOptima Policies HH.1101: CalOptima Provider Complaint, HH.1102: CalOptima Member Complaint, HH.1108: State Hearing Process and Procedures, and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.~~, shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

J. The Member UM Appeal process set forth in this policy is a separate process from the Member Grievance Process in CalOptima Policy HH.1102: Member Grievance and Member State Hearing Process in CalOptima Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Policy HH.1101: CalOptima Provider Complaint.

K. CalOptima shall give a Member, a Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. ~~In the case of an Appeal subject to an expedited review,~~ CalOptima and a Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

L. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

M. A Member may be represented by anyone they choose during the Appeal process, including ~~an attorney. For purposes of this policy, a Member representative must be authorized by the Member, in writing, to represent the Member in the Appeal process, or the representative must submit a copy of a durable power of attorney for Health Care or similar legal appointment of representative document; or otherwise be recognized under California law as a legal representative of the Member.~~a legal representative.

~~N. CalOptima or a Health Network shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.~~

~~O.~~N. The Member has the right to request an Appeal in the event that CalOptima or a Health Network fails to issue a NABD/NOA within the required time frame, ~~it~~which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

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~~P.~~O. CalOptima shall provide, upon request by the Member ~~or,~~ his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, before and during the Appeals process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals process. CalOptima shall provide records ~~to the Member or his or her Authorized Representative~~ at no cost.

~~Q.~~P. CalOptima shall ensure that the person reviewing the UM Appeal was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

~~R.~~Q. CalOptima shall ensure that for UM Appeals ~~involving Medical Necessity decisions,~~ the person making the final decision for the proposed resolution of an Appeal has ~~not~~neither participated in any prior decisions related to the Appeal, ~~and~~nor is a ~~health care professional with~~subordinate of someone who has participated in a prior decision and has clinical expertise ~~that may be demonstrated by appropriate specialty training, experience or certification by the American Board of Medical specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions~~ in treating ~~a~~the Member's condition or disease~~.~~ if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

~~S.~~R. A Member shall receive the continuation of the benefit until one (1) of the following occurs:

1. Member withdraws the Appeal;

2. Ten (10) days pass after CalOptima mails the NABD/NOA;

3. Grievance and Appeals Resolution Services (GARS) issues an Appeal decision adverse to the Member; and

4. The time period or service limits of a previously authorized service has been met.

~~S.~~T. A Provider, with the Member's written consent, may request a UM Appeal on behalf of the Member, for services rendered to that ~~-~~CalOptima Member, by submitting a written request to CalOptima within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network, in accordance with the provisions of this policy.

~~T.~~U. Upon notice of a CalOptima decision to deny an authorization request, a Member ~~or a Provider may request an expedited UM Appeal~~, a Member's Authorized Representative, or a Provider, acting on behalf of the Member with the Member's written consent, may request an expedited UM Appeal when it is determined or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

~~V. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at the request of the Member or if there is a need for additional information and how the delay is in the Member's best interest.~~

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~~W. For any extensions not requested by the Member, CalOptima must provide the Member with written notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from the oral notification of the extension.~~

~~W.~~V. All medical Appeals are referred to the Chief Medical Officer (CMO), or to his or her Designee, who has the authority to require corrective action, and did not make the initial utilization management decision.

W. CalOptima and a Health Network shall provide the CalOptima Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract.

~~Y.~~X. CalOptima shall provide language assistance to Members, by CalOptima staff ~~for Threshold Languages and~~ or language line ~~interpretation~~interpreter services, ~~as needed,~~for Threshold Languages to register and resolve ~~Grievances in all other languages.~~Appeals.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima shall provide the complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Appeal, and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Appeal Process

1. GARS shall:

a. Date stamp and document the substance of the Appeal in the GARS database, verifying demographics and network affiliation.

b. Determine the category of Appeal (coverage dispute, ~~medical necessity~~Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, indicating receipt of the Appeal and identifying a GARS staff member whom the Member may contact regarding the Appeal, and provide the Member with an estimated completion date of Resolution.

d. Send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member, excluding expedited Appeals.

i. The date of the oral Appeal establishes the filing date for the Appeal.

e. Process the Appeal whether or not a signed written Appeal confirmation is received from the Member.

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~~d.~~f. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Appeal.

~~e.~~g. Review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited review as required in the CalOptima contract with Department of Health Care Services (DHCS).

~~f.~~h. Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Appeal.

~~g.~~i. Send the Member or Provider, if applicable, a Notice of Appeal Resolution letter within thirty (30) calendar days after receipt of the Appeal.

~~h.~~j. Translate Notice of Appeal Resolution letters into Threshold Languages, and offer oral interpretation for a Notice of Appeal Resolution letter for all other languages.

i. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter in the electronic file and document any oral notification provided to the Member.

2. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

~~a. Summary of the Member's Appeal;~~

a. ~~The investigation made in the review process, including any~~The results of the resolution and the date it was completed;

b. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

~~b.~~d. Any referrals to the Quality Improvement (QI) Department for quality of care review;

~~c.~~e. Alternative resources or references, when applicable; and

~~d. The Member's right to a State Hearing.~~

~~3.~~f. ~~GARS staff shall close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter and document any oral notification provided to the Member end date and save the electronic file.~~The State Hearing process and right to request

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and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

C. UM Pre-service Appeal

1. Request for UM Appeal

a. A CalOptima Member, or his or her Authorized Representative, or a Provider with Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network by the following methods:

i. To CalOptima's Customer Service Department, by telephone, or in person; or

ii. To CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at ~~www.caloptima.org~~www.caloptima.org.

~~b.~~ A Provider ~~or Practitioner~~ may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of ~~a NABD/NOA from CalOptima regarding Covered Services~~the denial for ~~a CalOptima Member, with the Member's written consent. The Provider~~authorization or ~~Practitioner shall:~~

b. ~~i. Submit~~payment for services already received by the ~~request orally or in writing, via mail or facsimile, to CalOptima's Grievance and Appeals Resolution Services.~~ Member.

c. This request serves as the documentation of the substance of the Appeal and any action taken;

~~ii~~i. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

~~iii~~ii. Clearly label the request with "UM Appeal."

2. Acknowledgement of UM ~~Pre-service~~ Appeal

~~a. In instances of an oral Appeal request, excluding expedited Appeals, made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.~~

~~i. The date of the oral Appeal establishes the filing date for the Appeal.~~

~~ii. In the event that CalOptima does not receive a written, signed Appeal confirmation from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.~~

~~b.~~a. Except as otherwise provided in Section III.D of this policy, CalOptima's Grievance and Appeals Resolution Services shall send the CalOptima Member, or Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.

~~c.~~b. The letter shall indicate the receipt of the UM Appeal, and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative

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or Provider, acting on behalf of the Member with the Member's written consent, may contact if they choose to submit additional information (written or in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.

3. UM Pre-service Appeal Processing

   a. Upon receipt of a UM Appeal from a CalOptima Member or his or her Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, an appeals nurse specialist in CalOptima's Grievance and Appeals Resolution Services shall investigate the Appeal, including any aspects of clinical care involved, by:

      i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider ~~or Practitioner~~, or Member without regard to whether such information was submitted or considered in the initial action;

      ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; or

      iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

   b. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action and did not make the initial utilization management decision.

   c. CalOptima shall utilize specialist consultants, as appropriate.

4. UM Pre-service Appeals Resolution

   a. Except as otherwise provided in Section III.D of this policy, CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

      i. If CalOptima completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

      ii. If CalOptima does not completely overturn the denial, such written notice shall include information regarding the title, qualification, and specialty of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf when he or she Appeals.

      iii. If CalOptima upholds a UM decision involving the delay, denial, or modification of health care services, the Notice of Appeal Resolution shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

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iv. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services~~.~~ and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. UM Expedited Appeal

1. If CalOptima determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, Authorized Representative, or a Provider, may request an expedited UM Appeal to CalOptima as follows:

   a. A CalOptima Member, Authorized Representative, or Provider on behalf of the CalOptima Member, with the Member's written consent, may request an expedited UM Appeal by contacting CalOptima's Customer Service Department by telephone or in-person, or contacting CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

   b. CalOptima staff shall inform the Member of limited time to present evidence in person or writing to support the UM Appeal.

2. Upon receipt of a Member request for an expedited UM Appeal, CalOptima's CMO or his or her Designee shall review the request to determine if expedited review criteria is met and shall conduct a medical review as deemed necessary based on whether a delay:

   a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

   b. In the opinion of a Provider with knowledge of the Member's Medical Condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. CalOptima shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

4. Expedited Appeals filed by a physician shall be processed as expedited without further review.

5. CalOptima shall utilize specialist consultants, as appropriate.

6. CalOptima shall make a decision on the expedited UM Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima receives the expedited UM Appeal request.

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7. CalOptima shall notify a Member, the Member's Authorized Representative, or Provider that made the request on behalf of the CalOptima Member within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the verbal notice, if the Appeal does not meet expedited UM Appeal criteria.

8. CalOptima shall notify the Member, the Member's Authorized Representative, and all involved Providers of the expedited UM Appeal decision by facsimile or verbal communication within seventy-two (72) hours after receiving the expedited UM Appeal request. CalOptima shall provide a written notice within one (1) business day after a verbal notice.

~~E. Extension of Timeframes~~

~~1. CalOptima shall extend the resolution timeframes for either standard or expedited Appeals by up to fourteen (14) calendar days if any of the following two (2) conditions apply:~~

~~a. The Member requests the extension;~~

~~b. CalOptima demonstrates to the satisfaction of the DHCS upon request, that there is a need for additional information and how the delay is in the Member's best interest.~~

~~2. For any extension not requested by the Member, CalOptima is required to provide the Member with written notice of the reason for the delay.~~

~~a. CalOptima shall make reasonable efforts to provide the Member with oral notice of the extension.~~

~~b. CalOptima shall provide written notice of the extension within two (2) calendar days and notify the Member of the right to file a Grievance if the beneficiary disagrees with the extension.~~

~~c. CalOptima shall resolve the Appeal as expeditiously as the Member's health condition requires but not beyond the initial fourteen (14) calendar day extension.~~

~~d.1. In the event CalOptima fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.~~

~~F. UM Post-service Appeal~~

~~a) A CalOptima Member, Authorized Representative, or Provider may request a UM Appeal within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member. This request shall serve as the documentation of the substance of the Appeal, and any action taken, by submitting the request to:~~

~~a. CalOptima's Customer Service Department by telephone or in person; or~~

~~b. CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing; or through the CalOptima Website at www.caloptima.org.~~

~~b) A Provider may request a UM Appeal on his own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member.~~

~~c) Acknowledgement of UM Post-service Appeal~~

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~~a. GARS shall send the CalOptima Member, or Authorized Representative, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.~~

~~b. The letter shall indicate the receipt of the UM Appeal and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative, or Provider may contact if they choose to submit additional information (written comments, documents or other information relevant to the Appeal or come in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.~~

~~c. In instances of an oral Appeal request made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.~~

~~i. The date of the oral Appeal establishes the filing date for the Appeal.~~

~~ii. In the event that CalOptima does not receive a written, signed Appeal confirmation from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.~~

~~4.~~E. UM Post-service Appeal processing

~~a.~~1. CalOptima Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative, or Provider.

~~b.~~2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or his or her Designee for review.

~~c.~~3. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action, is of the same or similar specialty, and did not make the initial utilization management decision.

~~d.~~4. CalOptima shall utilize specialist consultants as appropriate.

5. UM Post-service Appeals resolution

a. If CalOptima completely overturns the decision, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

c. If CalOptima does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in

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accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when he or she Appeals.

d. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

e. If CalOptima upholds a UM decision involving the denial of health care services, the Notice of Appeal Resolution shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member.

f. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall clearly specify the provisions of the contract that exclude that service and or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested..

F. ~~5.~~ External Appeals

~~a.~~1. CalOptima shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Website at www.caloptima.org. CalOptima must also advise Members of their right to file an expedited State Hearing.

~~b.~~2. CalOptima shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

3. In the event CalOptima fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

4. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model Program, the Member's family or designated caregiver may appeal a Contintuity of Care limitation ~~to the DHCS director or his or her designee after exhausting the Appeal Process~~ in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and this policy.

G. In addition to any rights set forth in this policy, a Member shall also have the right to:

1. Request that CalOptima provide an interpreter, or auxiliary aide, for assistance in the Appeal Process, or to provide translation of Appeal correspondence; and

2. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

3. CalOptima shall inform a Member of ~~this~~ these rights annually, and in every Notice of Appeal Resolution letter.

~~a. A Member may request a State Hearing within one hundred twenty (120) calendar days after the Notice of Appeal Resolution.~~

~~b. To request a State Hearing, a Member may:~~

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~~i. Write to: Department of Social Services~~
~~State Hearings Division~~
~~P. O. Box 944243, M.S. 19-37~~
~~Sacramento, CA 95814; or~~

~~ii. Call: (800) 952-5253, or for TDD only, (800) 952-8349.~~

~~d. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.~~

~~e. A Member may request continuation of services by requesting a State Hearing within ten (10) calendar days after the Notice of Appeal Resolution Appeal. CalOptima shall grant the Member Aid Paid Pending until a State Hearing decision is reached.~~

H. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Appeal Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

I. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where an Appeal may be submitted, and related procedures regarding the Appeal Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall submit a report of aggregated Appeal data, as required by DHCS.

4. CalOptima shall submit on a quarterly basis aggregate and detailed Appeals data to the Quality Assurance Committee.

5. CalOptima shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or

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Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

6. CalOptima shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Notice of Appeal Resolution (Uphold)
C. Notice of Appeal Resolution (Overturn)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network (CCN) Members, or Members Enrolled in a Shared-Risk Group
D. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~D.~~E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~E.~~F. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~F.~~G. CalOptima Policy HH.1102: CalOptima Member ~~Complaint~~ Grievance
~~G.~~H. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~H.~~I. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
~~I.~~J. CalOptima Member Handbook
~~J.~~K. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~K.~~L. Title 22, California Code of Regulations, § 53858
~~L.~~M. Title 28, California Code of Regulations, § 1300.68 (except Subdivision 1300.68(c)(g) and (h))
~~M.~~N. Title 28, California Code of Regulations, § 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
~~N.~~O. Title 42, Code of Federal Regulations, §§ 438.10, 438.402(c)(2)(ii), 438.402(c)(3)(ii), 438.406(b)(3), 438.408(d)(2)(ii), 438.410, 438.420(a)(b)(c)

VI. REGULATORY AGENCY APPROVAL(S)

~~A. 06/21/17: Department of Health Care Services~~
~~B.~~A. 02/03/16: Department of Health Care Services
~~C.~~B. 06/22/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

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~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	10/1995	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/1998	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	05/1999	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	08/01/2004	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2007	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	06/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2011	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2012	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	09/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	11/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	04/01/2016	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal

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~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	TBD	GG.1510	Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definitions
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	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.
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.~~For purposed of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
California Children's Services	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An expression of dissatisfaction about any matter other than an adverse benefit determination.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury

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Term	Definitions
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Utilization Management (UM) Appeal	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.

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Policy #:	GG.1510
Title:	**Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
Revised Date:	TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Utilization Management (UM) appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory and contractual requirements.

B. A Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this policy.

C. CalOptima's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

D. CalOptima shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section III.G.1 of this Policy.

E. CalOptima shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

F. CalOptima shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

G. CalOptima and a Health Network shall inform a Member, during the Appeal Process, of their right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

H. Neither CalOptima, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a Member, a Member's Authorized Representative, or a Provider on the grounds that he or she filed an Appeal.

I. A Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) sent by CalOptima or a Health Network notifying a Provider or a Member of a CalOptima or Health Network UM decision to delay, deny, modify, or recommend an alternative option to a requested service, shall

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inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

J. The Member UM Appeal process set forth in this policy is a separate process from the Member Grievance Process in CalOptima Policy HH.1102: Member Grievance and Member State Hearing Process in CalOptima Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Policy HH.1101: CalOptima Provider Complaint.

K. CalOptima shall give a Member, a Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. CalOptima and a Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

L. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

M. A Member may be represented by anyone they choose during the Appeal process, including a legal representative.

N. The Member has the right to request an Appeal in the event that CalOptima or a Health Network fails to issue a NABD/NOA within the required time frame, which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

O. CalOptima shall provide, upon request by the Member, his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, before and during the Appeals process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals process. CalOptima shall provide records at no cost.

P. CalOptima shall ensure that the person reviewing the UM Appeal was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

Q. CalOptima shall ensure that for UM Appeals, the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

R. A Member shall receive the continuation of the benefit until one (1) of the following occurs:

1. Member withdraws the Appeal;

2. Ten (10) days pass after CalOptima mails the NABD/NOA;

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3. Grievance and Appeals Resolution Services (GARS) issues an Appeal decision adverse to the Member; and

4. The time period or service limits of a previously authorized service has been met.

T. A Provider, with the Member's written consent, may request a UM Appeal on behalf of the Member, for services rendered to that CalOptima Member, by submitting a written request to CalOptima within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network, in accordance with the provisions of this policy.

U. Upon notice of a CalOptima decision to deny an authorization request, a Member, a Member's Authorized Representative, or a Provider, acting on behalf of the Member with the Member's written consent, may request an expedited UM Appeal when it is determined or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

V. All medical Appeals are referred to the Chief Medical Officer (CMO), or to his or her Designee, who has the authority to require corrective action, and did not make the initial utilization management decision.

W. CalOptima and a Health Network shall provide the CalOptima Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract.

X. CalOptima shall provide language assistance to Members, by CalOptima staff or language line interpreter services, for Threshold Languages to register and resolve Appeals.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima shall provide the complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Appeal, and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Appeal Process

1. GARS shall:

a. Date stamp and document the substance of the Appeal in the GARS database, verifying demographics and network affiliation.

b. Determine the category of Appeal (coverage dispute, Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, indicating receipt of the Appeal and identifying a GARS staff member whom the

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Member may contact regarding the Appeal, and provide the Member with an estimated completion date of Resolution.

d. Send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member, excluding expedited Appeals.

   i. The date of the oral Appeal establishes the filing date for the Appeal.

e. Process the Appeal whether or not a signed written Appeal confirmation is received from the Member.

f. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Appeal.

g. Review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited review as required in the CalOptima contract with Department of Health Care Services (DHCS).

h. Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Appeal.

i. Send the Member or Provider, if applicable, a Notice of Appeal Resolution letter within thirty (30) calendar days after receipt of the Appeal.

j. Translate Notice of Appeal Resolution letters into Threshold Languages, and offer oral interpretation for a Notice of Appeal Resolution letter for all other languages.

i. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter in the electronic file and document any oral notification provided to the Member.

2. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. The results of the resolution and the date it was completed;

b. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

d. Any referrals to the Quality Improvement (QI) Department for quality of care review;

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e. Alternative resources or references, when applicable; and

f. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

C. UM Pre-service Appeal

1. Request for UM Appeal

a. A CalOptima Member, or his or her Authorized Representative, or a Provider with Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network by the following methods:

i. To CalOptima's Customer Service Department, by telephone, or in person; or

ii. To CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

b. A Provider may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member.

c. This request serves as the documentation of the substance of the Appeal and any action taken;

i. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

ii. Clearly label the request with "UM Appeal."

2. Acknowledgement of UM Appeal

a. Except as otherwise provided in Section III.D of this policy, CalOptima's Grievance and Appeals Resolution Services shall send the CalOptima Member, or Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.

b. The letter shall indicate the receipt of the UM Appeal, and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, may contact if they choose to submit additional information (written or in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.

3. UM Pre-service Appeal Processing

a. Upon receipt of a UM Appeal from a CalOptima Member or his or her Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, an appeals nurse specialist in CalOptima's Grievance and Appeals Resolution Services shall investigate the Appeal, including any aspects of clinical care involved, by:

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i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; or

iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

b. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action and did not make the initial utilization management decision.

c. CalOptima shall utilize specialist consultants, as appropriate.

4. UM Pre-service Appeals Resolution

a. Except as otherwise provided in Section III.D of this policy, CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

i. If CalOptima completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

ii. If CalOptima does not completely overturn the denial, such written notice shall include information regarding the title, qualification, and specialty of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf when he or she Appeals.

iii. If CalOptima upholds a UM decision involving the delay, denial, or modification of health care services, the Notice of Appeal Resolution shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

iv. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

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D. UM Expedited Appeal

1. If CalOptima determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, Authorized Representative, or a Provider, may request an expedited UM Appeal to CalOptima as follows:

    a. A CalOptima Member, Authorized Representative, or Provider on behalf of the CalOptima Member, with the Member's written consent, may request an expedited UM Appeal by contacting CalOptima's Customer Service Department by telephone or in-person, or contacting CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

    b. CalOptima staff shall inform the Member of limited time to present evidence in person or writing to support the UM Appeal.

2. Upon receipt of a Member request for an expedited UM Appeal, CalOptima's CMO or his or her Designee shall review the request to determine if expedited review criteria is met and shall conduct a medical review as deemed necessary based on whether a delay:

    a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

    b. In the opinion of a Provider with knowledge of the Member's Medical Condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. CalOptima shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

4. Expedited Appeals filed by a physician shall be processed as expedited without further review.

5. CalOptima shall utilize specialist consultants, as appropriate.

6. CalOptima shall make a decision on the expedited UM Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima receives the expedited UM Appeal request.

7. CalOptima shall notify a Member, the Member's Authorized Representative, or Provider that made the request on behalf of the CalOptima Member within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the verbal notice, if the Appeal does not meet expedited UM Appeal criteria.

8. CalOptima shall notify the Member, the Member's Authorized Representative, and all involved Providers of the expedited UM Appeal decision by facsimile or verbal communication within seventy-two (72) hours after receiving the expedited UM Appeal request. CalOptima shall provide a written notice within one (1) business day after a verbal notice.

E. UM Post-service Appeal processing

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1. CalOptima Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative, or Provider.

2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or his or her Designee for review.

3. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action, is of the same or similar specialty, and did not make the initial utilization management decision.

4. CalOptima shall utilize specialist consultants as appropriate.

5. UM Post-service Appeals resolution

    a. If CalOptima completely overturns the decision, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

    b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

    c. If CalOptima does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when he or she Appeals.

    d. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

    e. If CalOptima upholds a UM decision involving the denial of health care services, the Notice of Appeal Resolution shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member.

    f. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall clearly specify the provisions of the contract that exclude that service and or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested..

F. External Appeals

1. CalOptima shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Website

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at www.caloptima.org. CalOptima must also advise Members of their right to file an expedited State Hearing.

2. CalOptima shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

3. In the event CalOptima fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

4. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model Program, the Member's family or designated caregiver may appeal a Contintuity of Care limitation in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and this policy.

G. In addition to any rights set forth in this policy, a Member shall also have the right to:

1. Request that CalOptima provide an interpreter, or auxiliary aide, for assistance in the Appeal Process, or to provide translation of Appeal correspondence; and

2. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

3. CalOptima shall inform a Member of these rights annually, and in every Notice of Appeal Resolution letter.

H. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

a. Maintenance of the Appeal Process;

b. Review of the operations; and

c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

I. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where an Appeal may be submitted, and related procedures regarding the Appeal Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution

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Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall submit a report of aggregated Appeal data, as required by DHCS.

4. CalOptima shall submit on a quarterly basis aggregate and detailed Appeals data to the Quality Assurance Committee.

5. CalOptima shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

6. CalOptima shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Notice of Appeal Resolution (Uphold)
C. Notice of Appeal Resolution (Overturn)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network (CCN) Members, or Members Enrolled in a Shared-Risk Group
D. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.1102: CalOptima Member Grievance
H. CalOptima Policy HH.1108: State Hearing Process and Procedures
I. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
J. CalOptima Member Handbook
K. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
L. Title 22, California Code of Regulations, § 53858
M. Title 28, California Code of Regulations, § 1300.68 (except Subdivision 1300.68(c)(g) and (h))
N. Title 28, California Code of Regulations, § 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
O. Title 42, Code of Federal Regulations, §§ 438.10, 438.402(c)(2)(ii), 438.402(c)(3)(ii), 438.406(b)(3), 438.408(d)(2)(ii), 438.410, 438.420(a)(b)(c)

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/03/16: Department of Health Care Services
B. 06/22/15: Department of Health Care Services

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VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/1995	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/1998	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	05/1999	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	08/01/2004	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2007	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	06/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2011	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2012	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	09/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	11/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2016	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	TBD	GG.1510	Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definitions
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	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.
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	For purposed of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
California Children's Services	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An expression of dissatisfaction about any matter other than an adverse benefit determination.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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Term	Definitions
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Utilization Management (UM) Appeal	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.

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

[CalOptima logo]

"Uphold"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf]* appealed the *[denial, delay, modification, or termination]* of *[Service requested]*.

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you need help reading this letter or have any questions, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff

who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

[CalOptima logo]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf],* appealed the *[denial, delay, modification, or termination]* of *[Service requested].*

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision].*

[CalOptima] has 72 hours to approve or provide you the service.

Your request has been approved *[under authorization number <#> from <date> to <date> with <provider> or payment has been made].* On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

If you need help reading this letter or have any questions, please call, *[Grievance and Appeals Resolution Services Staff Name],* at *[telephone number].*

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

Policy #:	GG.1814
Title:	**Appeals Process for Long Term Care Facility**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/1998
~~Last Review Date:~~	~~07/01/17~~
~~Last~~ Revised Date:	~~07/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy defines the process by which a Long Term Care (LTC) Facility provider may Appeal a CalOptima post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, or OneCare Connect Member.

II. POLICY

A. Upon receipt of a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) or Notice of Denial informing a LTC Facility provider of a denial, modification, or recommendation for an alternative option to a requested Long Term Care Facility daily rate, the LTC Facility provider shall have the right to appeal the Level of Care decision in accordance with the provisions set forth in this P~~p~~olicy.

B. In order to appeal the decision, a LTC Facility provider shall request reconsideration of the decision by submitting a written request for an Appeal within sixty (60) calendar days after receiving the NABD/NOA or Notice of Denial from CalOptima.

C. If CalOptima denies a LTC Facility provider's Appeal for the Level of Care, the LTC Facility provider may submit an Appeal for the Level of Care decision, within the applicable timeframe, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

III. PROCEDURE

A. A LTC Facility provider may request reconsideration of a Level of Care decision by submitting an Appeal, in writing, to the Grievance and Appeals Resolution Services (GARS) Department. The LTC Facility provider shall:

1. Submit the written request within sixty (60) calendar days after the date of the NABD/NOA or Notice of Denial;

2. Include all relevant materials, such as clinical documentation or other documentation supporting the request;

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3. Clearly label the request with "Appeal;" and

4. Include a new LTC Authorization Request Form (ARF).

B. Acknowledgement of LTC Appeal

1. The CalOptima Grievance and Appeal Resolution Services (GARS) Department shall send an Acknowledgment Letter within five (5) calendar days after receipt of a LTC Appeal.

2. The letter shall indicate the receipt of the LTC Appeal and identify a GARS nurse who can be contacted if they choose to submit additional information, including written comments, documents, or other information relevant to the Appeal.

C. CalOptima shall reconsider the Level of Care decision based upon a review of medical records and other documentation, as submitted by the LTC Facility provider, to support the Level of Care, including, but not limited to nursing notes, physician notes, and other records.

D. A GARS nurse shall investigate, review, and summarize the Appeal history and documentation, including any aspects of clinical care involved; for submission to the Chief Medical Officer (CMO) or their Designee for review.

E. For Medical Necessity decisions, CalOptima's CMO or their Designee shall render a decision.

F. Resolution of LTC Appeal

1. CalOptima shall send to the Provider, as appropriate, an Appeal Resolution Letter within thirty (30) calendar days after receipt of the LTC Appeal.

A. CalOptima shall notify the LTC Facility provider, in writing, of the decision. If CalOptima upholds the Level of Care decision to deny, modify, or recommend an alternative option to a requested LTC Facility daily rate, the LTC Facility provider notification shall include information regarding the LTC Facility provider's right to file a Complaint in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Appeal Resolution Letter

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy CMC.1000: Glossary of Terms
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. CalOptima Policy MA.9006: CalOptima Provider Complaint
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Title 22, California Code of Regulations (C.C.R.), §51003(g)
I. Title 22, California Code of Regulations (C.C.R.), §51334

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J. Title 22, California Code of Regulations (C.C.R.), §51335

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 02/03/16: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/1998	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	09/01/2004	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	02/01/2007	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	03/01/2008	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	11/01/2015	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	06/01/2016	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	07/01/2017	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	TBD	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Appeal	For the purposes of this policy, a request by a Provider for review of any decision to deny, modify, or recommend alternative options to a requested Level of Care decision.
Acknowledgement Letter	A written statement acknowledging receipt of a Complaint or Appeal.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility	Long Term Care (LTC) facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B [Skilled Nursing Facility (SNF)].
Level of Care	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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Policy #:	GG.1814
Title:	**Appeals Process for Long Term Care Facility**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy defines the process by which a Long Term Care (LTC) Facility provider may Appeal a CalOptima post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, or OneCare Connect Member.

II. POLICY

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B. In order to appeal the decision, a LTC Facility provider shall request reconsideration of the decision by submitting a written request for an Appeal within sixty (60) calendar days after receiving the NABD/NOA or Notice of Denial from CalOptima.

C. If CalOptima denies a LTC Facility provider's Appeal for the Level of Care, the LTC Facility provider may submit an Appeal for the Level of Care decision, within the applicable timeframe, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

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J. Title 22, California Code of Regulations (C.C.R.), §51335

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 02/03/16: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1998	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	09/01/2004	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
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Revised	03/01/2008	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	11/01/2015	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	06/01/2016	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	07/01/2017	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	TBD	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect

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Member	An enrollee-beneficiary of a CalOptima 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.

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>
Attention: <NAME>

RE: <MEMBER NAME>
ID #: <CIN>
DOS: <DATE OF SERVICE>

Dear <Provider>:

This letter is in response to the provider appeal CalOptima received on <DATE> for the above-referenced dates of service with respect to <_____> for CalOptima member, <_____>. The denial was issued due to <_____>.

In your appeal, you state that <_____>.

CalOptima's Grievance and Appeals Resolution Services has completed a review of the submitted appeal letter, <_____> and other supporting documentation available. As a result of this review, CalOptima has made the decision to <uphold or overturn> the denial based on the following:

- <_____>.

Based on the foregoing, <_____>.

If you disagree with this determination, you may file a complaint within sixty (60) calendar days after the date of this letter directed to:

CalOptima
Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

Should you have any questions regarding this letter, you may contact me at (714) <_____>.

Sincerely,

<Nurse Specialist Name>, RN

Grievance and Appeals Resolution Services

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Approval of Policy GG.1657, the Medical Board of California and the National Practitioner Data Bank Reporting Policy

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality Analytics & Population Health Management, (714) 246-8400

Recommended Actions

Recommend approval of Policy GG.1657, Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

Background/Discussion

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy has been developed to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

Fiscal Impact

There is no anticipated fiscal impact to the recommended action.

Concurrence

Gary Crockett, Chief Counsel

Attachments

GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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Policy #:	GG.1657ΔPP
Title:	**Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	TBD
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy is to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

II. POLICY

A. CalOptima and its delegated Health Networks shall comply with Medical Board and NPDB requirements for reporting certain actions related to CalOptima Practitioner credentialing and peer review activities.

B. If a reportable action is taken by CalOptima against a Practitioner, then CalOptima is the entity responsible for making the report(s) required by this Policy unless such reports are not required by applicable law.

C. Health Networks shall have policies and procedures that address credentialing and peer review reporting requirements. If a reportable action is taken by a Health Network against a Practitioner, then the Health Network is the entity responsible to make the report(s) unless such reports are not required by applicable law.

1. If a reportable action is taken by a Health Network, the Health Network shall report the reportable action, via mail or electronically, to the CalOptima Quality Improvement Department Director within thirty (30) calendar days from the date the action was reported.

III. PROCEDURE

A. Reports to the Medical Board Based on Business and Professions Code § 805

1. Entity Required to Report

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a. Only one peer review body is required to file an 805 Report for a Practitioner's Medical or Disciplinary Cause or Reason. If another peer review entity reports a Practitioner, CalOptima is not required to file a separate 805 Report attributable to the same conduct by the Practitioner.

2. Actions Requiring Reports

a. An 805 Report is filed with the Medical Board whenever any of the following actions become final:

i. Denial of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

ii. Non-renewal of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iii. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iv. Termination of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason; or

v. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason;

vi. Imposition of summary suspension of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

b. An 805 Report is filed with the Medical Board if the Practitioner takes any of the following actions listed below:

i. Resignation or leave of absence by a Practitioner from CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason;

ii. Withdrawal or abandonment of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or

Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or

iii. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

3. Timeframe for filing an 805 Report

a. Denial, Non-Renewal, Restriction or Termination

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the conclusion of all of the proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if a denial, non-renewal, restriction or termination results from such proceedings;

ii. CalOptima shall file an 805 Report within fifteen (15) calendar days if the Practitioner's participation is restricted for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason.

b. Summary Suspension

i. CalOptima shall file an 805 Report within fifteen (15) calendar days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) consecutive days.

a) CalOptima will also file an additional 805 Report with the Medical Board about the same Practitioner following conclusion of all proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, or after the effective date of resignation or leave of absence by a Practitioner related to such summary suspension/investigation, within the timeframes provided in Section III.A.3.a.i. and Section III.A.3.c.i.

c. Resignation, Withdrawal or Leave of Absence

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the effective date of resignation or leave of absence by a Practitioner.

4. Exhaustion of Fair Hearing Rights

a. For any action taken by CalOptima pursuant to Section III.A.2.a.i. through Section III.A.2.a.iv., CalOptima shall not file an 805 Report until the Practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

5. Notification to the Practitioner

a. CalOptima shall provide the Practitioner with a copy of the 805 Report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

6. Additional Reporting Requirements

a. If the Practitioner is an osteopathic physician, dentist or psychologist, CalOptima shall also file a copy of the 805 Report with the Practitioner's respective Board (e.g. Osteopathic Medical Board of California, Dental Board of California, California Board of Psychology.)

B. Reports to the Medical Board Based on Business and Professions Code § 805.01

1. Actions Requiring Reports

a. An 805.01 Report is filed with the Medical Board whenever a peer review body (e.g. the Credentialing and Peer Review Committee) makes a final decision or recommendation, as specified in Section III.A.2.a.i. through Section III.A.2.a.iv. above, resulting in a final proposed action to be taken against a Practitioner based on the peer review body's determination, following formal investigation of Practitioner, that any of the acts listed below, may have occurred:

i. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a matter as to be dangerous or injurious to any person or the public;

ii. The use of, or prescribing for or administering to himself/herself, any controlled substance; or use of any dangerous drug, as defined in Business and Professions Code Section 4022, or of alcoholic beverages, that is dangerous or injurious to the Practitioner, any other person, public, or that the Practitioner's ability to practice safely is impaired by use;

iii. Repeated acts if clearly excessive prescribing, furnishing, or administering of controlled substances or related acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a Practitioner who is lawfully treating intractable pain be reported for excessive prescribing); or

iv. Sexual misconduct with one or more patients during a course of treatment or examination.

2. Timeframe for filing an 805.01 Report

a. CalOptima shall file an 805.01 Report within fifteen (15) calendar days after a final decision or recommendation regarding disciplinary action based upon a formal

investigation that concludes that based on an allegation that any of the acts listed in Section III.B.1. of this Policy have occurred.

3. Fair Hearing Rights

   a. CalOptima shall file an 805.01 Report (distinct from an 805 Report) regardless of whether the Practitioner is afforded his/her Fair Hearing Rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

   a. CalOptima shall provide the Practitioner with a copy of the 805.01 report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

C. Reports to the National Practitioner Data Bank

1. Actions Requiring Reports

   a. An NPDB Report is filed whenever any of the following actions become final:

      i. An adverse Clinical Privileges action that is based on the Practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the Practitioner's authority to provide care to CalOptima patients for more than thirty (30) calendar days. This includes actions taken against a Practitioner's privileges including reducing, restricting, suspending, revoking, denying or not renewing privileges;

      ii. Acceptance of the Practitioner's surrender of Clinical Privileges, or any restriction of such privileges by a Practitioner:

         a) While the Practitioner is under investigation relating to possible incompetence or improper professional conduct; or

         b) In return for not conducting such an investigation or proceeding.

      iii. Withdrawal of an initial application by Practitioner for Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action;

      iv. Practitioner does not apply for renewal of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action; or

v. Summary suspension imposed for more than thirty (30) days based on the Practitioner's professional competence or professional conduct of the Practitioner that adversely effects, or could adversely affect the health and welfare of a patient and is the result of a professional review action.

2. Timeframe for filing an NPDB Report

a. CalOptima shall file an NPDB Report within thirty (30) calendar days from the date the adverse action was taken or authority to provide care to CalOptima patients is voluntarily surrendered.

3. Fair Hearing Rights

a. Except in the event of a summary suspension in effect less than thirty-one (31) consecutive days or a surrender or restriction of authority to provide care to CalOptima patients, CalOptima shall file a NPDB Report after the Practitioner has had the opportunity to either waive or exhaust his/her fair hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. The NPDB will mail a copy of the submitted report to the Practitioner named in the report. The Practitioner will have the opportunity to review the report for accuracy, and may add a statement to the report, or may dispute the report directly with the NPDB.

5. Additional Reports

a. CalOptima shall file a Revision-to-Action report to supplement an initial report to the NPDB if the summary suspension of a Practitioner is modified or revised as part of CalOptima's final decision in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

D. Persons at CalOptima Required to Report

1. Reports to the Medical Board Based on Business and Professions Code § 805

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.A.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805 Report with the Medical Board in the appropriate time required in Section III.A.3. of this Policy.

2. Reports to the Medical Board Based on Business and Professions Code § 805.01

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.B.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805.01 Report with the Medical Board in the appropriate time required in Section III.B.3. of this Policy.

3. Reports to the National Practitioner Data Bank

   a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.C.2. of this Policy, Quality Improvement Credentialing Supervisor, shall file a report with the NPDB in the appropriate time required in Section III.C.3. of this Policy.

IV. ATTACHMENTS

A. Sample 805 Report
B. Sample 805.01 Report
C. Sample NPDB Report

V. REFERENCES

A. California Welfare and Institutions Code, § 14087.58(b)
B. California Business and Professions Code, §§ 805, 805.01 and 809
C. California Health and Safety Code § 1370
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
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. Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §11101 *et seq.*
K. National Practitioner Data Bank regulations, 45 CFR Part 60
L. National Practitioner Data Bank 2015 Guidebook
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing (2018) CR:7, Element A, Factor 2

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. TBD

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1657ΔPP	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Clinical Privileges	As provided in the NPDB Guidebook, Clinical Privileges are privileges, and other circumstances (e.g. network participation and panel membership) in which a physician, dentist, or other health care Practitioner is permitted to furnish medical care by a health care entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
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.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in Business and Professions Code Section 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 (HCQIA) and its implementing regulations.

MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, podiatrists, licensed midwifes and physician assistants must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information.

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	

Name	Telephone #
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report	Telephone #
Street address City	State Zip code

LICENTIATE

Name	License #

☐ Physician ☐ Podiatrist ☐ Licensed Midwife ☐ Physician Assistant

ACTION TAKEN

Date(s) of Action(s) and Duration (attached additional sheets if necessary)

Type(s) of Action(s) - Check all that apply. **CHECK HERE IF THIS IS A SUPPLEMENTAL REPORT** ☐

(a) For a medical disciplinary cause or reason:
- ☐ Denial/rejection of application for staff privileges
- ☐ Denial/rejection of application for membership
- ☐ Termination or revocation of staff privileges
- ☐ Termination or revocation of membership
- ☐ Termination or revocation of employment

(b) For a cumulative total of 30 days or more for any 12 month period, and for a medical disciplinary cause or reason:
- ☐ Restriction(s) imposed on staff privileges
- ☐ Restriction(s) imposed on membership
- ☐ Restriction(s) imposed on employment
- ☐ Restriction(s) voluntarily accepted on staff privileges
- ☐ Restriction(s) voluntarily accepted on membership
- ☐ Restriction(s) voluntarily accepted on employment

If staff privileges were restricted, list specific restrictions imposed or voluntarily accepted:

(c) Following notice of an impending investigation based on information indicating medical disciplinary cause or reason:
- ☐ Licentiate resigned from staff
- ☐ Licentiate resigned from membership
- ☐ Licentiate resigned from employment
- ☐ Licentiate took leave of absence from staff
- ☐ Licentiate took leave of absence from membership
- ☐ Licentiate took leave of absence from employment

(d) For a summary suspension that remains in effect for a period in excess of 14 days for a medical disciplinary cause or reason:
- ☐ Imposition of summary suspension on staff privileges
- ☐ Imposition of summary suspension on employment
- ☐ Imposition of summary suspension on membership

DESCRIPTION OF ACTION: Attach additional sheet(s) describing the facts and circumstances of the medical disciplinary cause or reason and any other relevant information related to the action taken, including, but not limited to, the number of cases reviewed, time frame covered, any patient deaths involved, any malpractice filings as a result of the physician's actions, any expert/peer opinions obtained, etc.

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2528 FAX: (916) 263-2435 www.mbc.ca.gov

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ADDITIONAL INFORMATION

To complete this form, for definition of terms, when, how, and who should report, please refer to Section 805 of the California Business and Professions Code. You may access this information via www.leginfo.ca.gov under California Law, Business and Professions Code.

PLEASE NOTE: Section 805(k) of the California Business and Professions Code states: "A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, 'willful' means a voluntary and intentional violation of a known legal duty."

Section 805(l) of the California Business and Professions Code states: "Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that, under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code."

Section 805(m) of the California Business and Professions Code states: "A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates."

CONFIDENTIALITY

This report is not a waiver of the confidentiality of medical records and committee reports. The contents of this report may be viewed only by those persons specified in Section 800(c) of the Business and Professions Code, except as required by Section 805.5 of the Business and Professions Code.

COPY TO LICENTIATE

A copy of the 805 report, with a cover letter informing the Licentiate of his or her right to submit additional statements or other information pursuant to Section 800(c) of the Business and Professions Code, must be sent by the reporting entity to the Licentiate.

SUPPLEMENTAL REPORT

A supplemental report must be made within thirty (30) days following the date the Licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as corrective action by the reporting entity.

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MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805.01 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, physician assistants, licensed midwifes and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason.

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	
Name		Telephone #
Chief Executive Officer/Medical Director/Administrator		Chief of Medical Staff
Name of person preparing report		Telephone #
Street address	City	State Zip code

LICENTIATE

Name			License #
☐ Physician	☐ Podiatrist	☐ Licensed Midwife	☐ Physician Assistant

REASON FOR FORMAL INVESTIGATION

Reason for formal investigation that resulted in recommended action:

- ☐ Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
- ☐ The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- ☐ Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- ☐ Sexual misconduct with one or more patients during a course of treatment or an examination.

RECOMMENDED ACTION

- ☐ Termination or revocation of staff privileges, membership or employment
- ☐ Summary suspension of staff privileges, membership or employment
- ☐ Restriction of staff privileges, membership or employment

List proposed specific restrictions:

Date final decision/recommendation made:

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2528 FAX: (916) 263-2435 www.mbc.ca.gov

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California Business and Professions Code Section 805.01

(a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) "Licentiate" has the same meaning as defined in Section 805.

(4) "Peer review body" has the same meaning as defined in Section 805.

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

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U.S. Department of Health & Human Services

NPDB National Practitioner Data Bank

Draft Medical Malpractice Payment Report (MMPR)
(Do not mail this form to the NPDB)

This form is for your convenience in drafting Medical Malpractice Payment Reports for ultimate submission to the NPDB. **Do not mail this form to the NPDB.** Medical Malpractice Payment Reports must be submitted to the National Practitioner Data Bank (NPDB) using the Integrated Querying and Reporting Service (IQRS), the Querying and Reporting XML Service (QRXS), or the Interface Control Document (ICD) Transfer Program (ITP), which are available at *https://www.npdb.hrsa.gov*.

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission. If spaces are provided for multiple responses to an item, you only need to complete as many of the responses as you have information for. There is no need to repeat responses or enter "Not Applicable," etc.

OMB # 0915-0126 expiration date 03/31/2021

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0126. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

Personal Information

Subject Name

Last Name	First Name	Middle Name	Suffix
(25 characters)	*(15 characters)*	*(15 characters)*	*(4 characters)*

Is Subject Deceased?

- ☐ No
- ☐ Unknown
- ☐ Yes – Deceased Date (MMDDYYYY):

Gender: ☐ Male ☐ Female ☐ Unknown

Birth Date (MMDDYYYY)**:**

Home Address/Address of Record

(See List A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Work Information

Organization Name *(60 characters)*:
Address
(See Lists A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Social Security Numbers (SSN) (Format NNNNNNNNN)

1. **2.**
3. **4.**

Drug Enforcement Administration (DEA) Numbers *(9 characters)*

1. **2.**
3. **4.**

Professional Schools Attended (Name, City, State/Country; *200 characters*) **Year of Graduation** (Format YYYY)

1.
2.
3.
4.
5.

Occupation and State Licensure Information

(Provide at least one license. Check 'No License' if the subject does not have a State License Number. Up to 60 licenses may be provided.)

1. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

2. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

3. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

4. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

5. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

6. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

7. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

8. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

9. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

10. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

Hospital Affiliation(s)

	Name *(60 characters)*	**City** *(28 characters)*	**State** (Choose State code from List A-1)
1.			
2.			
3.			
4.			
5.			

Payments by This Payer for This Practitioner

If you made a single payment for multiple practitioners and if the settlement agreement or judgment does not specify an amount for each practitioner, you must allocate the total payment between the practitioners and specify an amount greater than zero for this practitioner. If a settlement agreement specifically states that no payment was made for this practitioner, do not file this report. The total amount paid or to be paid by you for all practitioners must be specified in the appropriate field. You must file a separate report for each practitioner named in the claim and judgment or settlement unless the judgment or settlement specifically states that no payment was made for that practitioner.

Amount of This Payment for This Practitioner

(Format NNNNNNNNN.NN): $

Date of This Payment (MMDDYYYY):

Select the payment type (i.e., Single or Multiple) to indicate whether the payment specified in the Amount of This Payment field is a single final payment or is one of multiple payments to be paid in series. Only the first payment of a series of payments must be reported, except when a preliminary payment is made before a final settlement is reached.

If this payment represents a preliminary payment prior to settlement:

1. Select One of Multiple Payments in this field; enter the preliminary payment amount in both the Amount of This Payment for This Practitioner and the Total Amount Paid or to be Paid by This Payer for This Practitioner fields; and
2. Explain the circumstances of the preliminary payment in the Description of the Judgment or Settlement field.
3. Once the settlement is reached, file a Correction Report and provide the revised total amount of all payments in the Total Amount Paid or to be Paid by This Payer for This Practitioner field.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. In these cases:

1. Report the amount of the first payment in the Amount of This Payment for This Practitioner field.
2. Complete the Total Amount Paid or to be Paid by This Payer for This Practitioner field, consistent with the instructions below.

This Payment Represents: ☐ A Single Final Payment ☐ One of Multiple Payments

If this report concerns a preliminary payment before a final settlement is reached and the total amount ultimately to be paid is unknown:

1. Enter only the amount of this payment; and
2. Explain in the Description of the Judgment or Settlement field;
3. Then, file a Correction Report once the settlement is reached and the total amount is known.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. If this payment is part of a structured settlement, report the cost of purchasing the structured settlement arrangement or the present value of the total payments to be made over the lifetime of the obligation if a structured settlement arrangement is not purchased.

Total Amount Paid or to Be Paid by This Payer for This Practitioner
(Format NNNNNNNNN.NN): $

Payment Result of: ☐ Judgment ☐ Settlement ☐ Payment Prior to Settlement

Date of Judgment or Settlement, if Any (MMDDYYYY):

Adjudicative Body Case Number (if Applicable; *20 characters*):

Adjudicative Body Name (if Applicable; *60 characters*):

Court File Number (if Applicable; *10 characters*):

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment
(Limit 4,000 characters including spaces and punctuation)

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Payments by This Payer for Other Practitioners in This Case	
Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case (Including the Amount Specified Above for This Practitioner; Format NNNNNNNNN.NN):	$
Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:	

Payment Information

Relationship of Entity to This Practitioner (Choose one from list):

Note: A health insurance company, managed care organization, or health care entity (such as a hospital, health plan, group practice, government agency and department that provides health care services) that makes a payment for a practitioner on its own staff because the company pays its own malpractice claims rather than having coverage for malpractice claims under an insurance policy issued by another company should report as a Self-Insured Organization. A State fund should select the code "State Medical Malpractice Payment Fund as the Primary Payer for the Practitioner" if the fund is the payer of first resort for a claim and select the code "State Medical Malpractice Payment Fund as a Secondary Payer for the Practitioner" if the fund is the payer for any amount in excess of the primary amount.

☐ Insurance Company – Primary Insurer
☐ Insurance Company – Excess Insurer
☐ Self-Insured Organization
☐ Insurance Guaranty Fund
☐ State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner
☐ State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization.

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?
☐ Yes
☐ No
☐ Unknown

Amount Paid or Expected to Be Paid by the State Fund (Format NNNNNNNNN.NN): $

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund.

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?
☐ Yes
☐ No
☐ Unknown

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies (Format NNNNNNNNN.NN): $

Classification of Act(s) or Omission(s)

Patient Information

Patient's Age at Time of Initial Event (enter 0 days if the patient is a fetus):
- ☐ Days (if less than 1 month)
- ☐ Months (if less than 1 year)
- ☐ Years
- ☐ Unknown

Patient's Gender: ☐ Male ☐ Female ☐ Unknown

Patient Type: ☐ Inpatient ☐ Outpatient ☐ Both ☐ Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)

Enter a narrative description of the actual diagnosis with which the patient presented for treatment. Do not report a misdiagnosis. If the patient had more than one condition, enter the condition most applicable to the alleged acts or omissions. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Description of the Procedure Performed

Enter a narrative description of the treatment rendered by the insured to the patient for the initial medical condition specified in this report. If more than one procedure was performed by the insured, report the one that is most significant to the claims generation. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Nature of Allegation (choose one from list)**:**

- ☐ Anesthesia Related
- ☐ Behavioral Health Related
- ☐ Diagnosis Related
- ☐ Equipment/Product Related
- ☐ IV & Blood Products Related
- ☐ Medication Related
- ☐ Monitoring Related
- ☐ Obstetrics Related
- ☐ Surgery Related
- ☐ Treatment Related
- ☐ Other Miscellaneous

Specific Allegation (Select the most significant allegation first.)

Note: Only select the same code for both allegations if the alleged act or omission occurred more than once and on different dates.

1. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

2. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

Outcome (Choose one from list)**:**

- ☐ Emotional injury only
- ☐ Insignificant injury
- ☐ Minor temporary injury
- ☐ Major temporary injury
- ☐ Minor permanent injury
- ☐ Major permanent injury
- ☐ Significant permanent injury
- ☐ Quadriplegic, brain damage, lifelong care
- ☐ Death
- ☐ Cannot be determined from available records

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

Reporting entities must use this field to summarize the allegations of the plaintiff or claimant in demanding payment even if the reporting entity believes these allegations to be without merit. Reporters may also use this section to summarize important issues in the case and to provide, as needed, additional information not reported in the Classification of Acts or Omissions section of this report. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the NPDB, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference (e.g., claim number; *20 characters*):

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use (*20 characters*):

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Recommend reappointment of Patrick Moore to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term effective March 7, 2019.

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

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

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

Discussion
The candidate recommended for reappointment, Patrick Moore, has consistently provided leadership and service to CalOptima's investment strategies through his participation as an IAC member and chairman.

Mr. Moore, an attorney, represented health care provider clients for 40 years before retiring in 2018. He started his own firm, Patrick K. Moore Law Corporation, in March 2001. Prior to that, he was in-house counsel for the University of California and a partner at several law firms with significant health care practices. Mr. Moore now serves as an arbitrator, mediator and expert witness in health care disputes. He holds preeminent A/V peer review rating in the Martindale-Hubbell Law Directory.

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Mr. Moore has served as director of the California Society for Healthcare Attorneys, the UCI Foundation (Executive and Finance Committees), Laguna Playhouse and Anaheim Memorial Medical Center (Finance and Audit Committees). He was a member of the Audit Committee of Memorial Health Services.

Mr. Moore started serving on the committee when it was initiated in November 1996. During the years of 2000 through 2002, he was a partner at Foley & Lardner, which at the time was CalOptima's counsel, and did not allow him to serve on the committee. He returned to the IAC in January 2002 and has served continuously since that time. His current term expires on March 6, 2019.

Fiscal Impact
There is no fiscal impact. Individuals appointed to the IAC would assist 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. In addition, the candidate has already provided outstanding service as a member and chairman of the IAC. Based upon review of counsel, this individual does not appear to have a conflict of interest provided that no CalOptima investment transactions involve his financial interests.

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

Attachment
None

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Ratification of Amendment to CalOptima's Medi-Cal Fee-For-Service Specialist Physician Contract with Children's Hospital of Orange County (CHOC), Authorization of Pediatric Network Recruitment Fee to Ensure Access to Specialists for CalOptima Health Networks, and Authorization of WCM Contract Amendments with CHOC-Affiliated Specialists

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Ratify amendment to the CalOptima Medi-Cal, Fee-For-Service Specialist Physician Contract with Children's Hospital of Orange County (CHOC) to incorporate California Children Services (CCS) under the Whole-Child Model (WCM) program and other regulatory updates; and
2. Authorize a pediatric network recruitment fee to ensure access to CHOC specialists for CalOptima health networks in an amount not to exceed $1.4 million in Fiscal Year (FY) 2019-20.

Background

CCS is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The California Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan contracts for County Organized Health System plans on a phased-in basis. This transition, referred to as the WCM program, is outlined in Senate Bill 586, signed by former Governor Brown on September 25, 2016, and All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018. This APL was superseded by APL 18-023 released on December 23, 2018.

On November 9, 2018, DHCS changed the timing of Orange County's transition of the CCS program to WCM from January 1, 2019, to no sooner than July 1, 2019. On November 21, 2018, DHCS released new health network adequacy standards that more explicitly established the number and type of CCS-paneled providers required for a health network to participate in WCM. DHCS established adequacy standards for 27 identified provider types and specialties. CalOptima health networks are required to contract with 23 specialties. Health networks that do not meet these requirements will not be eligible to participate in the WCM program on July 1, 2019.

CalOptima is responsible for contracting with the remaining four following rare specialty types on behalf of the entire network:

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Specialty Type	Number of CCS-paneled Providers Statewide
Pediatric Dermatology	23
Pediatric Developmental and Behavioral Medicine	5
Oral and Maxillofacial Surgery	20
Transplant Hepatology	6

The CCS-paneled physicians in Orange County affiliated with CHOC are an-integral part of CalOptima's-WCM provider network providing coordination of care to a significant number of CalOptima Orange County members with CCS conditions. As such, this panel of CCS physicians affiliated with CHOC, is currently necessary for health networks to provide ~~a~~ continuum of care to assigned members with CCS conditions and to newly eligible members with qualifying conditions once the CCS program transitions to CalOptima. Of CalOptima's 13 Medi-Cal health networks, 11 either have contracts with or are planning to contract with CHOC Children's Specialists as part of their-network to provide access to CCS paneled providers and for purposes of providing care under the WCM. As a children's hospital, CHOC is able to provide a broad continuum of care for members with CCS conditions. Through its CCS specialty care centers, CHOC provides services to members with conditions including Sickle Cell disease, renal failure, infectious diseases, hemophilia, cancer, metabolic diseases, congenital anomalies and cystic fibrosis. In all, CHOC is uniquely situated as the exclusive children's hospital in Orange County and provider continuum of services for 15 types of Specialty Care Centers

The target implementation date for the WCM program in Orange County is July 1, 2019, and subject to DHCS approval, CalOptima staff anticipates that all currently-contracted health networks will participate in the WCM program, provided that they meet network adequacy requirements, including meeting the DHCS adequacy standards for the 27 identified provider types and specialties referenced above. As indicated, many of CalOptima's health networks will, at least initially, contract with CHOC to meet these requirements.

Discussion

Pediatric Specialty Access Program Fee
CHOC's specialist network is part of CHOC Children's Hospital Network, which is the primary pediatric safety net provider and CCS Regional Center in Orange County. It includes approximately 245 CCS-paneled providers.

Staff recommends that the Board authorize the establishment of a pediatric network recruitment fee to ensure access to specialists for CalOptima health networks (Specialist Access Fee). In other words, members in the WCM program assigned to other networks which contract with CHOC would have

access to CHOC specialists when medically indicated and when such a specialist is not otherwise available in the member's health network.

Subject to Board approval, the Specialist Access Fee would total an amount not to exceed $1.4 million in FY 2019-20 (assuming a July 1, 2019 start date for the CalOptima WCM program).

As part of ongoing efforts to provide access to pediatric specialty services to CalOptima members, CalOptima staff proposes to provide 25% of the total FY 2019-20 Fee to CHOC in the form of a lump sum payment beginning the first month of the WCM implementation, anticipated to begin July 1, 2019. CHOC will be eligible to receive distribution of the remaining 75% in equal increments over the next four quarters (i.e., 18.75% of the total fee amount will be available for payment each quarter beginning in the second quarter of fiscal year 2019-20). Each quarterly payment will be calculated based on the number of executed contracts between CHOC and CalOptima's other health networks, including the CalOptima Community Network, that provide access for both CCS and non-CCS services for CalOptima members and access to CHOC CCS-paneled specialists (see table below). For example, if CHOC executes 6 contracts in the first quarter, CalOptima will provide 65% of that quarter's available funding, or 0.65 multiplied by 18.75% of the total fee amount for that quarter.

Number of health networks contracted with CHOC Children's as of the beginning of the quarter	Percent of Available Quarterly Fee
0-3	0%
4-5	40%
6-7	65%
8 or more	100%

Staff requests Board approval of the Specialist Access Fee to facilitate access of WCM members to CHOC CCS-paneled providers (via contracts with other health networks) and will return with recommendations for future years.

Fiscal Impact

Based on draft capitation rates received from DHCS on September 13, 2018, staff estimates the total WCM program costs to be approximately $274 million annually, with the CalOptima Community Network comprising approximately 8% of the WCM population and projected costs. Staff anticipates WCM revenues will be sufficient to cover the costs associated with the recommended actions. However, given the high acuity and variability of medical utilization associated with the relatively small CCS population, costs for the program are difficult to predict. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program on an ongoing basis.

Staff estimates the recommended action to pay a establish a Specialist Access Fee for services provided to all CalOptima members from CHOC providers, and amend contracts, as necessary, at a maximum of

$1.4 million in FY 2019-20. Since the first quarter payment is tied to the launch of the WCM program (currently targeted to begin on July 1, 2019), costs associated with the Specialty Access Fee will be included in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The approval of this Board action promotes the transition the CCS program to CalOptima and supports local access to specialty care services to CalOptima's pediatric members and children with CCS-eligible conditions. The Pediatric Specialty Access Fee recognizes CalOptima's commitment to support Orange County's safety net providers, including CHOC, which serves the complex care needs of some of the most vulnerable children in our community.

Concurrence

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

Attachments

None

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Authorizing Amendment of the Kaiser Foundation Health Plan, Inc. Contract to Address the Payment Terms Related to CalOptima's Whole-Child Model Program

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into a contact amendment with Kaiser Foundation Health Plan, Inc. to establish the payment methodology for Kaiser Foundation Health Plan, Inc. (Kaiser) under CalOptima's Whole-Child Model (WCM) Program.

Background
The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. The California Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis, with the implementation in Orange County scheduled to occur no sooner than July 1, 2019.

On June 7, 2018, the CalOptima Board of Directors approved CalOptima's WCM delivery model to include CCS services in qualified health network contracts according to the current health network delivery structure. The methodology to determine the capitated financial model for all health networks, excluding Kaiser, was also established. Kaiser's capitation rate structure is different in that Kaiser's health care system assumes financial risk for services carved out of the other health networks including pharmacy, non-medical transportation, transplants, and treatment for end stage renal disease and hemophilia. As a result, the staff report to the referenced June 7, 2018 Board action noted that additional discussions would be required before finalizing the WCM payment methodology with Kaiser.

On August 2, 2018, the Board authorized amending CalOptima's contract with Kaiser to reflect requirements and rates associated with the WCM. At its December 6, 2018 meeting, the Board authorized amending provider contracts to reflect an implementation date of the WCM to no sooner than July 1, 2019.

Discussion
Due to the limited availability of CCS population utilization data, CalOptima sought to mitigate the degree of financial risk delegated to CalOptima's health networks when it developed the reimbursement methodology for the WCM Program. The following factors were considered in developing the WCM reimbursement methodology: a) Medi-Cal revenue received from DHCS included both CCS and non-CCS services; b) highly variable and volatile medical costs; c) limited ability at the health network level to spread high cost cases across a larger enrollment; and d) the

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limited experience data available to forecast medical expenses and make definitive assessments of potential financial risks. In consideration of these factors, the WCM reimbursement methodology includes estimated capitation rates consistent with DHCS methodology, interim reimbursement for catastrophic cases, and retrospective risk corridors.

CalOptima initially considered offering the same WCM reimbursement methodology to all health networks, including Kaiser. However, as noted above, Kaiser's delivery model is somewhat different than the other CalOptima health networks. In addition to the services delegated to the other health networks, Kaiser is delegated for other services, including pharmacy, non-medical transportation, transplants, and treatment for end stage renal disease and hemophilia. Considering the limited data available on the CCS population and the potential volatility associated with the cost of providing care, staff recommends reimbursement to Kaiser for medical services for assigned CalOptima WCM members on a fee-for-service retrospective basis in lieu of prospective capitation.

Under the proposed modified WCM reimbursement methodology, Kaiser will coordinate care, authorize services, and pay claims for CCS eligible members. Staff proposes to reimburse Kaiser for WCM administrative services on a capitation basis and to reimburse Kaiser for medical services on a fee-for-services basis. Professional, ancillary, and hospital services provided internally through the Kaiser system for will be reimbursed at one-hundred percent (100%) of the CalOptima Medi-Cal fee schedule, with the exception of professional services provided by a CCS paneled provider. Services provided by a CCS paneled provider will be reimbursed at one-hundred-forty percent (140%) of the CalOptima Medi-Cal fee schedule. Kaiser, as per its current model, will not refer members outside of the Kaiser system unless required and per guidelines set forth by DHCS. Services provided outside of the Kaiser system will be reimbursed at the lesser of CalOptima contracted rates or Kaiser contracted or negotiated rates. Services provided by non-Kaiser, and CalOptima non-contracted providers, will be paid based on rates paid by Kaiser. CalOptima will reimburse 100% of the amount Kaiser pays to non-contracted providers outside of the Kaiser system (i.e., out of network providers) based on a manual process whereby Kaiser submits reports (and any other required detail/documentation) of its claim payment details to CalOptima. CalOptima will actively monitor Kaiser's WCM practices for appropriate and reasonable utilization.

Upon Board approval, CalOptima staff and Kaiser will establish a schedule to submit and reconcile claim payment reports for reimbursement. Kaiser shall process and reimburse all claims for WCM members prior to submitting claims payments reports to CalOptima. CalOptima will continue to monitor the sufficiency of the WCM rates and work closely with DHCS to ensure adequate Medi-Cal revenue to support the program. Additionally, CalOptima staff will modify affected polices and return to the Board with future recommendations as required.

Fiscal Impact

The recommended action to establish a payment methodology for Kaiser under CalOptima's WCM program is projected to be budget neutral to CalOptima. While reimbursement on a fee-for-service basis carries additional financial risk, CalOptima staff will actively monitor utilization and expense metrics to ensure that costs for Kaiser's WCM members are appropriate and reasonable.

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Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual CalOptima WCM program costs at approximately $274 million. Management plans to include projected revenues and expenses associated with the WCM program in the CalOptima Fiscal Year 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program. Considering the limited data available on the CCS population, the volatility associated with the cost of providing their care, and the protections being proposed for the health networks, the underlying assumption behind the staff recommendation is that the state will ensure that the program is adequately funded.

Rationale for Recommendation

The recommended actions will facilitate the implementation of the WCM effective upon the DHCS-approved commencement date currently anticipated for July 1, 2019. This will also allow time for CalOptima to gain WCM utilization and claims experience to modify the WCM reimbursement methodology.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
2. CalOptima Board Action dated August 2, 2018, Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology
3. CalOptima Board Action dated August 2, 2018, Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente
4. CalOptima Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date
5. Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *2/27/2019*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive, Program Implementation, 714-246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018: | Rev. 6/7/2018
        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~ | 6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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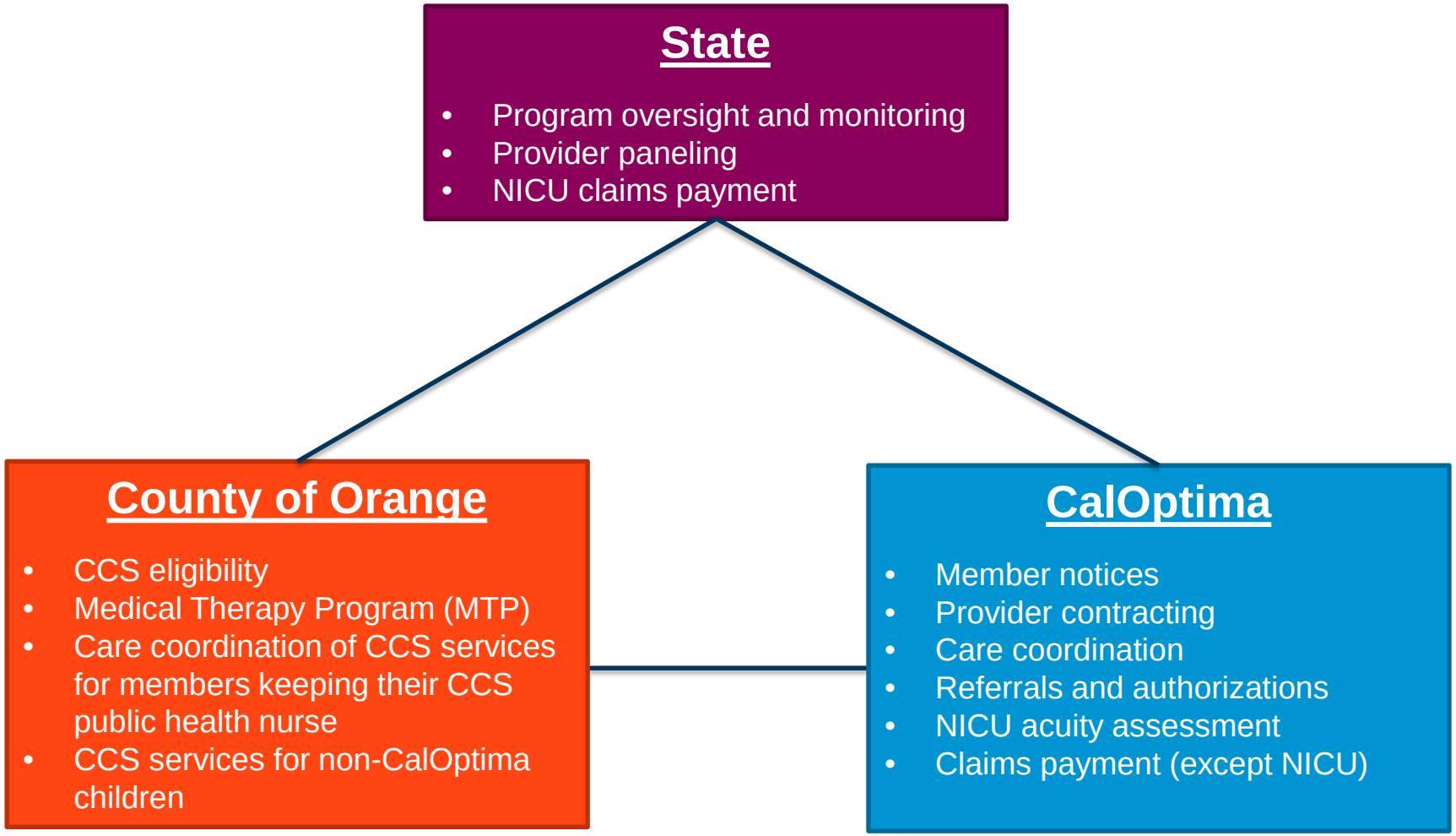
Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



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WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

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WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

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2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

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Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

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Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

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Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

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Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

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WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

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WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

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Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

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Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

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1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

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2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

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a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Actions Related to CalOptima's Medi-Cal Whole-Child Model Program Provider Payment Methodology

Contact

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

Recommended Actions

Approve provider payment methodology for the CalOptima Medi-Cal Whole-Child Model (WCM) program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS will implement the WCM program on a phased-in basis, with implementation for Orange County scheduled to begin no sooner than January 1, 2019. CalOptima will assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorization activities, claims management (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for Neonatal Intensive Care Unit (NICU) services. The Orange County Health Care Agency (OC HCA) will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members, including individuals who exceed the Medi-Cal income thresholds and undocumented children who transition out of CalOptima when they turn 18 years old. OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

In order to ensure compliance with regulatory requirements, CalOptima will refer to SB 586, guidance issued by DHCS through All Plan Letters (APL), plan contract amendments and readiness requirements, and CCS requirements published in the CCS Numbered Letters. Previously, CCS was carved-out of CalOptima's Medi-Cal MCP contract. As such, CalOptima CCS services were not included in the existing delivery model or health network contracts. CalOptima members receiving

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CCS services were enrolled with CalOptima Direct (COD), CalOptima's Community Network (CCN), or other contracted health networks.

To meet the goals of the WCM, beginning January 1, 2019, CalOptima plans to allow members receiving CCS services to remain enrolled with either CalOptima's Community Network or other contracted CalOptima health networks. CalOptima will delegate CCS services to health networks according to the current health network models. The three health network models include Health Maintenance Organization (HMO), Physician-Hospital Consortium (PHC), or Shared-Risk Group (SRG).

Discussion

DHCS Capitation Rates

CalOptima received draft Fiscal Year (FY) 2018-19 (effective January 2019 – June 2019) capitation rates from DHCS on April 27, 2018. The rates reflect reimbursement for both CCS and non-CCS services. CalOptima will continue to monitor the sufficiency of the WCM rates, and work closely with DHCS to ensure adequate Medi-Cal revenue to support the new program.

Projected Medical Costs

Staff has analyzed high-level data on the transitioning CCS-eligible group provided by the State. Generally, the transitioning group appears to incur extensive medical costs that are highly variable and volatile. In addition, the WCM population is relatively small, which reduces the ability to spread high cost cases across a larger enrollment. CalOptima has limited experience data available to forecast medical expenses and to make definitive assessments of potential financial risks.

Provider Payment Model

In order to mitigate potential financial risks to the health networks resulting from the implementation of the WCM program, CalOptima recommends creating a new provider reimbursement methodology specific to the WCM population, as summarized below. The goal of the new reimbursement methodology is to reduce the likelihood of unreasonable financial burdens on health networks due to potentially high costs for the WCM population. The following sections describe CalOptima's proposed WCM provider reimbursement by network arrangement type.

CalOptima Direct Networks (COD/CCN)

For direct fee-for-service providers, reimbursement will depend on whether the providers are contracted with CalOptima and whether they are paneled to provide CCS services.

For non-professional services, including hospital and ancillary, CalOptima will pay contracted providers at the contracted rate for both CCS and non-CCS members. CalOptima will reimburse non-contracted providers at 100% of the designated Medi-Cal payment rates.

For professional specialist services, CalOptima will continue to reimburse providers under the current CCS payment policy. Providers who are CCS paneled, whether they are contracted or non-contracted, will be reimbursed at 140% of the Medi-Cal Fee Schedule for all services provided to members under 21.

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Service Type	Contracted Provider	Non-Contracted Provider
Hospital & Ancillary	Contracted Rates	100% of CalOptima Medi-Cal Fee Schedule
PCP	Contracted Rates	100% of CalOptima Medi-Cal Fee Schedule
CCS Paneled Specialist	140% of CalOptima Medi-Cal Fee Schedule	140% of CalOptima Medi-Cal Fee Schedule
Non-CCS Paneled Specialist	Contracted Rates	100% of CalOptima Medi-Cal Fee Schedule

Delegated Health Networks (HMO/PHC/SRG)
To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. To develop the initial capitation rate, CalOptima will employ the following methods:

- Establish estimated professional and hospital capitation rates that are consistent with DHCS' pricing methodology and include payments for CCS and non-CCS services;
- Align the service category pricing as closely as possible to the contracted division of financial responsibility associated with each health network and hospital;
- Carve out financial risk from the capitation rate for prescription drugs, managed long-term services and supports, and high cost conditions, including but not limited to members diagnosed with hemophilia, members in treatment for end stage renal disease (ESRD), members receiving an organ transplant, and maintenance and transportation costs for specific cases requiring special arrangements;
- Exclude projected expenses from the capitation rate for catastrophic cases. CalOptima will reimburse expenses to delegated health networks and hospitals through an interim catastrophic reimbursement process and risk corridor settlement;
- Apply blended capitation rates developed across all members and that are not separated into different age/gender bands. However, CalOptima will apply an age/gender factor by health network to adjust for cost variances due to the enrollment mix;
- Apply acuity risk factors to adjust for cost variances due to medical acuity; and
- Include an administration load to the both the professional and hospital capitation rates to address administrative expenses and medical management. The proposed 6.6% administration load is consistent the amount DHCS applies to CalOptima's WCM capitation rate. As proposed, CalOptima will keep this percentage fixed to ensure that health networks and hospitals are adequately compensated for the expenditures required to implement and manage the WCM program.

CalOptima recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, CalOptima will implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases and (2) Retrospective risk corridor.

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1) Interim Reimbursement for Catastrophic Cases: The purpose of providing interim catastrophic reimbursement payments is to mitigate potential cash flow shortfalls due to the occurrence of high cost cases. CalOptima proposes implementing the following process to reimburse delegated health networks and hospitals for catastrophic cases to supplement their monthly capitation payments:

   - Reimbursement will be determined by the total delegated medical costs incurred for a given member within a given reconciliation period. If the total delegated medical costs for a given member exceed a prescribed threshold, CalOptima will reimburse the provider for the costs in excess of the threshold;
   - CalOptima will evaluate professional expenses and hospital expenses for a given member separately and will apply CalOptima's existing reinsurance thresholds of $17,000 per member per year for professional expenses and $150,000 per member per year for hospital expenses. CalOptima will not apply a coinsurance level to members in the WCM program;
   - Networks will be required to submit complete and accurate payment data to substantiate all incurred expenses. Payment data will be validated and repriced, similar to CalOptima's existing reinsurance reimbursement process; and
   - Initially, CalOptima will process the interim catastrophic reimbursement on a quarterly basis to minimize cash flow issues for health networks and hospitals. However, CalOptima may adjust the frequency of the reimbursement process in the event a health network or hospital requires reimbursement on a more timely basis.

2) Retrospective Risk Corridor: CalOptima will implement a retrospective risk corridor to better align health network and hospital capitation to their incurred costs. Risk corridors can serve as a safety net for providers that incur a high level of expenses relative to the capitation that they receive. CalOptima will work with health networks and hospitals to construct risk corridor parameters that provide adequate compensation, while still maintaining a reasonable financial incentive to efficiently manage utilization and costs. The risk corridor will be based on the following parameters:

   - Risk corridors will only apply to the medical component (excludes medical management and administration expenses) of the WCM capitation rate;
   - The prospective capitation rate will be used as the basis for the risk corridor reconciliation. CalOptima will also account for funding previously paid through the interim catastrophic reimbursement payment process during the reconciliation process;
   - The number of risk corridors applied and the range of each will be determined from an evaluation of projected risk to the delegated health networks and hospitals. Risk corridors will be set at levels that were projected to achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers;
   - Each risk corridor will have an associated percentage that splits risk between CalOptima and the provider. Similarly, risk sharing will be set at levels that achieve an optimal balance that provides sufficient risk mitigation and financial incentives for providers. The following table gives the proposed risk corridor ranges and risk sharing percentages:

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Medical Loss Ratio Threshold	CalOptima's Risk/Surplus Share	Description
> 115%	95%	CalOptima will reimburse 95% of incurred medical expenses that are >115%
>105% to ≤ 115%	90%	CalOptima will reimburse 90% of incurred medical expenses that are >105% and ≤ 115%
>102% to ≤ 105%	75%	CalOptima will reimburse 75% of incurred medical expenses that are >102% and ≤ 105%
>100% to ≤ 102%	50%	CalOptima will reimburse 50% of incurred medical expenses that are >100% and ≤ 102%
100%	0%	No change in reimbursement
< 100% to ≥ 98%	50%	CalOptima will recoup 50% of capitation if medical expenses are <100% and ≥ 98%
< 98% to ≥ 95%	75%	CalOptima will recoup 75% of capitation if medical expenses are <98% and ≥ 95%
< 95% to ≥ 85%	90%	CalOptima will recoup 90% of capitation if medical expenses are <95% and ≥ 85%
< 85%	100%	CalOptima will recoup 100% of capitation if medical expenses are <85%

* Risk corridor will be evaluated from the medical component of the capitation rate.

- For SRG and PHC networks, risk corridor reconciliations will be evaluated separately for each capitation type (e.g. professional capitation and hospital capitation). For HMO health networks, risk corridor reconciliations will be evaluated against total capitation, which may include professional, hospital, pharmacy, or other delegated services, if applicable; and
- Risk corridor reconciliations will be performed on a calendar year basis, beginning with the period from January 1, 2019, to December 31, 2019. CalOptima may adjust the frequency as more experience becomes available. Each annual reconciliation report shall include refreshed reports from the previous two (2) annual settlement periods. After two (2) years, the refreshed report shall be considered final.

Fiscal Impact

Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Considering the limited data available on the CCS population, the volatility associated with the cost of providing their care, and the protections being proposed for the health networks, the underlying

assumption behind the staff recommendation is that the state will ensure that the program is adequately funded. If this assumption were to prove inaccurate, the program could potentially represent significant economic downside to CalOptima.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of CCS to the WCM, and to mitigate financial risks to our delegated health networks and hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contract amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente to:

1. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole-Child Model program to the extent authorized by the Board of Directors in a separate Board action; and
2. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff extended the Kaiser contract through June 30, 2019, and received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

Discussion

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure

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that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into the Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless the provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Fiscal Impact

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology
4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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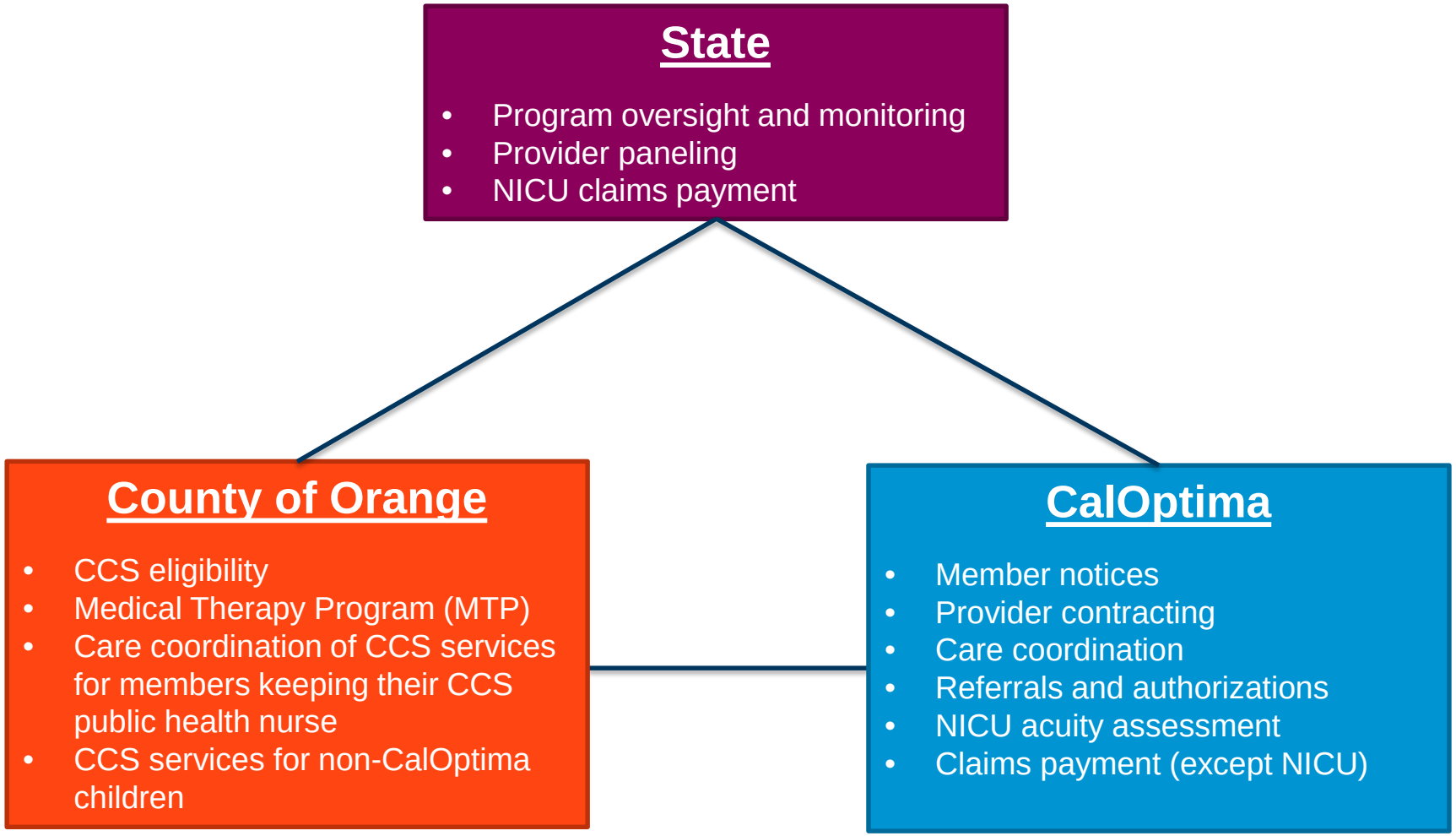
Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



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WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

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WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

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2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

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Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

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Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

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Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

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Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

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WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

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WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

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Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

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Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

DRAFT

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

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2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

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a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

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Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

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WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

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4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

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integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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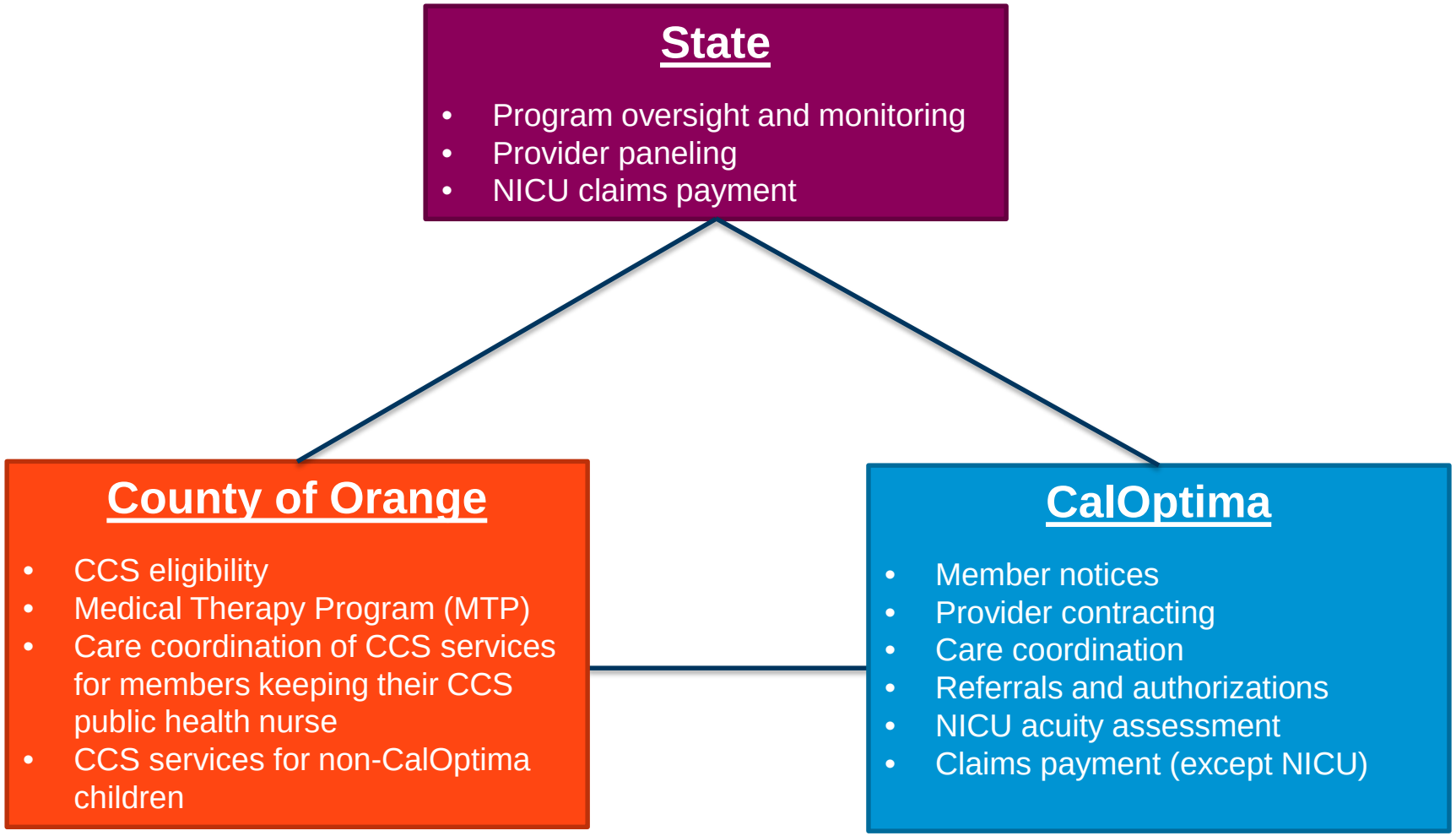
Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



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WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

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WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

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2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

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Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

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Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

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Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

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Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

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WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

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WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

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Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

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Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

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1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

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2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

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1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

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a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

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None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

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Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 Walnut Street	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing Contracts with Additional Community-Based Adult Services Centers to Serve as Alternative Care Setting Sites for CalOptima Program of All-Inclusive Care for the Elderly (PACE) Members

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, and subject to Board approval, to add contracts with any willing and qualified Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members based on established operational and quality standards and potential PACE participant need.

Rev. 3/7/2019

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE program provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support coordinated from a central location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 308 members.

PACE programs are required to provide seven core services:

- Primary care
- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

The Centers for Medicare & Medicaid Services (CMS) defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of Title 42 of the Code of Federal Regulations. In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site center or by a community-based physician, on an individualized basis.

Interdisciplinary Team assessment and care planning remain components provided directly by the PACE center. Primary care may be provided at the CalOptima PACE site or by a community-based

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physician, on an individualized basis. Necessary transportation services are provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards.

At its February 1, 2018 meeting, the Board authorized contracts with five CBAS facilities with the goal of increasing access to PACE in Orange County. The CBAS facilities were selected through a Request for Proposal (RFP) process in December 2017. The CBAS facilities were selected based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational capacity to provide services to a minimum of 15 CalOptima PACE members
- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process with their implementation date are listed in Attachment 1. A map of the CalOptima PACE delivery system is included as Attachment 2. The graphic illustrates member density and location of the PACE center and ACS sites.

Discussion

Staff successfully developed a program design for CalOptima PACE members to utilize ACS sites, including operational and quality standards required to be designated as an ACS. The addition of ACS sites has increased access to CalOptima PACE's culturally and linguistically competent, specialized services while allowing members to remain in close geographical proximity to their residences. CalOptima PACE membership has increased from approximately 250 to more than 300 and there are currently 18 PACE members using the ACS sites, and over time, as referral patterns mature, larger numbers are anticipated. Financial, quality, and member experience performance metrics have been maintained at high levels with the additional ACS sites.

The northern, southern and coastal areas of Orange County continue to require increased access to PACE that can be addressed through the addition of local ACS sites in these areas. Multiple CBAS centers that were not included in the RFP selection have expressed interest in becoming ACS partners with CalOptima PACE. Additional ACS sties would allow CalOptima PACE to increase membership and better meet the needs of eligible residents of Orange County. CBAS centers interested in this opportunity would be required to submit a Letter of Interest to initiate the review process according to the criteria used in the RFP including geographical location.

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Fiscal Impact

The recommended action to add contracts with CBAS centers to serve as ACS sites for CalOptima PACE members is expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two to three members per month attributable to the addition of ACS sites. Increasing access to PACE services through the ACS strategy is expected to enable more eligible county residents to participate in the CalOptima PACE program and may improve operational efficiencies and increase economies of scale.

CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. For the given anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin for the PACE program will remain consistent with current levels through the current and next fiscal years.

Rationale for Recommendation

Alternative care settings have increased access to care for current PACE members. Specifically, these services are culturally competent and specialized, and in more convenient geographical locations to PACE members' residences. As of February 2019, approximately 6% of CalOptima PACE participants receive services at an ACS, with the goal of 20% by the end of FY 2020.While ACS 'satellite' sites throughout Orange County have increased access to eligible CalOptima members, access is needed in the most northern, southern and coastal areas of Orange County. The implementation of the initial ACS sites is evidence of a viable model to meet the needs of Orange County seniors. Additional ACS contracts in the northern, southern and coastal areas will allow CalOptima PACE to scale operations to meet the needs of these frail seniors.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. RFP-Qualified CBAS Providers
2. Service area map with CalOptima PACE Delivery System (February 2019)
3. Board Action dated February 1, 2018, Authorize PACE Alternative Care Setting Sites
4. PowerPoint Presentation: PACE Alternative Care Settings
5. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *2/27/2019*

Authorized Signature — **Date**

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RFP-Qualified CBAS Providers

The following Community Based Adult Services (CBAS) Centers were qualified by the December 2017 Request for Proposals (RFP) for PACE Alternative Care Settings (ACS). All of the following centers are now operating as ACS sites.

The listing, with addresses, shows the location of existing PACE ACS sites operating within Orange County.

1. Acacia Adult Day Services
   11391 Acacia Parkway, Garden Grove, CA 92840

2. SeniorServ – Anaheim Adult Day Health Care Center
   1158 N. Knollwood Circle, Anaheim, CA 92801

3. SeniorServ – Santa Ana Adult Day Health Care Center
   1101 S. Grand Avenue, Suite K-M, Santa Ana, CA 92705

4. South County Adult Day Services
   24260 El Toro Road, Laguna Woods, CA 92637

5. Sultan Adult Day Health Care
   125 W. Cerritos Avenue, Anaheim, CA 92805

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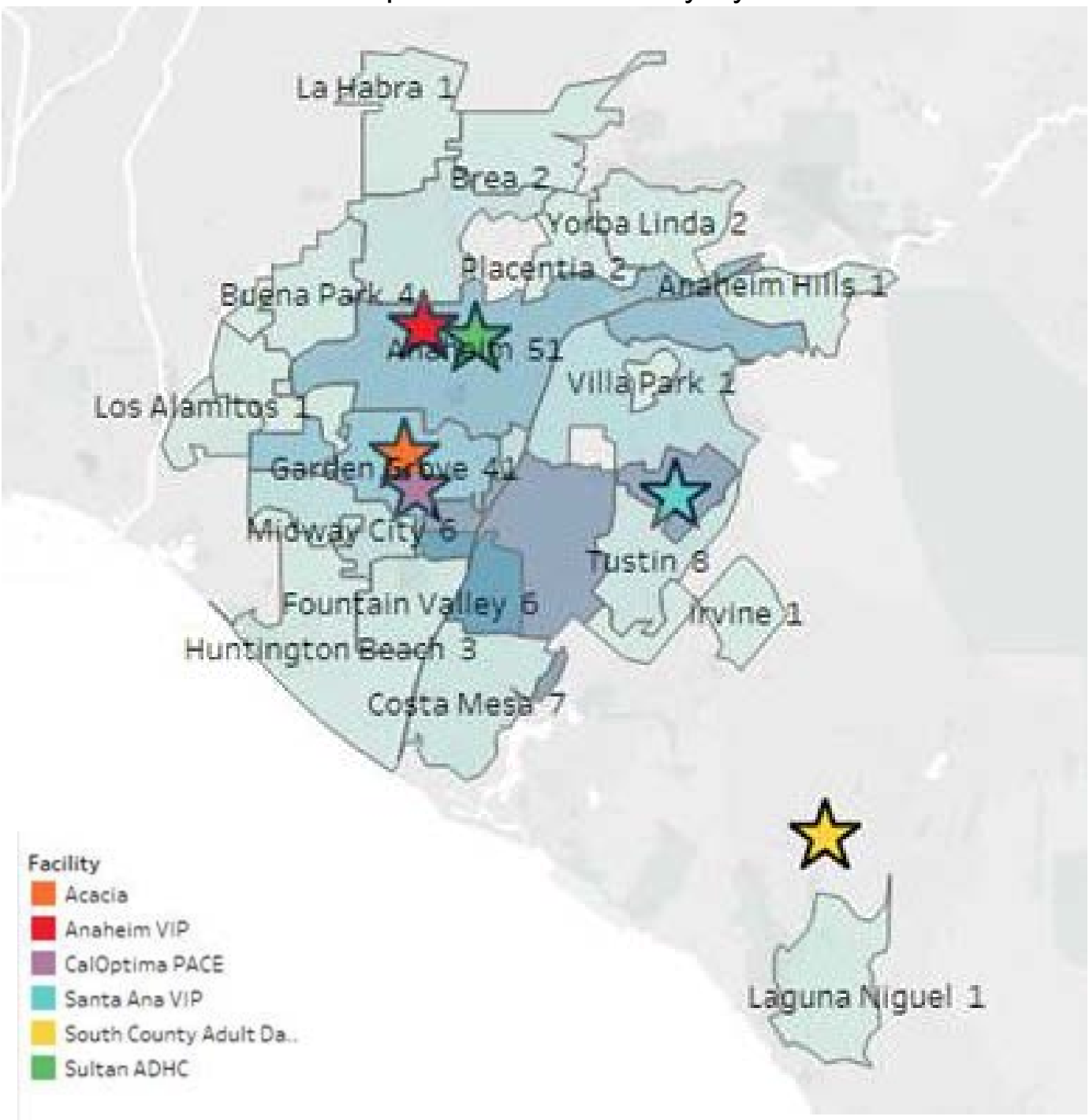
Service Area Map
with CalOptima PACE Delivery System



CalOptima PACE enrollment as of 2/1/19

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Contracts with Alternative Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Enter into contracts with Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members; ~~and~~
2. Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs, subject to Board approval; and
3. Staff to report performance metrics back to the Board.

Rev. 2/1/2018

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 238 members at the single location.

At its February 4, 2016 meeting, the Board authorized submission of a service area expansion to the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), authorized a Request for Proposal (RFP) process for the ACS model for PACE expansion satellite locations to include CBAS centers, and directed staff to perform additional analysis. Subsequently, at its May 4, 2017 meeting, the Board requested that staff first issue a Request for Information (RFI) on alternative care settings. The RFI was released on May 26, 2017. Findings from the RFI, including a market analysis, locations and capabilities of potential ACS sites, were used to develop a RFP, which was released on November 3, 2017. Staff has completed scoring of the proposals and qualified five CBAS centers based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational for a minimum of one year
- Capacity to provide services to a minimum of 15 CalOptima PACE members

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- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process are listed in Attachment 1.

While CalOptima's current service area is limited to north Orange County, the ACS model is expected to be an important step toward increasing access to PACE services throughout Orange County. CalOptima's request for expansion of the service area to include all Orange County Zip Codes is currently under review by CMS, with approval anticipated as soon as July 1, 2018. Four of the five CBAS centers qualified through the RFP are in the current service area, with one in the proposed expanded service area.

Discussion

Using alternative care settings for CalOptima PACE members is expected to increase access to culturally and linguistically competent, specialized services in close geographical proximity to participants' residences. CMS defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of U.S. Code: Title 42 (Public Health and Welfare).

In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site. ACS sites will provide the following six services:

- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

Interdisciplinary Team assessment and care planning will remain components provided directly by the PACE center. Primary care may be provided by CalOptima PACE or a community-based physician, on an individualized basis. Transportation services will be provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards. The proposed contracts include rates and terms for ACS sites deemed capable of providing transportation services.

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Through the RFP process, staff have developed a program design for CalOptima PACE to utilize ACS, including operational and quality standards required to be designated as an ACS. In the future, ACS sites may potentially be added based on a tool that determines operational and quality standards required to operate as an ACS, allowing CalOptima PACE to respond to access needs in specific areas of the county.

Fiscal Impact

The recommended actions to authorize contracts with CBAS centers to serve as PACE ACS sites are expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two members per month related to the addition of the ACS sites. Increasing access to PACE services through the ACS strategy is expected to allow more eligible county residents to participate in the CalOptima PACE program, and may improve operational efficiencies and increase economies of scale. CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. Given the modest anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin will remain consistent with current levels through the fiscal year.

Rationale for Recommendation

Alternative care settings will increase access to care for current PACE members. Specifically, these services are culturally competent and specialized, possibly in more convenient geographical locations to PACE members' residences. In addition, the alternative care setting strategy has been identified as a vehicle for expanding the PACE model of care to all Zip Codes of Orange County. Currently, service area is limited to 60-minute one-way ride radius from the PACE center in Garden Grove. With ACS 'satellite' sites throughout Orange County, eligible CalOptima members will have access to the coordinated quality care provided by CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. RFP-Qualified CBAS Providers
2. PowerPoint Presentation: PACE Alternative Care Setting (ACS) RFP Results

/s/ Michael Schrader *1/25/2018*
Authorized Signature **Date**

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RFP-Qualified CBAS Providers

Center Name	Contract Name	Contract Effective Date	Center Address
Acacia Adult Day Services	Acacia Adult Day Services	7/1/12	11391 Acacia Parkway Garden Grove, CA 92840
Anaheim VIP Adult Day Health Care	Community Seniorserv, Inc., dba Anaheim VIP Adult Day Health Care	7/1/12	1158 North Knollwood Circle Anaheim, CA 92801
Santa Ana/Tustin VIP Adult Day Health Care	Community Seniorserv, Inc., dba Santa Ana/Tustin VIP Adult Day Health Care	7/1/12	1101 South Grand Avenue, Suite L Santa Ana, CA 92705
South County Adult Day Services	Alzheimer's Orange County	7/1/12	24260 El Toro Road Laguna Woods, CA 92637
Sultan Adult Day Health Care Center	Pacific GIS, Inc., dba Sultan Adult Day Health Care Center	7/1/12	125 W. Cerritos Avenue Anaheim, CA 92805

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PACE Alternative Care Setting (ACS) RFP Results

Board of Directors Meeting

February 1, 2018

Richard Helmer, M.D., Chief Medical Officer

Elizabeth Lee, Director, PACE

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Goal of Implementing ACS

- To expand access to PACE to all eligible Orange County seniors
  - Geographic coverage in current North County service area and future South County service area, anticipated in July 2018

- To ensure PACE supports participants' unique needs
  - Culture competence
  - Language access
  - Health conditions

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ACS Background

- Staff progress on Board-approved ACS directives
  - September 2016: Presented financial information to Finance and Audit Committee (FAC)
  - February 2017: Updated FAC with additional financial performance metrics
  - May 2017: Conducted a three-hour PACE Study Session for the full Board, with a presentation by the state regulator and analysis of ACS by National PACE Association
  - May 2017: Issued a Request for Information (RFI) from potential ACS partners
  - August 2017: Distributed a 300-page PACE informational binder to the Board
  - November 2017: Released a Request for Proposal (RFP) for ACS partners

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PACE and CBAS Alignment

- PACE and Community-Based Adult Services (CBAS) centers serve similar populations
  - Are nursing home-eligible
  - Have multiple chronic conditions
  - Need help with activities of daily living
- PACE and CBAS centers have an opportunity to better meet participants' preferences and needs
  - Increased convenience and appropriateness for participants
    - Conditions, language and ethnicity, and residence
- PACE and CBAS centers seeking new avenues for growth
  - CBAS centers are a referral source to PACE
  - Partnership provides CBAS centers with stable revenue

CBAS as an ACS

- CBAS centers deliver six of seven core PACE services
  - Social services
  - Restorative therapies
  - Personal care and supportive services
  - Nutritional counseling
  - Recreational therapy
  - Meals

- CalOptima PACE retains responsibility for the seventh core service
  - Primary care

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RFI Background

- CalOptima issued an RFI for ACS sites in May 2017
- Responses were collected, with all Orange County respondents interviewed as of August 2017
- There were a total of 11 respondents, nine located in Orange County
  - Of those nine, eight were licensed CBAS centers

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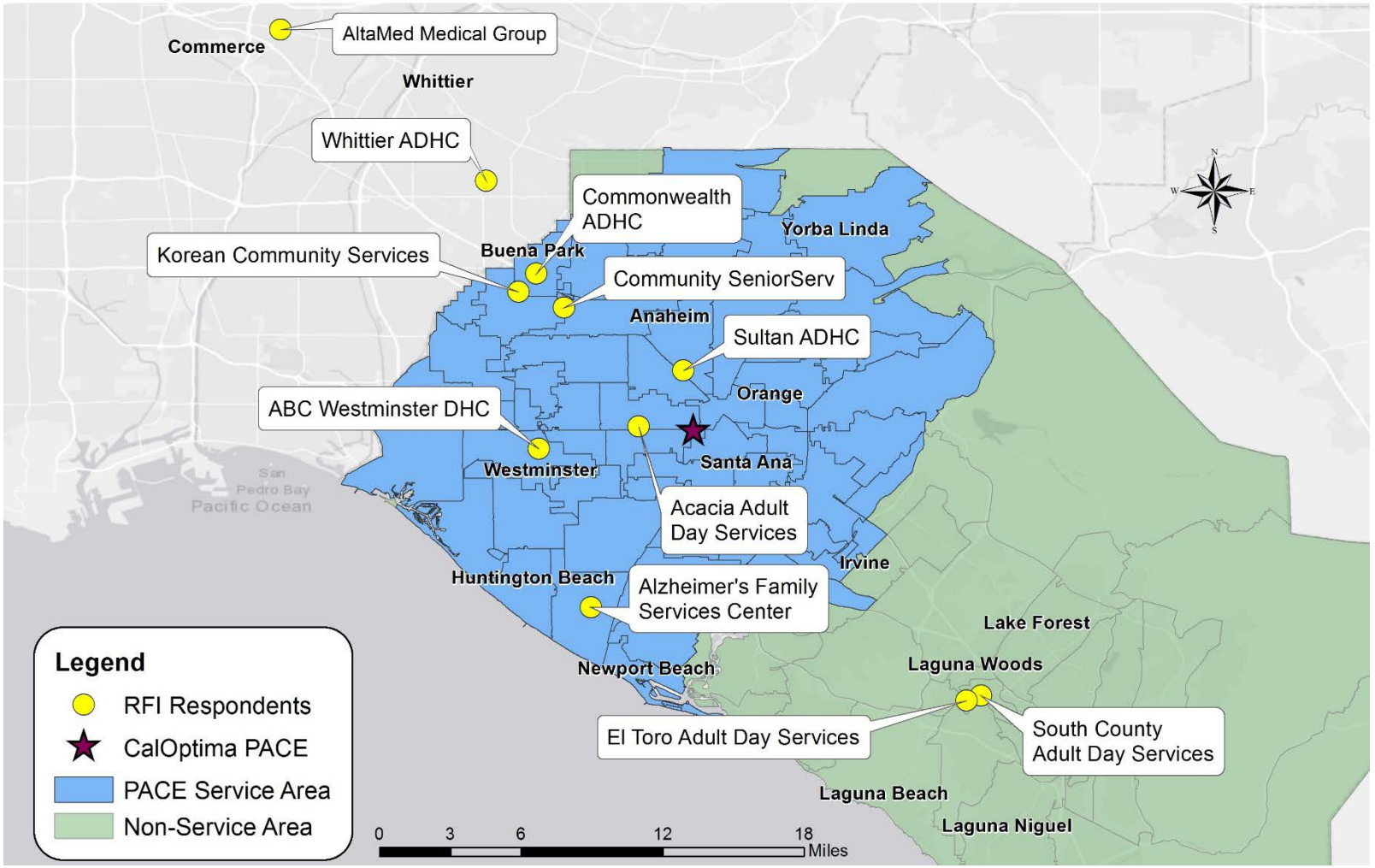
RFI Respondents/PACE Service Area



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RFI Findings

- Interest level provided a solid basis from which to move forward on a countywide RFP
- Respondents seemed to understand the ACS concept and have elements in place to participate
- Information from respondents helped the development of a program design, including operational, quality and capacity standards, for the RFP

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RFP Background

- CalOptima issued an RFP for ACS sites in November 2017
  - RFP included detailed criteria
    - Operational
    - Security
    - Financial
    - Compliance
    - Analytics
  - RFP included a proposed contract amendment, which defined rates and requirements
- There were eight respondents
- Site visits were conducted with respondents meeting the initial criteria
- Five respondents were deemed qualified

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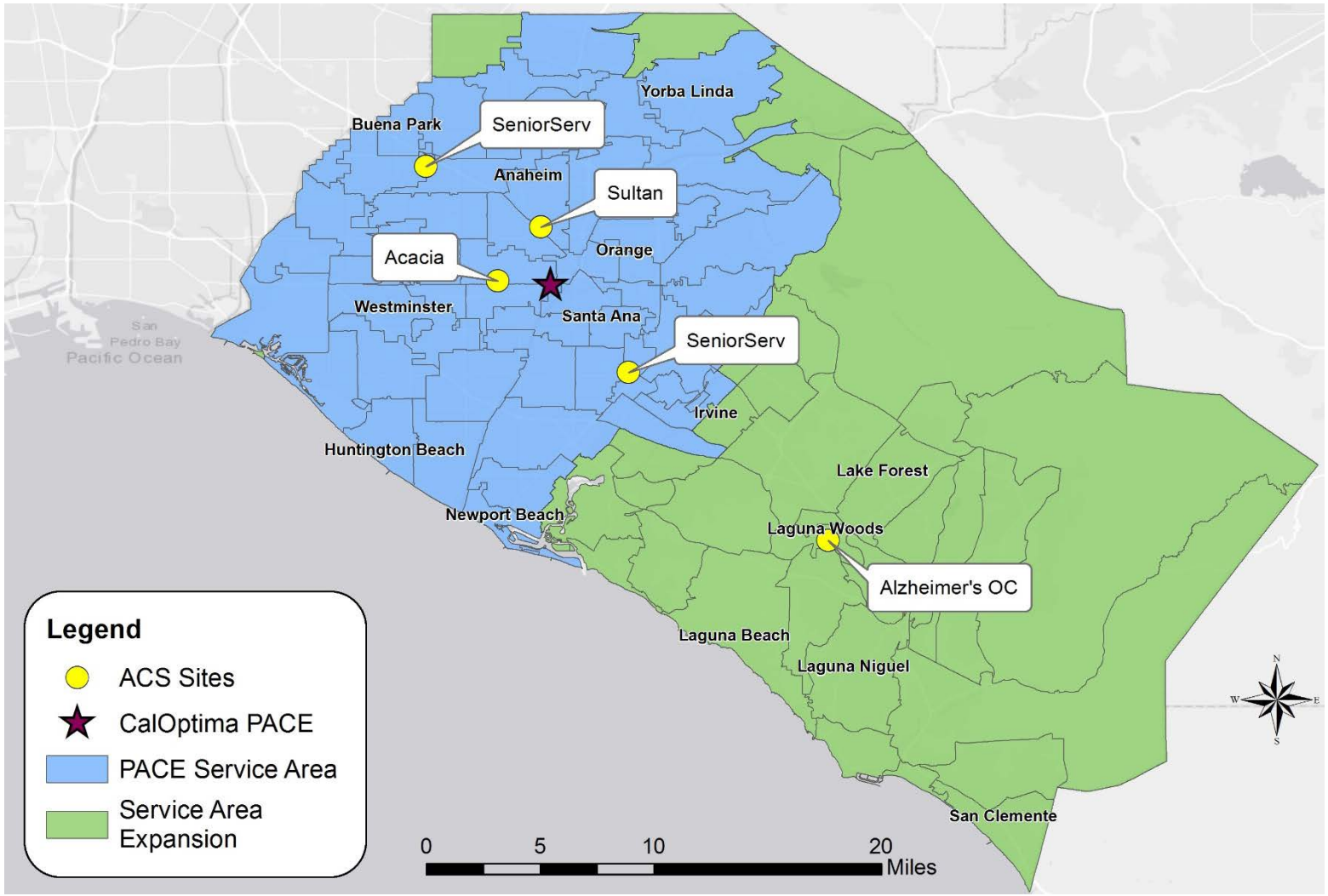
Proposed ACS Sites



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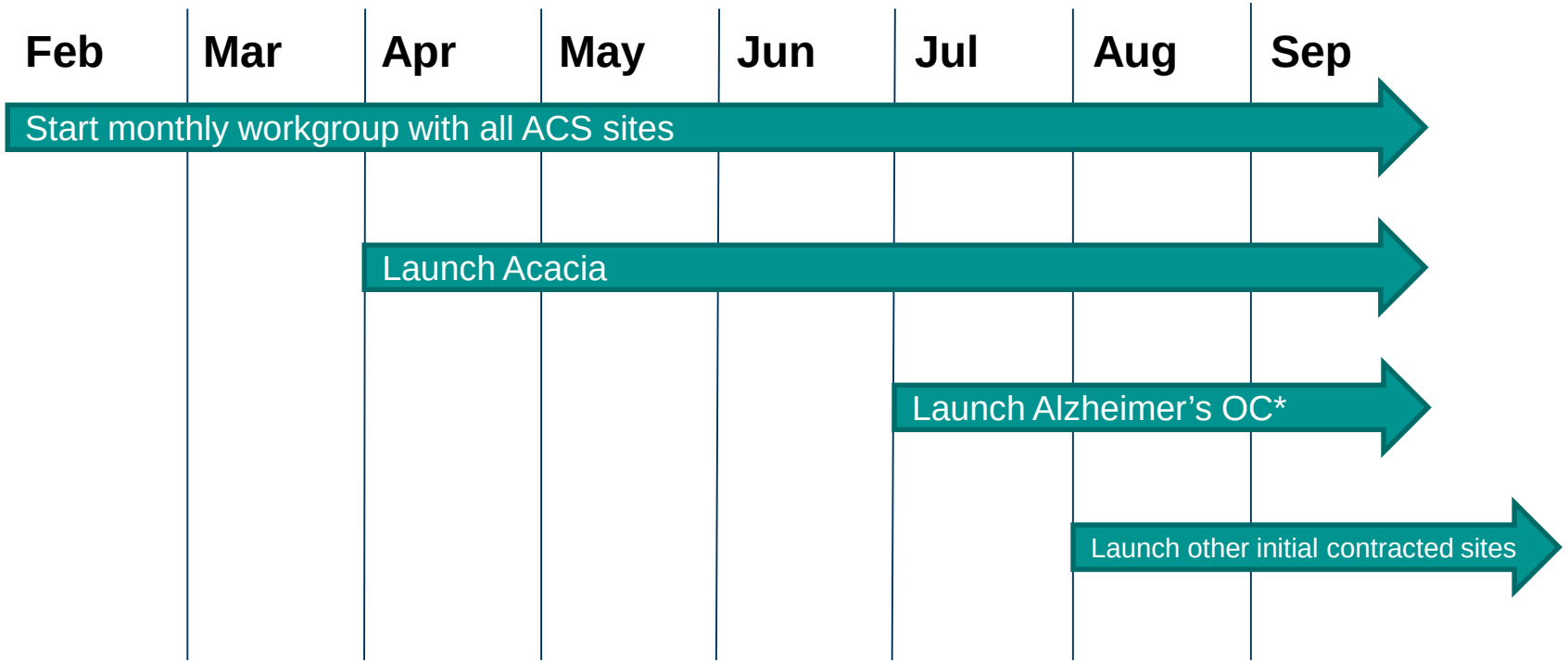
Phased Implementation

- Phased implementation supports use of best practices
- Monthly workgroup fosters collaboration from the start



** Pending CMS approval of service area expansion*

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Additional ACS Sites

- Program design allows for additional ACS sites to be added based on an application process that:
  - Assesses operational and quality standards
  - Considers potential PACE participant needs
  - Supports efficient use of time and resources
  - Accommodates future growth

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Staff Recommendation

- Authorize the Chief Executive Officer, with the assistance of legal counsel, to:

  - Enter into contracts with CBAS centers to serve as ACS sites for CalOptima PACE members, and;

  - Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs.

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PACE Alternative Care Settings

Board of Directors Meeting

March 7, 2019

Elizabeth Lee, MPA

Director, PACE Program

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Discussion Topics

- CalOptima PACE's role in the community
- Access to PACE
- Board-requested performance metrics on Alternative Care Setting (ACS) implementation
- Proposed next steps

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PACE's Role in the Community

- After five years, CalOptima PACE still holds steady to its original goal for seniors
  - Team-based services and support, with dignity and respect, that improve health and quality of life
  - Comprehensive health care services that promote independence
- PACE reflects the way health care should be delivered
  - Medical necessity: With creativity for improved health outcomes
  - Choices: A modern PACE center with options for care at home or in community centers that reflect cultural and geographic preferences
  - People: Compassionate, qualified and competent staff who to provide care for elderly with complex conditions

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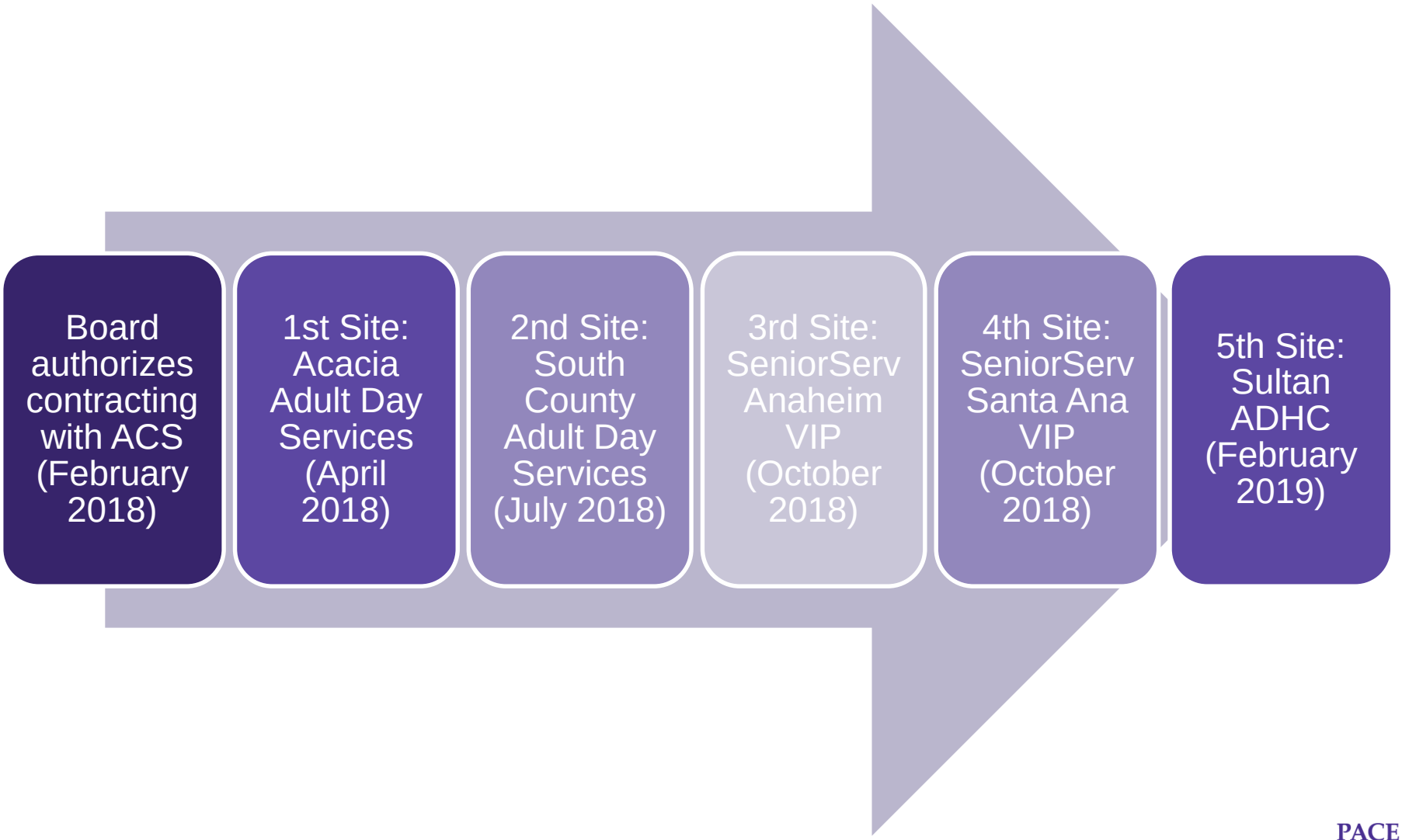
PACE ACS Timeline



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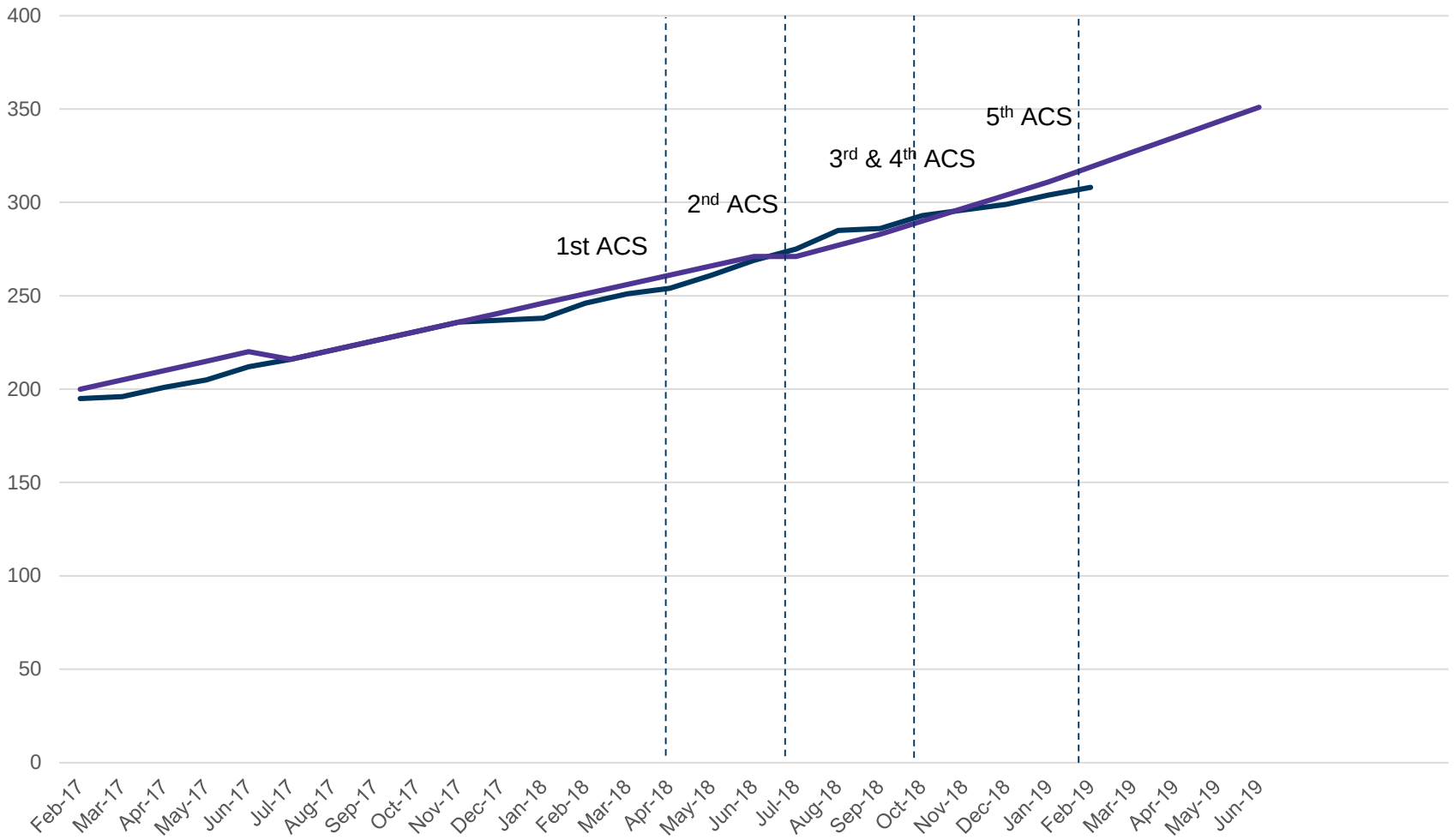
Enrollment Trends With ACS



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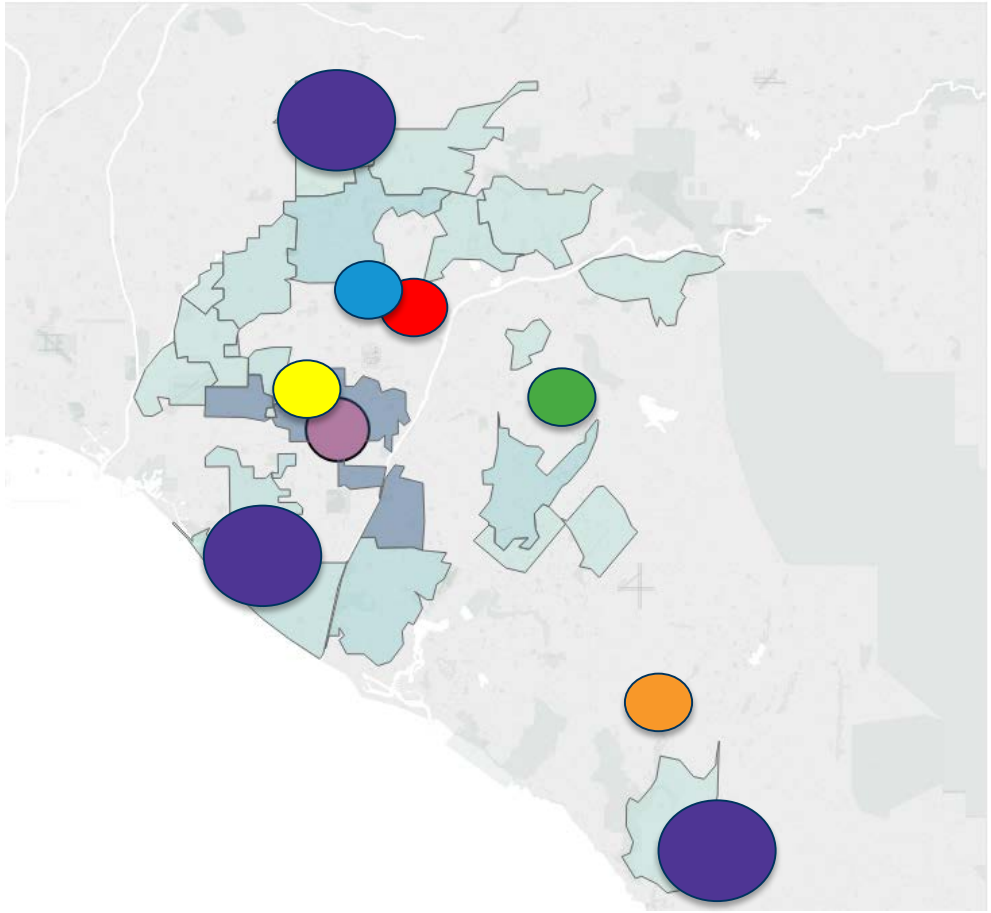
PACE Delivery System

1 PACE Center + 5 Alternative Care Settings + Medical Services at the PACE Center, in the community and visits to members' homes



Need exists for increased access to specific areas of Orange County:

- North – Fullerton / La Habra area
- Coastal – Huntington Beach/Westminster
- South – San Clemente

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PACE CalOptima A Public Agency Better. Together.

Performance Metrics

- Maintaining CY 2018 Quality Indicators while implementing Alternative Care Settings:
  - Only two participants were in LTC in 2018
  - Completed a successful DHCS/CMS Audit and two successful DHCS Level of Care Audits
  - 98% Influenza immunization rate
  - Infection Rates lower than national benchmarks
  - 95% medication reconciliation rate following a hospital discharge
  - 100% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
  - One ride over 60 minutes in duration out of 45,000+ trips
  - >92% transportation on-time performance

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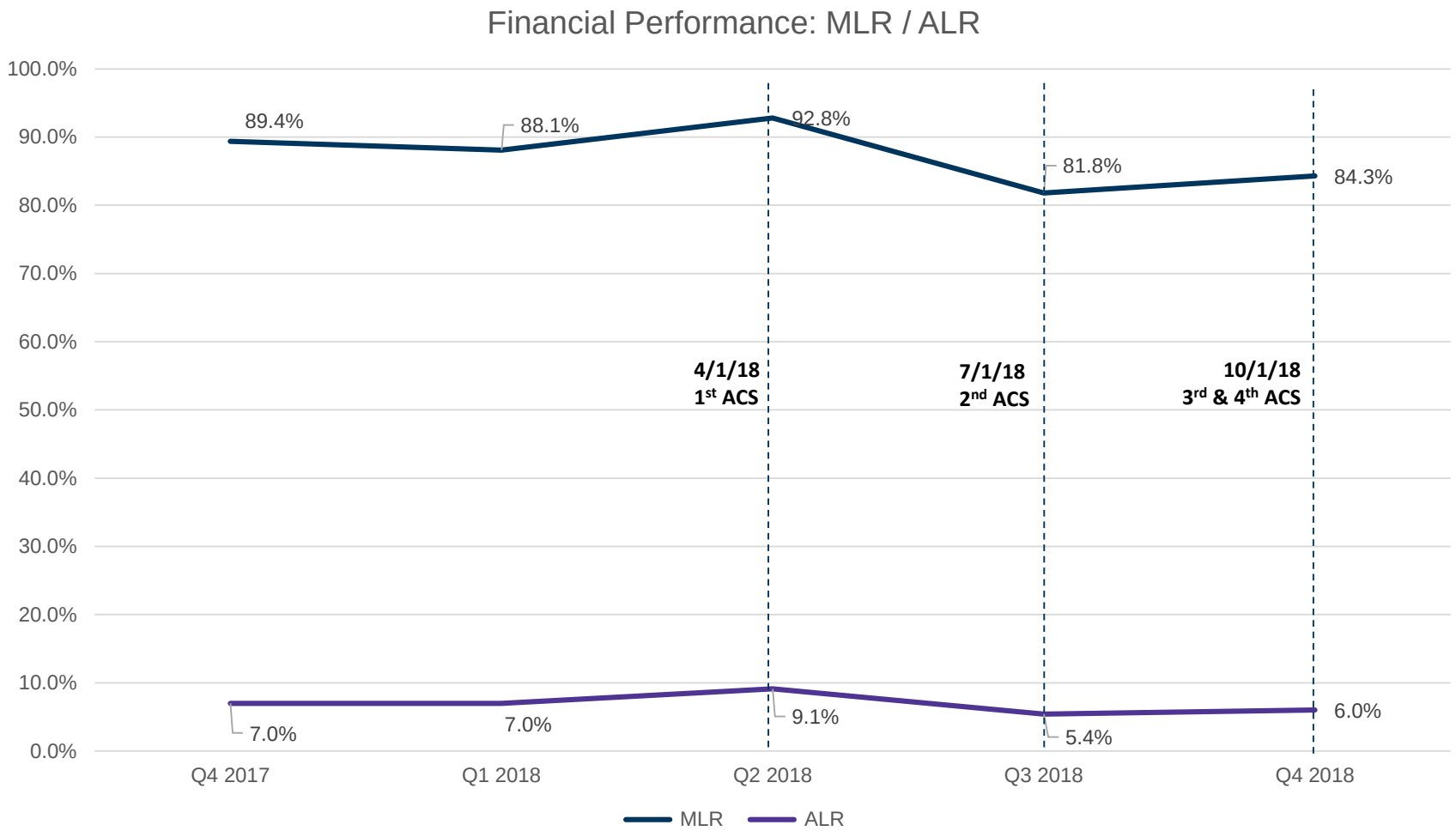
Performance Metrics



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Proposed Next Steps

- Request authorization to add contracts with CBAS centers located in northern, southern and coastal areas of Orange County to serve as ACS sites for CalOptima PACE members based on established operational and quality standards and potential PACE participant needs.

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim VIP Adult Day Health Center	1158 N Knollwood Circle	Anaheim	CA	92801
New Life Adult Day Health Care Center	716 S Beach Blvd	Anaheim	CA	92804
Sultan Adult Day Health Care Center	125 W Cerritos Ave	Anaheim	CA	92805
Commonwealth Adult Day Health Care Center	7811 Commonwealth Ave.	Buena Park	CA	90621
St. Christopher Adult Day Health Care Center	4180 Green River Rd	Corona	CA	92880
Meridian Health Care Corp	4470 Lincoln Ave., Suite 1,2,3	Cypress	CA	90630
Sarang Adult Day Health Care Center	5171 Lincoln Ave	Cypress	CA	90630
Home Avenue Adult Day Health Care	8114 Telegraph Rd	Downey	CA	90240
Rehabilitation Institute of So Calif Fullerton	130 Laguna Rd	Fullerton	CA	92835
Acacia Adult Day Services	11391 Acacia Pkwy	Garden Grove	CA	92840
Evergreen World	9856 Westminster Ave	Garden Grove	CA	92844
Helping Hands for Better Living	10281 Chapman Ave	Garden Grove	CA	92840
Regent West Adult Day Health Care Center	8341 Garden Grove Blvd	Garden Grove	CA	92844
Alzheimer's Family Services Center	9451 Indianapolis Ave	Huntington Beach	CA	92646
Irvine Adult Day Health Service Center	20 Lake Rd	Irvine	CA	92604
Happy (Brea) Adult Day Health Care	401 W Whittier Blvd., Suite 201	La Habra	CA	90631
La Puente Adult Day Health Care Center	17331 E Valley Blvd	La Puente	CA	91744
El Toro Adult Day Services	24300 El Toro Rd., Bldg A	Laguna Woods	CA	92637
SoCal Senior Services LLC	24260 El Toro Rd	Laguna Woods	CA	92637
Joy Adult Day Health Care	12110 Firestone Blvd	Norwalk	CA	90650
Life Sharing Health Care	13000 San Antonio Dr	Norwalk	CA	90650
Rehabilitation Institute of Southern California	1800 E La Veta Ave	Orange	CA	92866
Hzor Medical Services ADHCC	740 E Washington Blvd	Pasadena	CA	91104

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Well and Fit Adult Day Health Care	105 Mercury Cir	Pomona	CA	91768
Emerald Health Services Inc	17520 Castleton St., Suite 103	Rowland Heights	CA	91748
Joyful Adult Day Health Care Center	18951 Colima Rd	Rowland Heights	CA	91748
Rehabilitation Institute of So CA Rio San Clemente	2021 Calle Frontera	San Clemente	CA	92673
ABC Santa Ana Day Health Center	206 W 15th Street	Santa Ana	CA	92701
Santa Ana/Tustin VIP Adult Day Health Care	1101 S Grand Ave., Suite K	Santa Ana	CA	92705
Get Together Adult Day Health Care	16636 S Crenshaw Blvd	Torrance	CA	90504
Spring Adult Day Health Care Center	19648 Camino De Rosa	Walnut	CA	91789
ABC Westminster Day Health Center	202 Hospital Circle	Westminster	CA	92683
Whittier Adult Day Health Care Center	14268 Telegraph Rd	Whittier	CA	90604

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Modifications of CalOptima Policies and Procedures Related to the CalOptima Provider Directory and Provider Education and Training

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

Recommended Actions
Authorize the Chief Executive Officer (CEO) to modify existing Policies and Procedures related to the CalOptima provider directory and provider education and training, as follows:

1. EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, Web-based Directory (Medi-Cal, OneCare, OneCare Connect, PACE); and
2. EE.1103Δ: Provider Education and Training (Medi-Cal, OneCare, OneCare Connect, PACE).

Background
Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified, laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated and subject to peer review.

New and modified Policy and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, or programs are established. Most recently, the following has impacted CalOptima's Policies and Procedures:

SB 137
SB 137 established requirements for health plans and health insurers (carriers) to make available updated provider directories providing information about contracting providers, including those who are accepting new patients. The bill requires directories to be updated weekly and available on carrier websites without requiring searchers to create or access an account or commit to signing up for the plan. Provider directories are required to include whether the provider or staff speaks any non-English language and if there is access for persons with disabilities. The bill also required the Department of Managed Health Care (DMHC) and the Department of Insurance to develop a standard provider directory by September 15, 2016 or within six months of that date.

Following is additional information regarding the modified policies:

1. ***EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory*** outlines the process for adding, changing, or terminating a Provider, Practitioner, or Facility in the CalOptima Provider Directory and Web-based Directory. This policy is being updated to add data elements to the Provider

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Directory and Web-based Directory as required by SB 137. Additionally, consistent with the annual review process, CalOptima's Provider and Web-based directories shall include Health Home Providers as required by APL 18-012.

2. ***EE.1103Δ: Provider Education and Training*** outlines the initial and ongoing training and education requirements for Medical, Behavioral Health, and Long-term Services and Support (LTSS) Providers, who serve CalOptima's Members participating in CalOptima's programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements. In addition to the current programs listed, CalOptima revised this policy to include training materials for Whole Child Model and Health Homes Programs.

Fiscal Impact

The recommended action to modify existing Policies and Procedures related to SB 137 will require additional data fields that may increase printing expenses for the Provider Directory. Staff will include projected administrative expenses in the CalOptima FY 2019-2020 Operating Budget.

Rationale for Recommendation

To ensure that CalOptima's policies are updated and in place to meet the requirements of Senate Bill 137 and other regulatory programs, adoption of the attached policies is recommended.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory (redlined and clean versions)
2. EE.1103Δ: Provider Education and Training (redlined and clean versions)
3. DHCS All Plan Letter 18-012 Health Homes Program
4. DHCS All Plan Letter 18-023: California Children's Services Whole Child Model Program
5. State of California Senate Bill (SB) 137

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

2/27/2019 — **Date**

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Policy #:	EE.1101Δ
Title:	**Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory**
Department:	Network Operations
Section:	~~Network Management~~Provider Relations
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/1995
~~Last Review Date:~~	~~07/01/17~~
~~Last~~ Revised Date:	~~07/01/17~~03/07/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider~~, Practitioner, or facility~~ in the CalOptima Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima program, CalOptima shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an addition, change, or termination of a Provider.

B. The Provider Directory shall include information on Health Networks and hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health providers, urgent care centers, ancillary providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima directly or through a subcontracted agreement with a Health Network.

~~A.~~C. CalOptima shall publish a Provider Directory for each CalOptima ~~line of business~~program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);
2. Name;
3. Gender;
4. Specialty;
5. Area of focus, if applicable;
~~5.~~6. National Provider Identifier (NPI);
~~6.~~7. Hospital affiliation(s);
~~7.~~8. Primary care clinic or Medical Group affiliations, if applicable;

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~~8.~~9. Board certification, if applicable;

~~9. Accepting new patients;~~

~~10. Age limits;~~

10. Age limits (Member age minimum, Member age maximum, gender restrictions);

11. Languages spoken by the ~~physician and/or~~ provider -including American Sign Language;

~~11.~~12. Languages spoken by clinical staff;

~~12.~~13. ~~Street~~Practice address~~;~~ (including suite number);

14. City ~~including zip;~~

15. State;

~~13.~~16. Zip code;

17. Telephone number including area code~~, including a ;~~

18. Proximity to public transportation;

~~14.~~19. After-hours telephone number ~~for after normal business hours, as applicable;;~~

~~15.~~20. Office days and hours;

21. California license number and type of license;

22. Web site URL, if applicable;

~~16.~~23. Public email address, if available and attestation is obtained (published no later than December 31, 2017); and

~~17. Web site URL, as appropriate;~~

~~18. Email address, if available (published no later than December 31, 2017); and~~

24. ~~Physical~~Administrative email address;

~~19.~~25. Facility physical accessibility ~~indicators.~~compliance (OSHA);

26. Provider type;

27. CalOptima program(s) (product/line of business);

28. Tier, if applicable;

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29. Health Network affiliation;

30. Facility affiliations (hospital name);

31. Hospital admitting privileges;

32. An individual Provider's panel status is at least one (1) of the following:

    a. Accepting new Members;

    b. Accepting existing Members;

    c. Available by referral only;

    d. Available only through a hospital or Facility; or

    e. Not accepting new patients;
    f. Accepting new and existing patients;

33. Special services, panel status, or certification such as California Children's Services (CCS) and/or Child Health and Disability Prevention (CHDP) and expiration; and

34. Supervising Physician full name and license number for mid-level practitioners, when applicable.

~~B.~~D. CalOptima's Provider and Web-based directories shall include:

1. All Providers who contract with a Health Network ~~or~~and CalOptima Community Network (CCN) to deliver health care services to Members including, but not limited to:

    a. Physicians and surgeons;

    b. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists;

    c. Federally Qualified Health Centers (FQHCs~~) or~~), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics~~;~~ to the extent they are available in CalOptima service area;

    d. Health Home Program Providers;

    ~~d.~~e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

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~~e.~~f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of providers that are not available to all or new Members.

3. Instructions and information on how to use the directory. The instructions shall describe and explain any acronyms and symbols used within the provider directory, information on how to use CalOptima services, and who to call for assistance.

   a. The directory shall be available in threshold languages, in accordance with CalOptima ~~Policy~~Policies CMC.4002: Cultural and Linguistic Services, DD.2002: Cultural and Linguistic Services~~.~~, MA.4002: Cultural and Linguistic Services;

4. A statement informing Members that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services.

5. Instructions on how to contact CalOptima if the provider directory information appears to be inaccurate.

6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the provider directory information appears to be inaccurate.

~~6.~~7. Instructions advising the Member to contact ~~Member services~~Customer Service to verify the availability of selected Providers.

~~7.~~8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

~~8.~~9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

~~C.~~E. ~~A~~ Health ~~Network or~~Networks and CCN shall submit to ~~CalOptima~~the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Provider Directory or Web-based Directory.

~~D.~~F. On a semi-annual basis, a Health ~~Network or~~Networks and CCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

~~E.~~G. CalOptima shall ~~develop~~maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the Department of ~~Healthcare~~Health Care Services (DHCS) and applicable contractual obligations.

~~F.~~H. CalOptima shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of

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Federal Regulations, ~~Section~~section 438.10(h)(4), and ~~Section~~section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. Health ~~Network or~~Networks and CCN Request to Add a Provider~~, Practitioner or Facility~~

1. A Health Network ~~or~~and CNN shall request to add a Provider~~, Practitioner, or Facility~~ to the CalOptima Provider Directory and Web-based Directory by submitting the following~~, including the CalOptima Add/Changes/Term (ACT) form,~~ to CalOptima's Provider Data Management Services (PDMS) Department including:

   a. CalOptima Add/Change/Term (ACT) form;

   b. A complete, signed W9 form;

   c. ~~For Providers or Practitioners,~~Health Network contract front and signature or CCN/COD Contract Summary;

   ~~a.~~d. Provider Profile: a complete ~~physician~~Provider profile that includes the following information:

      i. Legal, full name of the ~~Practitioner~~Provider, as shown on his or her medical license;

      ii. Program information (contracted CalOptima programs) and effective date;

      iii. Primary, secondary, and tertiary specialty, as applicable;

      iv. Board certified specialty, if applicable;

~~iv.~~

      v. Taxonomy;

      vi. Area of focus, if applicable;

      ~~v.~~vii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

      ~~vi.~~viii. State license number;

      ~~vii.~~ix. Gender;

      ~~viii.~~x. Address, phone and facsimile number for the ~~Practitioner~~Provider service location;

      ~~ix.~~xi. Days and hours of operation;

      ~~x.~~xii. Hospital affiliation~~;~~(s);

      ~~xi.~~xiii. Accepting new patients;

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~~xii. Age limits;~~

~~xiii.Practitioner languages;~~

~~xiv.Staff languages;~~

xiv. Accepting existing Members;

xv. Available by referral only;

xvi. Available only through a hospital or Facility; or

xvii. Not accepting new patients;

xviii. Accepting new and existing patients

xix. Age limits (member age minimum, member age maximum, gender restrictions;

xx. Languages spoken by the physician including American Sign Language;

xxi. Languages spoken by clinical staff;

~~xv.~~xxii. Medi-Cal ~~registered~~enrolled (Y/N~~);~~) and effective date;

~~xvi.~~xxiii. Medicare ~~registered~~enrolled (Y/N);

~~xvii. Remittance address, phone number, and facsimile number, if different than service location;~~

~~b.~~a. ~~A complete, signed W9 form;~~

~~xviii. A copy of the Provider's or Practitioner's Health Network contract face page and signature page; and~~

~~xix.~~xxiv. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

~~c.~~e. For Facilities, a complete ~~facility~~Facility profile, that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number

v. NPI; and~~and~~

~~v.~~

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~~vi. A copy of the Facility's contract face page and signature page.~~

vi. Languages spoken at facility.~~;~~ ~~and~~

2. A Health ~~Network or~~Networks and CCN shall submit a request to the PDMS Department by one (1) of the following methods:

   a. E-mail at ProviderOnline@caloptima.org; or

   ~~b. United States (U.S.) mail to the following address:~~

   ~~Attention: PDMS Department~~
   ~~CalOptima~~
   ~~505 City Parkway West~~
   ~~Orange, CA 92868~~

   b. Fax at 714-954-2330

3. If discrepancies are identified, the PDMS department shall reject and return the ~~profile~~request to the requesting Health ~~Network~~Networks or CCN for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider~~, Practitioner,~~ or Facility file(s) in the provider information system and, subsequently, the Web-based directory, within five (5) business days of receipt of completed information.

B. Health ~~Network or~~Networks and CCN Request to Change demographic or other information for a Provider, Practitioner or Facility

1. A Health Network ~~or~~and CNN shall request to change demographic or other applicable information for a Provider~~, Practitioner,~~ or Facility in the CalOptima Provider Directory and Web-based Directory by submitting changes ~~in any of~~to the following, including the CalOptima Add/Changes/Term (ACT) form, to the PDMS Department:

   a. Legal, full name of the Practitioner, as shown on his or her medical license;

   b. Program information (contracted CalOptima programs) and effective date;

   c. Primary, secondary, and tertiary specialty, as applicable;

   d. Board certified specialty, if applicable;
   e. Taxonomy;

   f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

~~e.~~

   g. Tax identification number (TIN);

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~~f.~~h. State license number;

~~g.~~i. Gender;

~~h.~~j. Address, telephone and facsimile number for the ~~Practitioner~~Provider service location, including a telephone number for after normal business hours, if applicable;

~~i.~~k. Days and hours of operation;

~~j.~~l. Hospital affiliation;

~~k.~~m. Accepting new patients;

~~l. Age limits;~~

~~m. Practitioner languages; and~~

~~n. Staff languages.~~

n. Age limits (Member age minimum, Member age maximum, gender restrictions);

o. Languages spoken by the physician including American Sign Language;

p. Languages spoken by clinical staff;

q. Medi-Cal enrolled (Y/N) and effective date; and

r. Medicare enrolled (Y/N).

2. A Health ~~Network or~~Networks and CCN shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

a. E-mail at ProviderOnline@CalOptima.org; or

~~b. U.S. mail to the following address:~~

~~Attention: PDMS Department~~
~~CalOptima~~
~~505 City Parkway West~~
~~Orange, CA 92868~~

b. Fax at 714-954-2330

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health ~~Network or~~Networks and CCN for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

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4. The PDMS Department shall update the Provider~~, Practitioner,~~ or Facility file(s) in the provider information system and the web~~-~~based directory within thirty (30) calendar days of receipt of completed information.

C. Health ~~Network or~~Networks and CCN Request to Terminate a Provider~~, Practitioner,~~ or Facility:

1. A Health Network or CNN shall request to terminate a Provider, Practitioner, or Facility from the CalOptima Provider Directory and Web-based Directory by submitting the following, including the CalOptima Add/~~Changes~~Change/Term (ACT) form, to the PDMS Department:

   a. A copy of the Provider~~, Practitioner~~ or Facility termination notice with the effective date for termination.

2. If a terminating Practitioner is a Primary Care Provider (PCP), CalOptima or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Policies DD.2008: Health Network Selection Process ~~and~~; DD.2012: Member Notification of Change in the Availability or Location of Covered Services; MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of PCP termination for purpose of Member notification and re-assignment of Members.

D. On a weekly basis, the PDMS Department shall send to the Health Networks and CCN Provider ~~and~~, Practitioner and Facility reports of additions, changes, and ~~removals~~terminations for review of accuracy.

1. If discrepancies are identified on any Provider ~~or Practitioner~~ files, Health Networks ~~or~~and CCN shall address the discrepancies.

   a. Upon addressing discrepancies, the Health Network or CCN shall notify the PDMS Department.

   b. The PDMS Department shall update the Provider ~~and~~, Practitioner and Facility files within five (5) business days in the provider information system~~,~~ and shall update the Web-based Directory.

E. On a monthly basis, CalOptima shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

F. Verification of Provider Information

1. CalOptima and Health Networks shall verify and update all information outlined in Section II.C of this policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

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a. Notification

~~1.~~ On a semi-annual basis, ~~all contracted Health Network or CCN Providers and Practitioners shall confirm or revise existing information as included in the directory. The request shall include the following:~~

~~a. Information as currently listed in the directory; and~~

~~b. A statement requiring the Provider or Practitioner to give an affirmative response or verify~~ CalOptima shall notify and instruct Providers of the ~~notification was received.~~

~~c. A statement that failure~~process to ~~respond to the notification may result in a delay of payment; and~~

i. ~~Instructions on how the provider~~verify or ~~practitioner can~~ update ~~their~~ information listed in the Provider Directory and Web-based Directory, in a manner consistent with guidance from ~~the Department of Healthcare Services (~~DHCS~~)~~ and applicable contractual obligations.

b. ~~If,~~Verification

i. On a semi-annual basis, CalOptima shall distribute a Provider Data Universe to Health Networks and CCN in the first (1st) and third (3rd) quarter of each calendar year.

ii. Health Networks and CCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this policy.

iii. Health Networks and CCN shall document the outcome of each attempt to verify provider information

iv. If through this process, a Health Networks and CCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima shall remove the Provider from the Provider Directory in accordance with Section III.C of this policy.

c. Provider Attestation

i. Health Networks and CCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, ~~a~~ Health ~~Network or CCN does not receive a response from the Provider or Practitioner, a Health Network or~~Networks and CCN shall ~~then~~attempt to verify if the ~~Provider's or Practitioner's~~Provider information is accurate or requires updating within fifteen (15) business days. ~~A Health Network or CCN will document the receipt and outcome of each attempt to verify information.~~

iii. If a Health ~~Network or~~Networks and CCN is ~~not able~~unable to verify ~~if~~whether the Provider's ~~or Practitioner's~~ information is accurate or requires updating, a ~~Health~~

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~~Network or CCN will send a notice to the Provider or Practitioner~~notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this policy.

a) Health Networks and CCN shall notify Providers ten (10) business days prior to removal from the ~~directory. The~~ Provider ~~or Practitioner~~Directory.

i) Providers that fail to respond will ~~not~~ be removed from the ~~directory~~Provider Directory in accordance with Section III.C of this policy.

~~i)~~ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

~~iii.~~v. General acute care hospitals shall not be required to provide ~~an affirmative~~a response.

~~d. If through this process, Health Network or CCN discovers a Provider or Practitioner has retired, ceased practicing, or if the Provider or Practitioner is no longer affiliated with a practice, PDMS shall remove the Provider or Practitioner from the directory.~~

d. Collection and Submission of Provider Attestation

i. Health Networks and CCN shall collect written provider attestations from all contracted Providers for annual submission to CalOptima's Audit and Oversight Department.

ii. Health Networks and CCN shall submit written Provider attestations, as requested by CalOptima's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

G. Access to CalOptima Provider Directory~~,~~ and Web-based Directory ~~in alternate formats~~

1. CalOptima shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Provider Directory~~,~~ and Web-based Directory in alternate media formats. Alternate media formats include:

a. Print

i. CalOptima staff shall send by U.S. Postal Service mail to new Members the CalOptima Provider Directory upon enrollment in the CalOptima program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Policy DD.2008: Health Network Selection Process; or

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b. Telephone

i. CalOptima staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Provider Directory, CalOptima staff shall print and send the requested information to the Member by U.S. mail.

J. CalOptima shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;

2. Reading level;

3. Ease of navigation;

4. Intuitive content organization;

5. Directories in different languages.

K. Validation of Web-based Directory

1. A Health ~~Network or~~Networks and CCN shall validate the Web-based Directory Provider ~~and~~, Practitioner and Facility information at least annually. Validation shall consist of the following:

a. Data sources, and

b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider ~~and~~, Practitioner and Facility validation and frequency table:

	Provider Definition	**Information Collection and Validation**
Name	~~N/A~~The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors,	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
	qualified autism service providers, nurse midwives, and dentists; Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
NPI	National provider identifier of the practitioner (**NPI type 1, 10 digits**) National provider identifier of the hospital (**NPI type 2, 10 digits**)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
~~Office Location~~ Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Specialty	The clinical area in which the CalOptima contracted physician ~~practices.~~received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy	The taxonomy code of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Hospital Affiliations (Hospital Name)	~~A listing of the network hospitals where the provider cares for patients.~~The name of CalOptima contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames~~.~~
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	**Information Collection and Validation**
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.
Acceptance of ~~new members~~New Patients	Indicates whether the provider is accepting new patients ~~in his/her practice~~, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider ~~or clinical staff~~ speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, ~~facility~~Facility, work environment, service, or program that is easy to approach, enter, operate, participate in,	Upon completion of a provider ~~facility~~Facility site review, by using the data obtained through Attachment C of the

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	Provider Definition	Information Collection and Validation
	and/or use safely and with dignity by a person with a disability.	FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network~~:~~ Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Program (product)	The line of business the provider and/or Facility participates in	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS and CHDP.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Supervising Physician Full Name and License Number for Mid-level Practitioners	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

3. CalOptima's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

   a. Data sources; and

   b. Limitations for each item of information on the Web-based Directory.

K. Web-based Directory ~~Hospital~~Facility validation and frequency table:

	~~Hospital~~Facility Definition	Information Collection and Validation

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Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.~~.~~	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the ~~facility~~Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Hospital Quality Data from Recognized Sources		Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

IV. ATTACHMENT(S)

A. CalOptima Health Network Affiliation Addition, Change, and Termination Form

V. REFERENCES

A. CalOptima Contract for Health Provider Care Services
B. CalOptima Three-W~~w~~ay Contract~~Agreement~~ with the Department of Health Care Services (DHCS) and Centers for Medicaid & Medicare Services (CMS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy CMC.4002: Cultural and Linguistic Services
G. CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification
~~C.~~H. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~D.~~I. CalOptima Policy DD.2008: Health Network Selection Process
~~E.~~J. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
~~F.~~K. CalOptima Policy GG.1608Δ: Full Scope Site Review

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L. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
M. CalOptima Policy MA.4002: Cultural and Linguistic Services
N. CalOptima Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
~~G.~~O. Health and Safety Code (HSC), § 1367.27
~~H.~~P. Medi-Cal Managed Care Division (MMCD) Policy Letter 00-02, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
~~I.~~Q. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
~~J.~~R. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

A. 07/06/15: Department of Health Care Services
B. 01/26/15: Department of Health Care Services
C. 03/17/14: Department of Health Care Services

VII. BOARD ACTION(S)

~~None to Date~~A. 03/07/2019: Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal

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~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Revised	03/07/2019	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks shall submit ACT forms and required documentation required as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks shall submit ACT forms and required documentation required as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Homes Program (HHP) Provider	A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State to be qualified to be a health home for eligible Members with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic: 1. Has the systems and infrastructure in place to provide HHP Services; and 2. Satisfies the qualification standards established by DHCS and CalOptima.

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Primary Care Provider (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under CalOptima program.
~~Practitioner~~Provider	~~A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.~~All contracted Providers including physicians, ancillary providers, and Facilities.
~~Provider~~Terminations	~~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 referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

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Policy #:	EE.1101Δ
Title:	**Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/1995
Revised Date:	03/07/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider in the CalOptima Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima program, CalOptima shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an addition, change, or termination of a Provider.

B. The Provider Directory shall include information on Health Networks and hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health providers, urgent care centers, ancillary providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima directly or through a subcontracted agreement with a Health Network.

C. CalOptima shall publish a Provider Directory for each CalOptima program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);
2. Name;
3. Gender;
4. Specialty;
5. Area of focus, if applicable;
6. National Provider Identifier (NPI);
7. Hospital affiliation(s);
8. Primary care clinic or Medical Group affiliations, if applicable;

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9. Board certification, if applicable;
10. Age limits (Member age minimum, Member age maximum, gender restrictions);
11. Languages spoken by the provider including American Sign Language;
12. Languages spoken by clinical staff;
13. Practice address (including suite number);
14. City;
15. State;
16. Zip code;
17. Telephone number including area code;
18. Proximity to public transportation;
19. After-hours telephone number;
20. Office days and hours;
21. California license number and type of license;
22. Web site URL, if applicable;
23. Public email address, if available and attestation is obtained (published no later than December 31, 2017); and
24. Administrative email address;
25. Facility physical accessibility compliance (OSHA);
26. Provider type;
27. CalOptima program(s) (product/line of business);
28. Tier, if applicable;
29. Health Network affiliation;
30. Facility affiliations (hospital name);
31. Hospital admitting privileges;
32. An individual Provider's panel status is at least one (1) of the following:

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a. Accepting new Members;

b. Accepting existing Members;

c. Available by referral only;

d. Available only through a hospital or Facility; or

e. Not accepting new patients;
f. Accepting new and existing patients;

33. Special services, panel status, or certification such as California Children's Services (CCS) and/or Child Health and Disability Prevention (CHDP) and expiration; and

34. Supervising Physician full name and license number for mid-level practitioners, when applicable.

D. CalOptima's Provider and Web-based directories shall include:

1. All Providers who contract with a Health Network and CalOptima Community Network (CCN) to deliver health care services to Members including, but not limited to:

a. Physicians and surgeons;

b. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists;

c. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics to the extent they are available in CalOptima service area;

d. Health Home Program Providers;

e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of providers that are not available to all or new Members.

3. Instructions and information on how to use the directory. The instructions shall describe and explain any acronyms and symbols used within the provider directory, information on how to use CalOptima services, and who to call for assistance.

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a. The directory shall be available in threshold languages, in accordance with CalOptima Policies CMC.4002: Cultural and Linguistic Services, DD.2002: Cultural and Linguistic Services, MA.4002: Cultural and Linguistic Services;

4. A statement informing Members that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services.

5. Instructions on how to contact CalOptima if the provider directory information appears to be inaccurate.

6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the provider directory information appears to be inaccurate.

7. Instructions advising the Member to contact Customer Service to verify the availability of selected Providers.

8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

E. Health Networks and CCN shall submit to the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Provider Directory or Web-based Directory.

F. On a semi-annual basis, a Health Networks and CCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

G. CalOptima shall maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the Department of Health Care Services (DHCS) and applicable contractual obligations.

H. CalOptima shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. Health Networks and CCN Request to Add a Provider

1. A Health Network and CNN shall request to add a Provider to the CalOptima Provider Directory and Web-based Directory by submitting the following to CalOptima's Provider Data Management Services (PDMS) Department including:

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a. CalOptima Add/Change/Term (ACT) form;

b. A complete, signed W9 form;

c. Health Network contract front and signature or CCN/COD Contract Summary;

d. Provider Profile: a complete Provider profile that includes the following information:

i. Legal, full name of the Provider, as shown on his or her medical license;

ii. Program information (contracted CalOptima programs) and effective date;

iii. Primary, secondary, and tertiary specialty, as applicable;

iv. Board certified specialty, if applicable;

v. Taxonomy;

vi. Area of focus, if applicable;

vii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

viii. State license number;

ix. Gender;

x. Address, phone and facsimile number for the Provider service location;

xi. Days and hours of operation;

xii. Hospital affiliation(s);

xiii. Accepting new patients;

xiv. Accepting existing Members;

xv. Available by referral only;

xvi. Available only through a hospital or Facility; or

xvii. Not accepting new patients;

xviii. Accepting new and existing patients

xix. Age limits (member age minimum, member age maximum, gender restrictions;

xx. Languages spoken by the physician including American Sign Language;

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xxi. Languages spoken by clinical staff;

xxii. Medi-Cal enrolled (Y/N) and effective date;

xxiii. Medicare enrolled (Y/N);

xxiv. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

e. For Facilities, a complete Facility profile, that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number

v. NPI; and

vi. Languages spoken at facility.

2. A Health Networks and CCN shall submit a request to the PDMS Department by one (1) of the following methods:

a. E-mail at ProviderOnline@caloptima.org; or

b. Fax at 714-954-2330

3. If discrepancies are identified, the PDMS department shall reject and return the request to the requesting Health Networks or CCN for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and, subsequently, the Web-based directory, within five (5) business days of receipt of completed information.

B. Health Networks and CCN Request to Change demographic or other information for a Provider, Practitioner or Facility

1. A Health Network and CNN shall request to change demographic or other applicable information for a Provider or Facility in the CalOptima Provider Directory and Web-based Directory by submitting changes to the following, including the CalOptima Add/Changes/Term (ACT) form, to the PDMS Department:

a. Legal, full name of the Practitioner, as shown on his or her medical license;

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b. Program information (contracted CalOptima programs) and effective date;

c. Primary, secondary, and tertiary specialty, as applicable;

d. Board certified specialty, if applicable;

e. Taxonomy;

f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

g. Tax identification number (TIN);

h. State license number;

i. Gender;

j. Address, telephone and facsimile number for the Provider service location, including a telephone number for after normal business hours, if applicable;

k. Days and hours of operation;

l. Hospital affiliation;

m. Accepting new patients;

n. Age limits (Member age minimum, Member age maximum, gender restrictions);

o. Languages spoken by the physician including American Sign Language;

p. Languages spoken by clinical staff;

q. Medi-Cal enrolled (Y/N) and effective date; and

r. Medicare enrolled (Y/N).

2. A Health Networks and CCN shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

   a. E-mail at ProviderOnline@CalOptima.org; or

   b. Fax at 714-954-2330

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health Networks and CCN for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and the web-based directory within thirty (30) calendar days of receipt of completed information.

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C. Health Networks and CCN Request to Terminate a Provider or Facility:

1. A Health Network or CNN shall request to terminate a Provider, Practitioner, or Facility from the CalOptima Provider Directory and Web-based Directory by submitting the following, including the CalOptima Add/Change/Term (ACT) form, to the PDMS Department:

   a. A copy of the Provider or Facility termination notice with the effective date for termination.

2. If a terminating Practitioner is a Primary Care Provider (PCP), CalOptima or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Policies DD.2008: Health Network Selection Process; DD.2012: Member Notification of Change in the Availability or Location of Covered Services; MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of PCP termination for purpose of Member notification and re-assignment of Members.

D. On a weekly basis, the PDMS Department shall send to the Health Networks and CCN Provider, Practitioner and Facility reports of additions, changes, and terminations for review of accuracy.

1. If discrepancies are identified on any Provider files, Health Networks and CCN shall address the discrepancies.

   a. Upon addressing discrepancies, the Health Network or CCN shall notify the PDMS Department.

   b. The PDMS Department shall update the Provider, Practitioner and Facility files within five (5) business days in the provider information system and shall update the Web-based Directory.

E. On a monthly basis, CalOptima shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

F. Verification of Provider Information

1. CalOptima and Health Networks shall verify and update all information outlined in Section II.C of this policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

   a. Notification

      i. On a semi-annual basis, CalOptima shall notify and instruct Providers of the process to verify or update information listed in the Provider Directory and Web-based Directory,

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in a manner consistent with guidance from DHCS and applicable contractual obligations.

b. Verification

i. On a semi-annual basis, CalOptima shall distribute a Provider Data Universe to Health Networks and CCN in the first (1st) and third (3rd) quarter of each calendar year.

ii. Health Networks and CCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this policy.

iii. Health Networks and CCN shall document the outcome of each attempt to verify provider information

iv. If through this process, a Health Networks and CCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima shall remove the Provider from the Provider Directory in accordance with Section III.C of this policy.

c. Provider Attestation

i. Health Networks and CCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, Health Networks and CCN shall attempt to verify if the Provider information is accurate or requires updating within fifteen (15) business days.

iii. If a Health Networks and CCN is unable to verify whether the Provider's information is accurate or requires updating, a notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this policy.

a) Health Networks and CCN shall notify Providers ten (10) business days prior to removal from the Provider Directory.

i) Providers that fail to respond will be removed from the Provider Directory in accordance with Section III.C of this policy.

ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

v. General acute care hospitals shall not be required to provide a response.

d. Collection and Submission of Provider Attestation

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i. Health Networks and CCN shall collect written provider attestations from all contracted Providers for annual submission to CalOptima's Audit and Oversight Department.

ii. Health Networks and CCN shall submit written Provider attestations, as requested by CalOptima's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

G. Access to CalOptima Provider Directory and Web-based Directory

1. CalOptima shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Provider Directory and Web-based Directory in alternate media formats. Alternate media formats include:

a. Print

i. CalOptima staff shall send by U.S. Postal Service mail to new Members the CalOptima Provider Directory upon enrollment in the CalOptima program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Policy DD.2008: Health Network Selection Process; or

b. Telephone

i. CalOptima staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Provider Directory, CalOptima staff shall print and send the requested information to the Member by U.S. mail.

J. CalOptima shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;

2. Reading level;

3. Ease of navigation;

4. Intuitive content organization;

5. Directories in different languages.

K. Validation of Web-based Directory

1. A Health Networks and CCN shall validate the Web-based Directory Provider, Practitioner and Facility information at least annually. Validation shall consist of the following:

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a. Data sources, and

b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider, Practitioner and Facility validation and frequency table:

	Provider Definition	**Information Collection and Validation**
Name	The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists; Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	**Information Collection and Validation**
	for MD and DO; E for DPM) and license number together and no space in between.	
NPI	National provider identifier of the practitioner (**NPI type 1**, **10 digits**) National provider identifier of the hospital (**NPI type 2**, **10 digits**)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Specialty	The clinical area in which the CalOptima contracted physician received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy	The taxonomy code of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Hospital Affiliations (Hospital Name)	The name of CalOptima contracted hospital where the practitioner him/herself is on	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames

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	Provider Definition	Information Collection and Validation
	staff and/or having admitting privilege.	
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.
Acceptance of New Patients	Indicates whether the provider is accepting new patients, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	**Information Collection and Validation**
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, Facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.	Upon completion of a provider Facility site review, by using the data obtained through Attachment C of the FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Program (product)	The line of business the provider and/or Facility participates in	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS and CHDP.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Supervising Physician Full Name and License Number for Mid-level Practitioners	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

3. CalOptima's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

    a. Data sources; and

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b. Limitations for each item of information on the Web-based Directory.

K. Web-based Directory Facility validation and frequency table:

	Facility Definition	**Information Collection and Validation**
Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Hospital Quality Data from Recognized Sources		Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

IV. ATTACHMENT(S)

A. CalOptima Health Network Affiliation Addition, Change, and Termination Form

V. REFERENCES

A. CalOptima Contract for Health Provider Care Services
B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicaid & Medicare Services (CMS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy CMC.4002: Cultural and Linguistic Services
G. CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification
H. CalOptima Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Policy DD.2008: Health Network Selection Process

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J. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
K. CalOptima Policy GG.1608Δ: Full Scope Site Review
L. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
M. CalOptima Policy MA.4002: Cultural and Linguistic Services
N. CalOptima Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
O. Health and Safety Code (HSC), § 1367.27
P. Medi-Cal Managed Care Division (MMCD) Policy Letter 00-02, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
Q. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
R. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

A. 07/06/15: Department of Health Care Services
B. 01/26/15: Department of Health Care Services
C. 03/17/14: Department of Health Care Services

VII. BOARD ACTION(S)

A. 03/07/2019: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	03/07/2019	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks shall submit ACT forms and required documentation required as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks shall submit ACT forms and required documentation required as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Homes Program (HHP) Provider	A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State to be qualified to be a health home for eligible Members with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic: 1. Has the systems and infrastructure in place to provide HHP Services; and 2. Satisfies the qualification standards established by DHCS and CalOptima.

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Primary Care Provider (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under CalOptima program.
Provider	All contracted Providers including physicians, ancillary providers, and Facilities.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

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Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider's network affiliates.
A separate form must be completed for each contracted provider terminated or whose status is being changed.

Health Network Name:

Line of Business (Check all that apply) ☐ **Medi-Cal** ☐ **OneCare** ☐ **PACE** ☐ **OneCare Connect**

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
TAXONOMY	FACILITY PHYSICAL ACCESSIBILITY COMPLIANCE ☐ YES ☐ NO	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO	
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME			
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE / ZIP
REMIT ADDRESS		CITY	STATE / ZIP
OFFICE MANAGER	PHONE NUMBER	FAX NUMBER	PUBLIC E-MAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP	

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

ATTESTATION: I affirmatively confirm authorization to display my provider office e-mail in CalOptima's provider directory. The email address provided is only intended for patient communication, is regularly monitored and maintained in a manner consistent with state and federal healthy privacy laws.

Signature _____

A provider's office email address shall be displayed only with the written permission of the provider, and only if the provider has affirmatively verified that the email address is intended for patient communication, regularly monitored, and maintained in a manner consistent with state and federal health privacy laws.

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The PR Rep must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date **(required)**:	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)

PROVIDER TYPE

- ☐ **ANCILLARY/ALLIED HEALTH**
- ☐ **PCP**
- ☐ **SPECIALIST**

☐ **Open Panel /** ☐ **Closed Panel**

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

PROVIDER TYPE (If applicable, check both)

REQUIREMENTS: Panel changes are effective the date of processing.

- ☐ **PCP**
- ☐ **SPECIALIST**

☐ **Open Panel /** ☐ **Closed Panel**

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ TAX I.D. CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

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ACTION REQUIRED cont. (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date (required):	☐ **PCP** ☐ **SPECIALIST** ☐ **ANCILLARY**
Date CalOptima received the termination notice:	

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider Retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider Deceased
- ☐ Provider unwilling to accept member / payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	Current Facility Site Review Date (within last 3 years) Required if PCP site:		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	Current Facility Site Review Date (within last 3 years) Required if PCP site:		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours		
Office Manager		E-mail Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages Spoken by Provider

2. _____ 2. _____ 3. _____

☐ OTHER

Comments:

I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant's eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years; and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).

I hereby further certify that the applicant listed above and its agents will comply with all applicable laws including, without limitation, Medicare and Medi-Cal laws and regulations, and CalOptima's Compliance Program. I acknowledge and agree that CalOptima may recoup reimbursement paid to any ineligible provider.

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER RELATIONS REPRESENTATIVE SIGNATURE	DATE

CCN PROVIDER NAME
(Please print)

CCN PROVIDER SIGNATURE	DATE

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Policy #:	EE.1103Δ
Title:	~~Provider~~**Provider Education and Training**
Department:	~~Provider~~Network Operations
Section:	~~Not Applicable~~Provider Relations
CEO Approval:	Michael Schrader _____
Effective Date:	03/01/2001
~~Last Review Date:~~	~~10/01/17~~0/07/19
~~Last~~ Revised Date:	~~10/01/17~~12/01/18~~03/07/2019~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines the initial and ongoing training and education requirements for ~~M~~medical, ~~B~~behavioral ~~H~~health, and Long-Term Services and Support (LTSS) Providers, who serve CalOptima's Members participating in CalOptima's programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima or a Health Network shall provide initial and recurring training to identified contracted Providers who serve CalOptima's Members participating in CalOptima's health care programs. Additionally, CalOptima will provide training to appropriate staff of designated county agencies with which CalOptima partners. Training will include, at a minimum:

1. CalOptima programs and~~/or~~ initiatives, including but not limited to~~, to the~~ the Whole-Child Model (WCM)~~California Children's Services (CCS)~~ program and Health Homes Program~~Program~~;

~~1.~~2. CalOptima/Health Network operations;

~~2.~~3. Provider communications;

~~3.~~4. Member rights and responsibilities;

~~4.~~ CalOptima policies and procedures;

5.

~~5.~~6. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;

~~6.~~7. Member benefits;

~~7.~~8. Claims submission and payment;

~~8.~~9. Coordination of benefits;

~~9.~~10. Conflict resolution;

~~10.~~11. Critical Incident reporting; ~~and~~

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12. Member Grievance and Appeals process~~;~~.

13. Utilization ~~M~~Management Appeals and Provider d~~D~~ispute ~~R~~resolution process; and ~~11.~~
14. Prior ~~A~~authorization process.

B. CalOptima shall require disability~~,~~ and ~~literacy~~ cultural competency training for its medical, behavioral health, and LTSS Providers, including information about the following:

1. Various types of Chronic Conditions prevalent within the target population;

2. Awareness of personal prejudices;

3. Legal obligations to comply with the Americans with Disabilities Act (ADA) requirements and Section 504 of the Rehabilitation Act;

4. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

5. Types of barriers encountered by the target population;

6. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

7. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes;

8. Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code section 422.56;

9. Working with Members with mental health diagnoses, including crisis prevention and treatment; and

10. Working with Members with substance use conditions, including diagnosis and treatment.

C. CalOptima shall develop and make available training to staff and Providers, as applicable, who interact with Medi-Cal SPD Members, on standards for competency, cultural awareness, and sensitivity.

1. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff, contracted CalOptima and Health Network PCPs, Practitioners, ~~high~~ high-volume specialists, and speech, occupational, and physical therapists, in accordance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010 and Welfare and Institutions Code, ~~Section~~ section 14182-(b)(5).

D. CalOptima or Health Networks shall provide and disseminate additional ongoing training for contracted Providers:

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1. When determined necessary;

2. Refresher training, on an annual basis, including but not limited ~~Annual provider~~Provider re-education ~~to~~:

   a. Cultural ~~C~~competency ~~T~~training;

   b. ~~Seniors and Persons with Disabilities~~SPD ~~T~~trainings;

   c. Fraud, Waste, and Abuse and c~~C~~ompliance t~~T~~raining;

   d. OneCare Connect Program Overview;

   e. ~~and~~ Model of Care~~OneCare Connect Program oOverview~~; and

   ~~1.~~f. Access ~~S~~standards.

~~2.~~3. When conducting Provider forums, meetings, and outreach visits; and

~~3.~~4. Upon request from Providers.

E. CalOptima shall educate all CalOptima Direct and CalOptima Community Network contracted Providers. All Health Networks shall educate their contracted Providers, in accordance with DHCS and CMS ~~regulations~~requirements.

III. PROCEDURE

A. Initial and Recurring Training for Contracted Medical, Behavioral Health, and LTSS Providers

1. CalOptima or a Health Network shall conduct training for a newly contracted medical, behavioral health, or LTSS Provider within ten (10) business days from the Provider's placement on Active Status.

2. CalOptima or a Health Network, as necessary, shall make a Provider Manual accessible to all contracted medical, behavioral health, and LTSS Providers. The Provider Manual shall include, at a minimum, the following information:

   a. Updates and revisions;

   b. Overview and Model of Care;

   c. CalOptima or Health Network contact information;

   d. Member benefits covered by CalOptima;

   e. Eligibility determination and verification process;

   f. Quality improvement for health services programs;

   g. Member rights and responsibilities;

DRAFT

h. Provider billing and reporting;

i. The Member problem resolution processes;

j. The authorization process;

k. Provider cultural and linguistic requirements;

l. Regulatory and contractual requirements; and

m. Other activities and services needed to assist ~~beneficiaries~~ Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status.

3. CalOptima or a Health Network shall complete training no later than thirty (30) calendar days from the Provider's placement on Active Status.

4. Upon completion of the training, the Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.

5. If CalOptima~~,~~ or a Health Network~~,~~ is unable to complete the training within the thirty (30) calendar day requirement, CalOptima or Health Network shall send materials to the Provider's office, and document reasons and actions taken due to non-completion of the education.

6. CalOptima and its Health Networks shall track completion of the Provider's education, including the date of completion of the education.

7. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25^{th}) day of the month, following the end of the quarter. If the twenty-fifth (25^{th}) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.

8. Health Networks shall provide written confirmation that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs.

IV. ATTACHMENT(S)

A. Health Network Newly Contracted Provider and Practitioner Office Training Form

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy CMC.4001: Member Rights and Responsibilities
D. CalOptima Policy CMC.4002: Cultural and Linguistic Services
E. CalOptima Policy DD.2001: Member Rights and Responsibilities
F. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~F.~~G. CalOptima Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services

DRAFT

~~G.~~H. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
~~H.~~I. CalOptima Policy GG.1201: Health Education Programs
~~I.~~J. CalOptima Policy GG.1203: Individual Health Education Behavioral Assessments
~~J.~~K. CalOptima Policy HH.2004: Performance Reviews
~~K.~~L. CalOptima Policy MA.4001: Member Rights and Responsibilities
~~L.~~M. CalOptima Policy MA.4002: Cultural and Linguistic Services
~~M.~~N. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~N.~~O. Department of Health Care Services (DHCS) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
~~O.~~A. ~~Penal Code, §422.56~~
P. Title 42, Code of Federal Regulations (CFR), §§ 438.206(c)(2), 438.236(c), and 438.414
Q. Penal Code, §422.56
~~Q.~~R. Welfare and Institutions (W&I) Code, §14182 (b) (5)

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

A. 02/24/13: Department of Health Care Services
B. 04/29/10: Department of Health Care Services

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

~~None to Date~~~~Not Applicable~~03/07/19: Regular Meeting of the CalOptima Board of Directors A.

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	Program(s)~~Line(s) of Business~~
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012~~4~~	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	~~12/01/2018~~ 03/07/2019	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Active Status	A ~~Provider~~Provider's, PCP's, and ~~Practitioner~~Practitioner's contract effective date with CalOptima, a Health Network or Physician Medical Group. Active status for a ~~Provider~~Provider, PCP and/or ~~Practitioner~~Practitioner added to a contracted medical group shall be the date the PCP and/or ~~Practitioner~~Practitioner is approved to provide services to Members within that group.
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 and 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. PACE: A Participant's action taken with respect to the CalOptima PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~persons~~individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Grievance	Medi-Cal: An expression of dissatisfaction about any matter 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~~Provider's operations, activities, or behavior, regardless of any request for remedial action. PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care.
Health Homes Program	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full

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Term	Definition
	range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG),~~ physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	An enrollee-beneficiary of a CalOptima program.
~~Provider~~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.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Threshold Language	As specified in annual guidance to Contractors on specific translation requirements for their service areas.

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Policy #:	EE.1103Δ
Title:	**Provider Education and Training**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	Michael Schrader _____
Effective Date:	03/01/2001
Revised Date:	03/07/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines the initial and ongoing training and education requirements for medical, behavioral health, and Long-Term Services and Support (LTSS) Providers, who serve CalOptima's Members participating in CalOptima's programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima or a Health Network shall provide initial and recurring training to identified contracted Providers who serve CalOptima's Members participating in CalOptima's health care programs. Additionally, CalOptima will provide training to appropriate staff of designated county agencies with which CalOptima partners. Training will include, at a minimum:

1. CalOptima programs and initiatives, including but not limited to the Whole-Child Model (WCM) program and Health Homes Program;
2. CalOptima/Health Network operations;
3. Provider communications;
4. Member rights and responsibilities;
5. CalOptima policies and procedures;
6. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;
7. Member benefits;
8. Claims submission and payment;
9. Coordination of benefits;
10. Conflict resolution;
11. Critical Incident reporting;
12. Member Grievance and Appeals process;

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13. Utilization Management Appeals and Provider dispute resolution process; and

14. Prior authorization process.

B. CalOptima shall require disability and cultural competency training for its medical, behavioral health, and LTSS Providers, including information about the following:

1. Various types of Chronic Conditions prevalent within the target population;

2. Awareness of personal prejudices;

3. Legal obligations to comply with the Americans with Disabilities Act (ADA) requirements and Section 504 of the Rehabilitation Act;

4. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

5. Types of barriers encountered by the target population;

6. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

7. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes;

8. Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code section 422.56;

9. Working with Members with mental health diagnoses, including crisis prevention and treatment; and

10. Working with Members with substance use conditions, including diagnosis and treatment.

C. CalOptima shall develop and make available training to staff and Providers, as applicable, who interact with Medi-Cal SPD Members, on standards for competency, cultural awareness, and sensitivity.

1. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff, contracted CalOptima and Health Network PCPs, Practitioners, high-volume specialists, and speech, occupational, and physical therapists, in accordance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010 and Welfare and Institutions Code, section 14182(b)(5).

D. CalOptima or Health Networks shall provide and disseminate additional ongoing training for contracted Providers:

1. When determined necessary;

2. Refresher training, on an annual basis, including but not limited to:

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a. Cultural competency training;

b. SPD trainings;

c. Fraud, Waste, and Abuse and compliance training;

d. OneCare Connect Program Overview;

e. Model of Care; and

f. Access standards.

3. When conducting Provider forums, meetings, and outreach visits; and

4. Upon request from Providers.

E. CalOptima shall educate all CalOptima Direct and CalOptima Community Network contracted Providers. All Health Networks shall educate their contracted Providers, in accordance with DHCS and CMS requirements.

III. PROCEDURE

A. Initial and Recurring Training for Contracted Medical, Behavioral Health, and LTSS Providers

1. CalOptima or a Health Network shall conduct training for a newly contracted medical, behavioral health, or LTSS Provider within ten (10) business days from the Provider's placement on Active Status.

2. CalOptima or a Health Network, as necessary, shall make a Provider Manual accessible to all contracted medical, behavioral health, and LTSS Providers. The Provider Manual shall include, at a minimum, the following information:

a. Updates and revisions;

b. Overview and Model of Care;

c. CalOptima or Health Network contact information;

d. Member benefits covered by CalOptima;

e. Eligibility determination and verification process;

f. Quality improvement for health services programs;

g. Member rights and responsibilities;

h. Provider billing and reporting;

i. The Member problem resolution processes;

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j. The authorization process;

k. Provider cultural and linguistic requirements;

l. Regulatory and contractual requirements; and

m. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status.

3. CalOptima or a Health Network shall complete training no later than thirty (30) calendar days from the Provider's placement on Active Status.

4. Upon completion of the training, the Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.

5. If CalOptima or a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima or Health Network shall send materials to the Provider's office, and document reasons and actions taken due to non-completion of the education.

6. CalOptima and its Health Networks shall track completion of the Provider's education, including the date of completion of the education.

7. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25th) day of the month, following the end of the quarter. If the twenty-fifth (25th) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.

8. Health Networks shall provide written confirmation that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs.

IV. ATTACHMENT(S)

A. Health Network Newly Contracted Provider and Practitioner Office Training Form

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy CMC.4001: Member Rights and Responsibilities
D. CalOptima Policy CMC.4002: Cultural and Linguistic Services
E. CalOptima Policy DD.2001: Member Rights and Responsibilities
F. CalOptima Policy DD.2002: Cultural and Linguistic Services
G. CalOptima Policy GG.1100: Alcohol and Substance Use Disorder Treatment Services
H. CalOptima Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
I. CalOptima Policy GG.1201: Health Education Programs
J. CalOptima Policy GG.1203: Individual Health Education Behavioral Assessments
K. CalOptima Policy HH.2004: Performance Reviews
L. CalOptima Policy MA.4001: Member Rights and Responsibilities
M. CalOptima Policy MA.4002: Cultural and Linguistic Services

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N. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
O. Department of Health Care Services (DHCS) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities
P. Title 42, Code of Federal Regulations (CFR), §§ 438.206(c)(2), 438.236(c), and 438.414
Q. Penal Code, §422.56
R. Welfare and Institutions (W&I) Code, §14182 (b) (5)

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/24/13: Department of Health Care Services
B. 04/29/10: Department of Health Care Services

VII. BOARD ACTION(S)

A. 03/07/19: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	03/07/2019	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima, a Health Network or Physician Medical Group. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
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 and 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. PACE: A Participant's action taken with respect to the CalOptima PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, C alifornia Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Grievance	Medi-Cal: An expression of dissatisfaction about any matter 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. PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care.
Health Homes Program	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.

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Term	Definition
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	An enrollee-beneficiary of a CalOptima 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.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Threshold Language	As specified in annual guidance to Contractors on specific translation requirements for their service areas.

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Health Network Newly Contracted Provider Office Education Report

Due Date: Before the twenty-fifth (25th) day of the month following the end of each quarter.

Health Network Name:
Year:
Quarter:
Prepared by:
Phone#:

As required by CalOptima policy EE.1103, Provider Education and Training, a health network shall:
1) Conduct training for newly contracted medical, behavioral or LTSS providers within ten (10) business days from the provider's placement on active status.
2) Complete training no later than thirty (30) calendar days from the provider's placement on active status.
3) Obtain a signed acknowledgement notice from the provider.

For Columns C, D and E, indicate the line of business with X or N/A if not applicable.

Provider Name	NPI	Medi-Cal	OneCare	OneCare Connect	Active Status Date	Date Training Conducted	Date Training Completed	Signed Acknowledgement Received (Y/N)	Comments/Explanation of Missed Deadline(s)

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

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and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program. This APL supersedes APL 18-011.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP serves as the primary vehicle for ensuring collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

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When a CCS-eligible member moves from one county to another, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP, as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program must communicate all resolved disputes in writing to the MCP. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;

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- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

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[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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Senate Bill No. 137

CHAPTER 649

An act to add Section 1367.27 to, and to repeal Section 1367.26 of, the Health and Safety Code, and to add Section 10133.15 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 8, 2015. Filed with Secretary of State October 8, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 137, Hernandez. Health care coverage: provider directories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires health insurers subject to regulation by the commissioner to provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed health care plans.

This bill, commencing July 1, 2016, would require a health care service plan, and a health insurer that contracts with providers for alternative rates of payment, to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees or the health insurer's insureds, and would require the plan or health insurer to make an online provider directory or directories available on the plan or health insurer's Internet Web site, as specified.

This bill would require the Department of Managed Health Care and the Department of Insurance to develop uniform provider directory standards. The bill would require a health care service plan or health insurer to take appropriate steps to ensure the accuracy of the information contained in the plan or health insurer's directory or directories, and would require the plan or health insurer, at least annually, to review and update the entire provider directory or directories for each product offered, as specified. The bill would require a plan or insurer, at least weekly, to update its online provider directory or directories, and would require a plan or insurer, at least quarterly,

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to update its printed provider directory or directories. The bill would require a health care service plan or health insurer to reimburse an enrollee or insured for any amount beyond what the enrollee or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory, as specified. The bill would authorize a plan or health insurer to delay payment or reimbursement owed to a provider or provider group, as specified, if the provider or provider group fails to respond to the plan's or health insurer's attempts to verify the provider's or provider group's information. By placing additional requirements on health care service plans, the violation of which is a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.26 of the Health and Safety Code is repealed.

SEC. 2. Section 1367.27 is added to the Health and Safety Code, to read:

1367.27. (a) Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.

(b) A health care service plan shall provide the directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, the department, and other state or federal agencies can easily identify the networks and plan products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, a health care service plan shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c) (1) An online provider directory or directories shall be available on the plan's Internet Web site to the public, potential enrollees, enrollees, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the plan, indicate interest in obtaining coverage with the plan, provide a member identification or policy number, provide any other identifying information, or create or access an account.

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(2) The online provider directory or directories shall be accessible on the plan's public Internet Web site through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the plan's public Internet Web site shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

(d) (1) A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) A health care service plan shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e) (1) The plan shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the plan of any of the following:

(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.

(B) A provider is no longer under contract for a particular plan product.

(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.

(D) Upon completion of the investigation described in subdivision (o), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(E) Any other information that affects the content or accuracy of the provider directory or directories.

(2) Upon confirmation of any of the following, the plan shall delete a provider from the directory or directories when:

(A) A provider has retired or otherwise has ceased to practice.

(B) A provider or provider group is no longer under contract with the plan for any reason.

(C) The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

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(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's Internet Web site.

(g) The provider directory or directories shall include the following disclosures informing enrollees that they are entitled to both of the following:

(1) Language interpreter services, at no cost to the enrollee, including how to obtain interpretation services in accordance with Section 1367.04.

(2) Full and equal access to covered services, including enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

(h) A full service health care service plan and a specialized mental health plan shall include all of the following information in the provider directory or directories:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees.

(8) A listing for each of the following providers that are under contract with the plan:

(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse midwives, and dentists.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and the name of the federally qualified health center or clinic.

(E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

(F) Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

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(9) The provider directory or directories may note that authorization or referral may be required to access some providers.

(10) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(11) Identification of providers who no longer accept new patients for some or all of the plan's products.

(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(13) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).

(i) A vision, dental, or other specialized health care service plan, except for a specialized mental health plan, shall include all of the following information for each provider directory or directories used by the plan for its networks:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license, if applicable.

(5) The area of specialty, including board certification, or other accreditation, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees.

(8) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan.

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(10) Identification of providers who no longer accept new patients for some or all of the plan's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occur:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

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(2) If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

(3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory or directories, the plan shall promptly investigate, and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.

(*l*) (1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.

(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.

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(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.

(4) If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the 10-business day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.

(5) General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).

(m) A plan shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under subdivision (*l*) shall be submitted by a plan annually to the department for approval and in a format described by the department pursuant to Section 1367.035.

(2) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the health care service plan. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the health care service plan.

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(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. These processes shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory Internet Web site linking to a form where the information can be reported directly to the plan through its Internet Web site.

(n) (1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.

(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the plan that the provider should be deleted from the provider group in the plan directory or directories.

(5) Section 1375.7, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

(o) (1) Whenever a health care service plan receives a report indicating that information listed in its provider directory or directories is inaccurate, the plan shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the plan shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the plan's

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investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to a plan's provider directory or directories are required as a result of the plan's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

(p) (1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (*l*). The plan shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. A plan may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.

(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

(2) A plan shall notify the provider or provider group 10 business days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the plan delays a payment or reimbursement pursuant to this subdivision, the plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the plan receives the information required to be submitted by the provider or provider group pursuant to subdivision (*l*).

(B) At the end of the one-calendar month delay described in subparagraph (A) or (B) of paragraph (1), as applicable, if the provider or provider group fails to provide the information required to be submitted to the plan pursuant to subdivision (*l*).

(3) A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a change in the information required to be in the directory or directories pursuant to this section.

(4) A plan that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the

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department pursuant to Section 1367.035. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(5) With respect to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code, this subdivision shall be implemented only to the extent consistent with federal law and guidance.

(q) In circumstances where the department finds that an enrollee reasonably relied upon materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories, the department may require the health plan to provide coverage for all covered health care services provided to the enrollee and to reimburse the enrollee for any amount beyond what the enrollee would have paid, had the services been delivered by an in-network provider under the enrollee's plan contract. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the enrollee were covered services under the enrollee's plan contract. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-plan provider shall not be used as a basis to deny reimbursement to the enrollee.

(r) Whenever a plan determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(s) This section shall apply to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code to the extent consistent with federal law and guidance and state law guidance issued after January 1, 2016. Notwithstanding any other provision to the contrary in a plan contract with the State Department of Health Care Services, and to the extent consistent with federal law and guidance and state guidance issued after January 1, 2016, a Medi-Cal managed care plan that complies with the requirements of this section shall not be required to distribute a printed provider directory or directories, except as required by paragraph (1) of subdivision (d).

(t) A health plan that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall meet the requirements of this section.

(u) Nothing in this section shall be construed to alter a provider's obligation to provide health care services to an enrollee pursuant to the provider's contract with the plan.

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(v) As part of the department's routine examination of the fiscal and administrative affairs of a health care service plan pursuant to Section 1382, the department shall include a review of the health care service plan's compliance with subdivision (p).

(w) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

SEC. 3. Section 10133.15 is added to the Insurance Code, to read:

10133.15. (a) Commencing July 1, 2016, a health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall publish and maintain provider directory or directories with information on contracting providers that deliver health care services to the insurer's insureds, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the insurer.

(b) An insurer shall provide the online directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, insureds, potential insureds, the department, and other state or federal agencies can easily identify the networks and insurer products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, an insurer shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c) (1) An online provider directory or directories shall be available on the insurer's Internet Web site to the public, potential insureds, insureds, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the insurer, indicate interest in obtaining coverage with the insurer, provide a member identification or policy number, provide any other identifying information, or create or access an account.

(2) The online provider directory or directories shall be accessible on the insurer's public Internet Web site through an identifiable link or tab and in a manner that is accessible and searchable by insureds, potential insureds, the public, and providers. By July 1, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the insurer's public Internet Web site shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

(d) (1) An insurer shall allow insureds, potential insureds, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the insurer through the insurer's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in

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subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) An insurer shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e) (1) The insurer shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the insurer of any of the following:

(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.

(B) A contracted provider is no longer under contract for a particular product.

(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.

(D) Upon the completion of the investigation described in subdivision (o), a change is necessary based on an insured complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(E) Any other information that affects the content or accuracy of the provider directory or directories.

(2) Upon confirmation of any of the following, the insurer shall delete a provider from the directory or directories when:

(A) A provider has retired or otherwise has ceased to practice.

(B) A provider or provider group is no longer under contract with the insurer for any reason.

(C) The contracting provider group has informed the insurer that the provider is no longer associated with the provider group and is no longer under contract with the insurer.

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the insurer if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the insurer's Internet Web site.

(g) The provider directory or directories shall include the following disclosures informing insureds that they are entitled to both of the following:

(1) Language interpreter services, at no cost to the insured, including how to obtain interpretation services in accordance with Section 10133.8.

(2) Full and equal access to covered services, including insureds with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

(h) The insurer and a specialized mental health insurer shall include all of the following information in the provider directory or directories:

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(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group currently under contract with the insurer through which the provider sees enrollees.

(8) A listing for each of the following providers that are under contract with the insurer:

(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the insurer.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 10144.51, nurse midwives, and dentists.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the insurer, the name of the provider, and the name of the federally qualified health center or clinic.

(E) Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

(F) Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

(9) The provider directory or directories may note that authorization or referral may be required to access some providers.

(10) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8 of the Insurance Code, if any, on the provider's staff.

(11) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(13) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).

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(i) A vision, dental, or other specialized insurer, except for a specialized mental health insurer, shall include all of the following information for each provider directory or directories used by the insurer for its networks:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license, if applicable.

(5) The area of specialty, including board certification, or other accreditation, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group or specialty insurer practice group currently under contract with the insurer through which the provider sees insureds.

(8) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the insurer.

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8 of the Insurance Code, if any, on the provider's staff.

(10) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the insurer and a provider shall include a requirement that the provider inform the insurer within five business days when either of the following occur:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an insured or potential insured seeking to become a new patient, the provider shall direct the insurer or potential insured to both the insurer for additional assistance in finding a provider and to the department to report any inaccuracy with the insurer's directory or directories.

(3) If an insured or potential insured informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall promptly investigate and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards

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shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, an insurer shall use the standards developed by the department for each product offered by the insurer.

(*l*) (1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the insurer shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the insurer shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the insurer shall notify its contracted providers to ensure that all of the providers are contacted by the insurer at least once annually.

(2) The notification shall include all of the following:

(A) The information the insurer has in its directory or directories regarding the provider or provider group, including a list of networks and products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The insurer shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider group is accepting new patients for each product.

(4) If the insurer does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory

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or directories pursuant to this section, within 30 business days, the insurer shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The insurer shall document the receipt and outcome of each attempt to verify the information. If the insurer is unable to verify whether the provider's information is correct or requires updates, the insurer shall notify the provider 10 business days in advance of removal that the provider will be removed from the directory or directories. The provider shall be removed from the directory or directories at the next required update of the provider directory or directories after the 10-business day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.

(5) General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).

(m) An insurer shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under subdivision (*l*) shall be submitted by an insurer annually to the department for approval and in a format described by the department.

(2) Every insurer shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the insurer. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the insurer.

(3) The insurer shall establish and maintain a process for insureds, potential insureds, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the insurer's provider directory or directories. These processes shall, at a minimum, include a telephone number and a dedicated email address at which the insurer will accept these reports, as well as a hyperlink on the insurer's provider directory Internet Web site linking to a form where the information can be reported directly to the insurer through its Internet Web site.

(n) (1) This section does not prohibit an insurer from requiring its provider groups or contracting specialized health insurers to provide information to the insurer that is required by the insurer to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health insurer. This responsibility shall be specifically documented in a written contract between the insurer and the provider group or contracting specialized health insurer.

(2) If an insurer requires its contracting provider groups or contracting specialized health insurers to provide the insurer with information described

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in paragraph (1), the insurer shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the insurer that the provider should be deleted from the provider group in the insurer's provider directory or directories.

(5) Section 10133.65, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

(o) (1) Whenever an insurer receives a report indicating that information listed in its provider directory or directories is inaccurate, the insurer shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the insurer shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the insurer's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to an insurer's provider directory or directories are required as a result of the insurer's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

(p) (1) Notwithstanding Sections 10123.13 and 10123.147, an insurer may delay payment or reimbursement owed to a provider or provider group for any claims payment made to a provider or provider group for up to one calendar month beginning on the first day of the following month, if the provider or provider group fails to respond to the insurer's attempts to verify the provider's information as required under subdivision (*l*). The insurer shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means

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to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. An insurer may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

(2) An insurer shall notify the provider or provider group 10 days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the insurer delays a payment or reimbursement pursuant to this subdivision, the insurer shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the insurer receives the information required to be submitted by the provider or provider group pursuant to subdivision (*l*).

(B) At the end of the one-calendar month delay described in subparagraph (A) or (B) of paragraph (1), as applicable, if the provider or provider group fails to provide the information required to be submitted to the insurer pursuant to subdivision (*l*).

(3) An insurer may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the insurer to a change in the information required to be in the directory or directories pursuant to this section.

(4) An insurer that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(q) In circumstances where the department finds that an insured reasonably relied upon materially inaccurate, incomplete, or misleading information contained in an insurer's provider directory or directories, the department may require the insurer to provide coverage for all covered health care services provided to the insured and to reimburse the insured for any amount beyond what the insured would have paid, had the services been delivered by an in-network provider under the insured's health insurance policy. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the insured were covered services under the insured's health insurance policy. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the insured.

(r) Whenever an insurer determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the insurer shall file a statement with the commissioner.

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(s) An insurer that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the requirements of this section.

(t) Nothing in this section shall be construed to alter a provider's obligation to provide health care services to an insured pursuant to the provider's contract with the insurer.

(u) As part of the department's routine examination of a health insurer pursuant to Section 730, the department shall include a review of the health insurer's compliance with subdivision (p).

(v) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Expenditures in Support of CalOptima's Whole-Child Model Family Advisory Committee Representative Attending the California Children's Services Advisory Group

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to reimburse CalOptima Whole-Child Model Family Advisory (WCM FAC) Committee representatives selected by the Department of Health Care Services (DHCS) up to $500 per quarterly meeting in eligible expenses incurred to attend California Children's Services Advisory Group (CCS AG) meetings, with the first such quarterly meeting scheduled for April 10, 2019 CCS AG in Sacramento, California in accordance with CalOptima Policy GA.50047: Travel Policy;
2. Authorize up to $500 in unbudgeted expenditures related to the April 10, 2019 meeting, and direct the CEO to include $500 in quarterly expenditures for this purpose in future budgets; and
3. Make a finding that such expenditures are for a public purpose and in the furtherance of CalOptima's mission and statutory purpose.

Background/Discussion

The CalOptima Board of Directors approved Resolution Number 17-1102-01 on November 2, 2017 to form the Whole-Child Model Family Advisory Committee as required by the Department of Health Care Services (DHCS). As part of the Resolution, it stated that a representative from the WCM FAC would be invited to serve on a statewide stakeholder advisory group. DHCS holds quarterly California Children's Services Advisory Group (CCS AG) meetings to engage stakeholders in improving the delivery of health care to CCS children and their families, address strategies on issues such as transition for youth aging-out of CCS, improving access for durable medical equipment and care coordination protocols. Should the recommended WCM FAC member be chosen by DHCS for a seat on the CCS AG, the required funding will be added to the proposed future budgets for subsequent quarterly meetings. It is anticipated that CalOptima would reimburse the allowable travel costs of no more than one WCM FAC representative per quarterly CCS AG meeting.

Staff recommends the authorization of expenditures of this nature in order for a member of the WCM FAC to participate in the CCS AG meetings to gain knowledge on strategies related to the Whole-Child Model Program and CCS program improvements, and report this information back to the CalOptima WCM FAC.

Fiscal Impact

The recommended action to reimburse eligible travel expenses up to $500 per CCS AG meeting for a WCM FAC committee member is an unbudgeted item. Management recommends using unspent

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budgeted funds from Travel and Training to fund reimbursement related to the April 10, 2019 meeting and proposes to include $500 in funding for travel reimbursement related to subsequent quarterly CCS AG meetings in future budgets.

Rationale for Recommendation
Because the CCS AG meetings are held in Sacramento, Staff recommends approval of this action in order to support CalOptima's WCM FAC at the State level and to develop and strengthen partnerships in support of CalOptima's programs and services related to the Whole-Child Model Program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Resolution Number 17-1102-01, Establishing Policy and Procedures for CalOptima Whole-Child Model Family Advisory Committee

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD
MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made

by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC.

Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES: Bartlett, Berger, DiLuigi, Khatibi, Nguyen, Schoeffel, Yost
NOES: None
ABSENT: Do, Penrose
ABSTAIN: None

/s/ _____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/ _____
Suzanne Turf, Clerk of the Board

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2019-20

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

Recommended Action
Authorize Procurement and Renewal of Insurance Policies for Policy Year (PY) 2019-20 at a premium cost not to exceed $2,650,000.

Background/Discussion
CalOptima's business insurance coverage, except employee group health insurance and benefits, expires on April 7 of each year. In addition to renewing the same coverage categories included during PY 2018-19, Staff recommends procuring insurance coverage for Fiduciary Liability, Excess Cyber Liability and Excess Wage and Hour. As reference, the following table provides brief descriptions for the proposed insurance policies included for PY 2019-20:

Coverage Type	Description
Property	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location, not due to an Earthquake.
General Liability	Provides coverage to third parties for bodily injury or property damage.
Commercial Auto	Provides coverage for bodily injury and property damage caused by CalOptima's company-owned van, as well as collision and comprehensive coverage for the van itself; provides excess liability for employees using personal vehicles for company business.
Workers' Compensation/ Employers Liability	Provides coverage for medical care and temporary disability benefits to employees for on-the-job injuries or illnesses.
Umbrella	Provides excess limits for general liability and commercial auto coverage over and above the respective policies.
Excess Liability	Provides excess limits over and above the Umbrella policy
Earthquake	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location, only due to an Earthquake
Cyber – primary and excess	Provides coverage for claims related to or arising from cyber incidents, such as a data breach (coverage includes, but is not limited to, regulatory fines and penalties), business interruption, credit monitoring, notice requirements, etc.) or and network extortion (e.g., ransomware).
Directors and Officers (D&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or breach of duty by a CalOptima employee or Board member when acting within his/her official capacity.

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Coverage Type	Description
Employment Practices Liability (EPL)	Provides coverage for claims brought by any past, present or prospective employee against CalOptima or a CalOptima employee (acting within the scope of his/her employment) alleging, for example, employment discrimination, harassment, or wrongful termination.
Crime	Provides coverage for claims related to employee theft or forgery of money, securities, or other property, and computer and funds transfer fraud.
Managed Care Errors and Omissions (E&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or omission in the performance of CalOptima's managed care activities (e.g., provider contracting, utilization review, implementation of clinical guidelines).
Medical Malpractice	Provides coverage for CalOptima employed physicians and certain other medical staff (i.e., CalOptima employed physician and therapists at the PACE center) in the event of a medical malpractice claim.
Pollution	Provides coverage for bodily injury, remediation expenses and property damages to third parties and remediation expenses to CalOptima in the event of a pollution incident, such as stored paint leaching into the ground water supply.
Wage and Hour – primary and excess	Provides coverage for actual or alleged violations of the Fair Labor Standards Act or any similar federal, state, or local laws governing or related to the payment of wages.
Fiduciary	Provides coverage for actual or alleged mismanagement of CalOptima's employee benefit and retirement plans.

The following table provides information on the coverage limits and deductibles for each type of insurance coverage:

Coverage	Limit	Deductible
Property	Building: $65,853,951	$25,000
	Business Personal Property: $25,902,348	$25,000
	Business Interruption & Extra Expense: $42,184,242	24 Hours
General Liability (GL)	GL: $1,000,000/$2,000,000 Employee Benefits Liability: $1,000,000	$0/$1,000
Commercial Auto	Auto Liability: $1,000,000 CSL	$0 Liability $1,000/$1,000 Damage
Workers' Compensation/ Employers Liability (EL)	WC: Statutory EL: 1,000,000/$1,000,000/$1,000,000	$0 (Guaranteed Cost)
Umbrella	$10,000,000	Primary limits for GL, Auto and EL

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Coverage	Limit	Deductible
Excess Liability	$25,000,000	$10,000,000
Earthquake	$75,000,000	EQ 5% subject to $50,000 minimum per occurrence
Cyber	$10,000,000	$250,000
Excess Cyber	$10,000,000	Primary limit for Cyber
D&O/EPL	$5,000,000 (Shared Limit)	$125,000
Crime	$5,000,000	$25,000
Excess D&O/EPL	$15,000,000	Primary limit for D&O/EPL
Managed Care E&O	$10,000,000	$150,000
Excess Managed Care E&O	$10,000,000	Primary limit for Managed Care E&O
Medical Malpractice (PACE)	$1,000,000/$3,000,000	$5,000
Pollution (3-year Policy Term)	$2,000,000/$4,000,000	$25,000
Wage and Hour	$5,000,000	$750,000
Excess Wage and Hour	$5,000,000	Primary Limit for Wage and Hour
Fiduciary	$5,000,000	$10,000

On February 8, 2019, Woodruff Sawyer, CalOptima's insurance broker, provided quotations for existing and additional coverage. Staff has reviewed and evaluated the quotations. Overall, CalOptima's insurance policy renewals for PY 2019-20 are approximately 5% or $120,305 higher than the previous year. Staff recommends the following renewals at a total estimated premium not to exceed $2,650,000:

Coverage	2018-19 Premium	2019-20 Premium	$ Difference from Prior Year	% Difference from Prior Year
Renewal Premiums				
Property	$51,832	$55,825	$3,993	8%
General Liability	$13,157	$13,575	$418	3%
Commercial Auto	$6,233	$5,197	($1,036)	-17%
Workers' Compensation/ Employers Liability*	$1,023,424	$1,156,241	$132,817	13%
Umbrella	$10,740	$10,282	($458)	-4%
Excess Liability	$35,030	$20,100	($14,930)	-43%
Earthquake	$160,373	$182,264	$21,891	14%
Cyber*	$122,296	$128,380	$6,083	5%
D&O/EPL, Crime	$150,340	$146,640	($3,700)	-2%
Excess D&O/EPL	$108,015	$112,200	$4,185	4%

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Managed Care E&O*	$253,457	$254,844	$1,387	1%
Excess Managed Care E&O*	$144,366	$141,084	($3,283)	-2%
Medical Malpractice (PACE)	$46,229	$33,866	($12,363)	-27%
Pollution (3-year Policy Term)	$5,292	$5,292	$0	0%
Wage and Hour	$150,000	$135,300	($14,700)	-10%
Total: Renewal Premiums	**$2,280,784**	**$2,401,089**	**$120,305**	**5%**

Coverage	2018-19 Premium	2019-20 Premium	$ Difference from Prior Year	% Difference from Prior Year
New Coverage Premiums				
Fiduciary	N/A	$23,616	N/A	N/A
Excess Cyber	N/A	$85,000	N/A	N/A
Excess Wage and Hour*	N/A	$120,000	N/A	N/A
Total: New Coverage Premiums	N/A	**$228,616**	N/A	N/A

*Estimated Premium; coverage still under negotiation

Due to CalOptima's use of an insurance broker and the inherent competitive quotation process, premium negotiations may often continue up to the day before policy expiration. As of February 27, 2019, the following insurance coverage policy terms are still being negotiated: Workers' Compensation/ Employers Liability, Cyber, Managed Care E&O – primary and excess, and Excess Wage and Hour.

Explanation of significant cost increases:

- **Property:** CalOptima's premium increased by 8% or $3,993 from the previous year. 7% of the increase is attributable to growth in aggregate property values, business personal property values and business interruption expense coverage, while the remaining 1% increase is related to carriers continuing to increase property premiums universally due to recent catastrophic losses, such as fires and floods. Woodruff Sawyer marketed the coverage but did not receive quotations from other carriers. Staff recommends renewing coverage through the incumbent carrier.

- **Workers' Compensation:** CalOptima's premium increased by 13% or $132,817 from the previous year. The primary factor is due to a 10% estimated increase in employees, which equates to an 8% estimated increase in payroll - the main driver of premium growth. In addition, CalOptima continues to experience a high frequency of ergonomic injuries, such as strains. Woodruff Sawyer marketed the coverage and received one quotation from another carrier. The responding carrier quoted a savings of 3% or $35,000 from CalOptima's current premium.

  Staff recommends renewing coverage through the incumbent carrier for the following reasons:(1) the new carrier is less experienced in claims management than the incumbent; (2)

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the current carrier has built a strong relationship with CalOptima and has been committed to working with CalOptima to provide training to Management and Staff on claims mitigation, ergonomics, and other programs to lessen the frequency and severity of claims; and (3) staff would encounter increased administrative burden with the new carrier, as staff would need to work with the incumbent current carrier to manage claims submitted before the end of the PY, while the new carrier would manage new claims beginning from the new policy's effective date.

- **Earthquake**: CalOptima's premium at the expiring $50,000,000 limit decreased by 9% or $14,284. However, as property values and the cost of labor have increased since the limit was last increased in 2011 when the building was purchased, Staff recommends renewal at a higher limit of $75,000,000, representing a 14% or $21,891 increase over the previous year's expiring premium to reflect the potential increases.

Fiscal Impact
The fiscal impact of the annual insurance policy renewals and new coverages related to the period of April 7, 2019, through June 30, 2019, is a budgeted item under the Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018. Management plans to include funding for the remaining policy period of July 1, 2019, through April 7, 2020, in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation
The continued procurement of business insurance, without a lapse in coverage, ensures that CalOptima's risk and exposure to claims is mitigated as much as possible.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Woodruff-Sawyer & Co.	50 California Street, Floor 12	San Francisco	CA	94111
Zurich	P.O. Box 66946	Chicago	IL	60666-0946
Travelers	One Tower Square	Hartford	CT	06183
AWAC	199 Water St, 25th Floor	New York	NY	10038
XL	100 Constitution Plaza #15	Hartford	CT	06103
OneBeacon	199 Scott Swamp Road	Farmington	CT	06032
TDCSU	29 Mill Street	Unionville	CT	06085
Navigators	83 Wooster Heights Road	Danbury	CT	06810
Ironshore	28 Liberty St, 5th Floor	New York	NY	10005
Argo Re	110 Pitts Bay Rd	Pembroke HM 08	Bermuda	
Beazley	60 Great Tower St	London EC3R 5AD	UK	
RT Specialty	180 N Stetson Ave, Ste 4600	Chicago	IL	60601
CNA	151 North Franklin St	Chicago	IL	

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize expenditures for CalOptima's participation in the following community events:
    a. Up to $2,000 and staff participation at the Iranian American Community Group's 6th Annual Persian Nowruz Festival in Irvine on March 24, 2019;
    b. Up to $2,000 and staff participation at Access California Services' 2nd Annual Peace of Mind: A Family and Wellness Event in Santa Ana on April 14, 2019;
    c. Up to $2,500 and staff participation at Kid Healthy's 8th Annual Cooking Up Change Greater Orange County Event in Santa Ana on April 25, 2019; and
    d. Up to $1,500 and staff participation at Team of Advocates for Special Kids (TASK) 2nd Annual Family Fun Day and Resource Fair 2019 in Costa Mesa on April 27, 2019.
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background
CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion
The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

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a. **Iranian American Community Group's 6th Annual Persian Nowruz Festival.** Staff recommends the authorization of expenditures for participation in the Iranian American Community Group's 6th Annual Persian Nowruz Festival. This is an educational event celebrating the Persian New Year that highlights the culture and traditions of the Persian community. The event will include cultural performances, traditional foods and resource tables. This event provides an opportunity to share information about CalOptima's programs and services with our members who speak Farsi, which is one of CalOptima's threshold languages. A $2,000 financial commitment for the Iranian American Community Group's 6th Annual Nowruz Festival includes: CalOptima's name and logo on recognition banner, event program and announcement on main stage, one (1) resource booth and invitation to VIP tent at the event. The event draws nearly 4,500 annually from the Persian community, Persian organizations and their members and Iranian-American community leaders. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Farsi and share information about CalOptima's programs and services.

b. **Access California Services' 2nd Annual Peace of Mind: A Family and Wellness Event**. Staff recommends the authorization of expenditures for participation in Access California Services' Family Wellness Event. This is an educational event with a focus on mental health to address behavioral health challenges, stigma, cultural barriers, acculturation, and access to health/mental health services. CalOptima will have an opportunity to highlight behavioral health services available to our members. This event also provides an opportunity for CalOptima to interact with our members who speak the threshold languages of Arabic and Farsi and other attendees about our behavioral health services. A $2,000 financial commitment for Access California Services' 2nd Annual Peace of Mind Family Wellness Event includes: Opportunity for CalOptima leadership to share information about CalOptima's behavioral health services, CalOptima's name and logo on all marketing materials, one (1) resource booth and verbal recognition on the day of the event. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Arabic and Farsi and share information about CalOptima's programs and services.

c. **Kid Healthy's 8th Annual Cooking Up Change Greater Orange County Event**. Staff recommends the authorization and expenditure for participation in Kid Healthy's Cooking up Change Greater Orange County Event. This event is a collaboration with school districts throughout Orange County to empower students to create and advocate for healthy school meals. Students from low-income schools are provided a platform to transform the school lunch menu using cost guidelines and high nutrition standards and develop their leadership skills. Twelve high school teams from the cities of Anaheim, Santa Ana, Fullerton, Buena Park, Garden Grove, La Habra and Whittier compete in this event. This event provides CalOptima an opportunity to share information about our programs and services with our members. A $2,500 financial commitment for Kid Healthy's 8th Annual Cooking Up Change Greater Orange County Event includes: One (1) resource booth, CalOptima's name and logo on event signage, social media and video, complimentary event tickets for six, and invitation for VIP reception for two. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share

information about CalOptima's programs and services. This event also provides CalOptima an opportunity to strengthen our relationship with the school districts serving our members.

d. **Team of Advocates for Special Kids 2nd Annual Family Fun Day and Resource Fair 2019**. Staff recommends the authorization of expenditures for participation TASK's 2nd Annual Family Fun Day and Resource Fair. This is an educational event designed to serve children with disabilities and their families and provides information about community resources, disability-centered programs, services and resource. This event provides CalOptima an opportunity to share information about CalOptima's programs and services, including the Whole-Child Model. Attendees for this event includes children who are enrolled in California Children Services (CCS). A $1,500 financial commitment for TASK's 2nd Annual Family Fun Day and Resource Fair includes: One (1) resource booth and CalOptima's name and logo on all event marketing materials, two (2) event banners, name and logo in two (2) email newsletters sent to 7,000 households, TASK social media outlets, TASK website for one (1) year, mention in press release and public recognition at the event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services, including the Whole-Child Model. They anticipate approximately four hundred (400) parents and their children in attendance for this event.

CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $8,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2018-19 Operating Budget approved by the CalOptima Board of Directors on June 7, 2018.

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Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Event Information Packages

/s/ Michael Schrader — *2/27/2019*
Authorized Signature — **Date**

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IAC Group
Iranian American Community Group

Nowruz 2019
Persian New Year Celebration

March 24, 2019
Bill Barber Community Park, Irvine, CA

Dear Nowruz Sponsor:

On behalf of Nowruz 2019 Iranian American Community Group (IACG) Festival Committee, I am pleased to invite you to join our circle of sponsors to support this exciting cultural event.

On Sunday, **March 24, 2019, from 1-6 pm,** the Persian community will celebrate the **6th Annual Persian Nowruz Festival (Eid)** at the Rose Garden at Bill Barber Community Park (next to Irvine's city hall), in Irvine, California.

For thousands of years Iranians have celebrated Nowruz as the beginning of the year. The colorful celebration of Nowruz marks the beginning of spring and Persian New Year, which is a time to begin a new life, and the first day of spring.

Since 2014, volunteers from several supporting non-profit organizations gather annually to create an extraordinary event to showcase the rich Persian culture. This fun event includes free entrance to the festival, music, dance, children's activities, Persian cuisine, and much more. The number of participants has grown steadily over the years to nearly 4,500 annually. This year we expect that number to be even greater.

Sponsorship of Nowruz provides your business with a unique opportunity to reach thousands of Iranian-Americans living in Southern California. While engaging and inspiring, your participation will allow you to extend your loyalty to Persian culture among thousands of visitors to the festival.

The enclosed materials provide information on the levels of sponsorship and the benefits associated with each level. Please take this opportunity to become involved with the community while promoting Persian culture and your business to thousands of attendees.

We look forward to recognizing you as one of our major sponsors at Nowruz 2019. Please e-mail us at iacgroupoc@gmail.com with any questions you may have.

Best Regards,

Kamran Taghdiri, PhD, IAC CFO
Nowruz Festival Committee

Sponsorship Levels

IAC Group is a 501 (c) (3) organization (**Tax ID #: 47-5363120**)

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Your sponsorship is a valuable component of Nowruz celebration festival. Your support will help us to exhibit and represent diverse collection of traditional events and lively programs. It will also encourage children to learn about their rich heritage by participating in this cultural event.

PLATINUM Sponsor ($ 2,000 +)

- Name and logo display on a recognized banner at a recognized section at the event
- Name and logo display on recognized section of the program hand out to participants
- Announcement on main stage as platinum sponsor
- A table at the event for distributing company's information (no sales transactions)
- Invitation to VIP tent of the event

GOLD Sponsor ($ 1,000 +)

- Name display on banner at a recognized section at the event
- Name on gold sponsors section of the program hand out to participants
- A shared table with other gold sponsors to hand out company's information (no sales transactions)

SILVER Sponsor ($ 500 +)

- Name display on banner at the event
- Name on silver sponsors section of the program hand out to participants

Friends of Nowruz ($ 100 +)

- Name on Friends of Nowruz section of program hand out to participants

Sponsor Information

First Name: _____ Last Name: _____

Company/Organization: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____

Email: _____

Sponsorship Levels: (Please check options)

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Description	Amount	Select
Platinum Sponsor	$ 2,000+	
Gold Sponsor	$ 1,000+	
Silver Sponsor	$ 500+	
Nowruz Friends	$ 100+	

Check: Check #_____ Bank Name_____

Sponsor Signature: ..... **Date:** .....

Please Mail to: **Nowruz 2019 Celebration**

IAC Group

6789 Quail Hill Pkwy, Suite 626

Irvine, CA 92603

(Tax ID #: 47-5363120)

Iranian American Community Group of Orange County: 6789 Quail Hill Pkwy, Suite 626, Irvine CA. 92603

www.iac-group.org *iacgroupoc@gmail.com*

Revised 1/14/2019 Tel. 949-431-6858

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ACCESS CALIFORNIA SERVICES

Tiffany Kaaikanmanu
Community Relations Manager
CalOptima
505 City Pkwy W, Orange, CA 92868

January 28, 2019

RE: 2nd Annual Peace of Mind: A Family Wellness Event

Dear Ms. Tiffany Kaaikamanu,

On behalf of Access California Services (AccessCal), I am delighted to announce our 2nd **Annual Peace of Mind: A Family Wellness Event**, which will be held on Sunday April 14th, 2019 from 9:00am to 4:00pm at the Delhi Community Center.

For this special occasion, I humbly invite you to join us as our sponsor. It is through your generous support that we are able to achieve milestones in helping our less fortunate and vulnerable community members learn about Behavioral Health challenges, stigma, cultural barriers, acculturation, access to health/mental health services. Your contributions help create these life-changing journeys that assist Communities becoming active and healthy members within our society in Orange County.

CalOptima continues to demonstrate its commitment to mental health services which is why AccessCal wishes to include such a prominent Orange County health care provider in this event. Through this sponsorship request, AccessCal is humbly requesting $2,000. In return, AccessCal will incorporate CalOptima's logo on all marketing materials as well as deliver acknowledgement of CalOptima on the day of the event, have a table/booth at the day of the event reserved, and in all marketing materials.

It would be an honor to have CalOptima as one of our sponsors and partners in this event as we together community members in a conversation surrounding the delicate yet critical topic of mental health and wellness.

The conference will also include registration, breakfast, and lunch as well as activities for children on-site. This will be a no charge event for attendees.

I hope we can count on CalOptima's continuous support for this critical event for the community

I truly look forward to having you join us as a sponsor.

We rely on you, so many can rely on us.

Sincerely,

Wali Abdul Hanifzai

Wali Abdul Hanifzai
Director of Mental Health Services

Board Members

Khouloud Bustami
Vice President at American Funds
Capital Group, Inc
CHAIR

Omar Khalil
Account Executive, Sled Division
Datalink Corporation
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Minzah Malik, MPH, MBA
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Manal Alawach
Vice President for Quality & Risk Management
California School of Health Sciences

Maria Khani
Educator & Public Speaker

Nadia Saad Bettendorf
Educator

Samer Nahas, Esq.
Attorney at Law

Yasser Barakat
Executive Business Consultant

Access California Services is a 501c(3) nonprofit community- based organization established in 1998, located in Anaheim, CA
Donations are tax-deductible
Federal Tax ID 33-0826205

Founded in 2003, Kid Healthy builds healthy communities by engaging students and families from socio-economic disadvantaged neighborhoods through culturally appropriate leadership programs that measurably improve health and wellness.

Join the Movement!

Dear Ms. Tiffany Kaaiakamanu,

4.9 Billion is a number that should grab our attention! Did you know, that's the number of school lunches served annually in the U.S.? Kid Healthy, based in Santa Ana, has a mission: to empower students to create and advocate for school meals that are healthy, appealing and delicious. We need you as a partner in Cooking up Change®, a program and event that provides students a platform to demonstrate their talent and lend their voice to the challenge of serving healthy school meals. Since 2012, we have partnered with Healthy Schools Campaign and Northgate Gonzalez Market to host the greater Orange County leg of this national movement. Please join us by supporting the 8th annual Cooking up Change® Greater Orange County event on Thursday, April 25, 2019.

More than a culinary event, Cooking up Change® provides high school students from low-income schools, an opportunity to transform the school lunch menu, develop valuable culinary arts skills, become leaders in school food reform, and inspires them to seek higher education. Following real life guidelines in cost, high nutrition standards and preparation, each team is challenged to design an innovative, low-cost, appealing entrée, and two side dishes. The teams, made up of 3-4 students, will present their culinary creations to an esteemed panel of judges, followed by a community celebration, at the Cooking up Change® Greater Orange County event held on April 25, 2019. Winning teams will earn scholarships, culinary prizes and the chance to see their menu served in local school districts. This program has led to an amazing showing of local culinary talent by students. It serves up life-changing opportunities that allow students to engage with health, education, and policy leaders to make an impact on local school food. These opportunities are made possible by Cooking up Change®.

We hope that you will consider becoming a part of this unique program and event by considering a sponsorship. Your participation will make a difference in the lives of these young students. I encourage you to also view the video highlights found by following the link below, it is a good perspective on the event.

2018 Event Highlights Video

The benefits of a sponsorship are attached; the benefits to the students are endless.
Thank you for your consideration.

Sincerely,

Linda Luna-Franks

Linda Luna-Franks
Executive Director, Kid Healthy
(949) 874-7701
linda@mykidhealthy.org

1901 E. Fourth Street, Suite 100
Santa Ana, CA 92705
www.mykidhealthy.org

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Cooking up Change

NATIONAL

Join the Movement: Students Transforming the Future of School Food
I would like to sponsor Cooking up Change® 2019 at the level indicated below (check one)

☐ **Change-Maker: $20,000 or above:**

- Company Logo on ALL event print materials
- Recognition in social media campaign weekly
- Complimentary event tickets for 20
- Invitation for 10 to VIP Reception
- Company logo and hot link on event website
- Company representative to welcome attendees
- Company representative to present awards to students
- Company representative interviewed in final event video
- Company logo on chef jackets
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook

☐ **Team Player: $15,000 or above:**

- Company logo on event print materials as Team Player
- Company logo on event signage as Team Player
- Recognition in social media campaign
- Complimentary event tickets for 15
- Invitation to VIP Reception for 8
- Company logo and hot link on event website
- Company representative to assist with awards presentation
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook

☐ **Health Champion: $10,000 or above**

- Company logo on event print materials as Champion
- Company logo on event signage as Champion
- Recognition in social media campaign & video as Champion
- Complimentary event tickets for 10
- Invitation to VIP Reception for 6
- Company logo on website, photo booth props
- Company logo in Cooking up Change® Cookbook

☐ **Leader: $5,000 or above:**

- Company Logo on event print materials as Leader
- Recognition on event signage as Leader
- Recognition in social media & video as Leader
- Complimentary event tickets for 8
- Invitation to VIP Reception for 4

☐ **Influencer: $2,500 or above:**

- Recognition in event signage as Influencer
- Complimentary event tickets for 6
- Invitation to VIP Reception for 2
- Recognition in social media & video as Influencer

☐ **Associate: $1,000 or above:**

- Recognition in event signage as Associate
- Complimentary event tickets for 4
- Recognition in social media & video as Associate

☐ **Supporter: $300 or above:**

(non- profits & individuals only)

- Complimentary event tickets for 2
- Recognition in event signage, as Supporter

☐ **Friend:**

Please accept my donation of $_____

Thank you for your support of Kid Healthy, please return this form by March 25, 2019:

Mail to:
Kid Healthy c/o OneOC
1901 E. Fourth Street, Suite 100 Santa Ana, CA 92705
linda@mykidhealthy.org

For Further Information Contact:
Linda Luna-Franks, Exec. Dir.
949.874.7701
linda@mykidhealthy.org

kid HEALTHY

Charge my (circle one): Visa MasterCard American Express Check (Enclosed)

Amount $_____(Please make checks payable to Kid Healthy)

Name on Card:_____CardNo._____

Signature:_____Expiration Date:_____SecurityCode:_____

Company/Name:_____

Address:_____

Contact:_____Phone: _____Email:_____

Kid Healthy is a fiscally sponsored project of OneOC, a 501C3 not for profit Organization. All gifts are tax deductible as allowed by law.

Tax ID# 95-2821700

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From:	Elena Arrojo
To:	Nguyen, Lisa; Kaalakamanu, Tiffany
Subject:	TASK - 2nd Annual Family Fun Day & Resource Fair - Sponsorship Opportunities
Date:	Tuesday, January 15, 2019 12:20:19 PM
Attachments:	Sponsorship Packet.pdf

Dear Lisa and Tiffany:
I hope you are both well and that you enjoyed a nice holiday break. I'm emailing you now to share another sponsorship opportunity that may interest CalOptima. Last year CalOptima kindly sponsored TASK's 40th Anniversary Family Day event. Thank you, again, for your support! The event was well-received and exhibitors and families have asked for us to offer it again. So, we are making this an annual event.

Our **2nd Annual Family Fun Day & Resource Fair** will take place on Saturday, April 27th at TeWinkle Park in Costa Mesa. We would be delighted to include CalOptima again as a sponsor and exhibitor. **The deadline for participation is April 1, 2019.** If you elect to participate and notify us sooner, we can promote your involvement for a longer period of time.

Attached is a sponsorship packet. As you will see, there are three higher levels of sponsorship. At the highest level, which is $5,000, CalOptima would receive a long list of benefits, that include the following highlights:

- Top billing on all marketing materials with the largest logo
- The best vendor space location with the highest foot traffic
- The opportunity to distribute branded materials to every attendee at check-in
- The opportunity to have the event emcee read a commercial provided by CalOptima over the loudspeaker
- A feature article for CalOptima (describing any services you might offer to our clientele) in a TASK email newsletter sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside, San Diego and Imperial Counties.

Because this event happens two weeks before Mother's day, we will also have a "Celebrating Mothers" component. Women represent 95% of our clients. Mothers represent 91%. Women and mothers are often the people who make decisions about the children and household, including healthcare, education, and finances. If this is a demographic that interests you for targeted marketing materials, perhaps there are opportunities we could explore, particularly at this highest sponsorship level and do something special for that group.

You can reach me at 714-533-8275, x215. I welcome the chance to talk with you further.

All the best,

Elena Arrojo
Manager, Communications & Development
T: 714-533-8275
E: elenaa@taskca.org | W: www.taskca.org

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TASK

CELEBRATING 40 YEARS



2nd Annual Family Fun Day & Resource Fair 2019

SPONSORSHIP OPPORTUNITIES

www.taskca.org

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TASK
GUIDANCE | EDUCATION | SUPPORT

EDUCATING AND EMPOWERING
PEOPLE WITH DISABILITIES AND THEIR FAMILIES

2nd Annual Family Fun Day & Resource Fair

Saturday, April 27, 2019, 11 a.m. to 3 p.m.

TeWinkle Park Accessible Playground, Costa Mesa

Dear Sponsor:

Join us! We invite you to become a sponsor for TASK's upcoming *Family Fun Day & Resource Fair* this spring and support families with disabilities. This is a great opportunity to market your programs, services and products to the disability community and align your brand with a worthy cause. In anticipation of Mother's Day, this year's event will have a special emphasis on celebrating moms, which comprise the vast majority of our clientele. Following is information about TASK, this free, community event, our demographics and ways you can get involved.

TASK is a private, 501c3 nonprofit organization headquartered in Anaheim whose mission is to educate and empower people with disabilities and their families. Our geographic focus spans six Southern California counties – including Imperial, Los Angeles, Orange, Riverside, San Diego and Ventura. The core of our service involves helping families navigate the complex worlds of special education, disability services and assistive technology. Often, we function as a clearinghouse of information about disability-centered concerns, especially special education, and offer referrals to community service providers that may be beneficial for our families. We support all disabilities. Our programs and services are offered free-of-charge, or at low cost and are available bilingually in English and Spanish.

TASK's Annual Family Fun Day & Resource Fair is a free, public event for people with disabilities and their families. It includes a resource fair—where families can seek out valuable, disability-centered programs, services and resources for all ages and all disabilities—and a family-oriented fun day with children's activities. It's held in an accessible park, where all children can participate and parents can relax, knowing they are in a safe and understanding space. There will be games, entertainment, music, children's crafts, door prizes, and concessions. This year, there will also be stations where children can make Mother's Day gifts and cards and we will offer special door prizes for mothers.

During our inaugural 2018 event, 420 people attended and three dozen exhibitors participated. The 2019 will be approximately 30% larger.

About our families:
TASK serves approximately 3,000 families annually across six counties.

- 95% of our clients are women
- 91% are mother's
- 40% are low-income
- 40% are Latino and/or Spanish-speaking
- 34% do not have English as a first language
- 60% of our families seek support for a developmental disability
- Autism is the disability families call us about more than any other disability.
- Behaviorial challenges and bullying are among the most common reasons people contact us.
- TASK's TECH Center in Anaheim offers unique opportunities within Southern California for people with disabilities to experiment with assistive technology options that can help with learning, communication and independence.

If you are interested in sponsoring this event, volunteer opportunities, or if you would like to know more about TASK, please contact me at (714) 533-8275, x215 or at elenaa@taskca.org.

Thank you for your interest! We look forward to partnering.

Sincerely,

Elena Arrojo

Elena Arrojo
Manager, Communications & Development

TASK
Celebrating
40 YEARS

2nd Annual Family Fun Day & Resource Fair

Saturday, April 27, 2019, 11 a.m. to 3 p.m.,
TeWinkle Park, Costa Mesa

SPONSORSHIP OPPORTUNITIES

Deadline: April 1, 2019

***Champion for Inclusion* - $5,000**

The *Champion for Inclusion* is the highest sponsorship level available for this event. These sponsors receive top billing at the event, with the event title reading, *TASK's 2nd Annual Family Fun Day & Resource Fair presented by...* This sponsorship level offers the most exposure opportunities.

- Top billing on all event marketing materials with largest logo
- Logo on two event banners displayed at event
- Name and logo included in two email newsletters sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside San Diego and Imperial Counties
- Name and logo included in three event-specific email blasts sent to 2,000 Orange and Los Angeles County households each
- Name and logo included in six Facebook posts and six Tweets
- Mentioned in press release
- Public, verbal recognition at event
- Best vendor space location with highest foot traffic
- Opportunity to distribute branded material to every attendee at check-in
- Logo placement with link to your homepage on TASK's website for one year
- Two, individual "thank you" posts on TASK's Facebook page with your logo and website link
- Emcee will read a commercial provided by your agency
- Article featuring your company/agency's services and/or products in a TASK email newsletter sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside San Diego and Imperial Counties

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***Innovator* - $3,000**

- Logo on event marketing materials with second largest logo
- Logo on event banner displayed at event
- Name and logo included in two email newsletters sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside San Diego and Imperial Counties
- Name and logo included in three event-specific email blasts sent to 2,000 Orange and Los Angeles County households each
- Name and logo included in six Facebook posts and six Tweets
- Mentioned in press release
- Public, verbal recognition at event
- Preferred vendor space location
- Logo placement with link to your homepage on TASK's website for one year
- Individual "thank you" on TASK's Facebook page with your logo and website link

***Opportunity Maker* - $1,500**

- Logo on event marketing materials with third largest logo
- Logo on two event banners displayed at event
- Name and logo included in two email newsletters sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside San Diego and Imperial Counties
- Name and logo included in two event-specific email blasts sent to 2,000 Orange and Los Angeles County households each
- Name and logo included in six Facebook posts and six Tweets
- Mentioned in press release
- Public, verbal recognition at event
- Good vendor space location
- Logo placement on TASK's website for one year

***Community Ally* - $500**

- Name included in two email newsletters sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside San Diego and Imperial Counties
- On-site vendor space in exhibitor area
- Name included in two event-specific email blasts sent to 2,000 Orange and Los Angeles County households each
- Public, verbal recognition at event

***Valued Friend* - $200**

- Name listed in one event "thank you" email newsletter sent to 7,000 households in Ventura, Los Angeles, Orange, Riverside San Diego and Imperial Counties

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Monetary donations in all increments are welcome and appreciated. Donations help TASK offer free programs and services to families in need. All donors are credited in a TASK email newsletter in the month following their donation. In-kind donations of prizes and services are also appreciated.

About TASK:

TASK is a nonprofit, 501(c)3 organization (Tax ID #95-3294319) founded in 1978 whose mission is to educate and empower people with disabilities and their families by helping them navigate special education, disability services and assistive technology. We serve approximately 3,000 families per year in six counties, including: Imperial, Los Angeles, Orange, Riverside, San Diego and Ventura. Our programs and services are largely free and offered bilingually in English and Spanish.

With funding from the U.S. Department of Education, Office of Special Education Programs, TASK serves as California's largest *Parent Training and Information Center* (PTI). With funding from the California Department of Education, we serve as a *Family Empowerment Center* in Orange County.

Questions?

Contact Elena Arrojo, Manager, Communications & Development at (714) 533-8275 or elenaa@taskca.org.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year (FY) 2018-19 Operating Budget for Translation Expenses

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

Recommended Action
Authorize reallocation of budgeted but unused funds in the amount of $190,000 from Cultural & Linguistic Services – Member Communications to Cultural & Linguistic Services – Purchased Services to fund translation expenses through June 30, 2019.

Background/Discussion
On March 1, 2012, the CalOptima Board of Directors adopted CalOptima Resolution No. 12-0301-01, which includes provisions that delegate authority to the Chief Executive Officer to make budget allocation changes within certain parameters. Pursuant to this resolution, budget allocation changes (i.e., movement of unexpended budget dollars from on Board-approved program, item, or activity to another within the same expense category) of $100,000 or more require Board approval.

Under the CalOptima FY 2018-19 Operating Budget, CalOptima's Cultural & Linguistics Department increased Purchased Services by 38% (from $314,000 to $510,000) to account for an expected increase in the cost of translating all member materials in threshold languages and face-to-face and telephonic interpreter services in any language for the Medi-Cal line of business. However, the utilization of these services was much higher than anticipated.

CalOptima's Cultural & Linguistics Department has experienced a 57% increase in the cost for translation & interpreter services compared to FY 2017-18. The primary driver for the increase in utilization has been the implementation of the Medi-Cal Behavioral Health Services beginning January 1, 2018. Based on this increase, anticipated expenditures for translation services as well as face-to-face and telephonic interpreting requirements are now projected to exceed the approved budgeted amount by $190,000 by June 30, 2019.

To address this shortfall, Management proposes to make a reallocation of budgeted but unused funds of $190,000 from Cultural & Linguistic Services – Member Communications. Management anticipates sending fewer member mailings during this fiscal year than planned due to delays in the start of key programs, thereby making these funds available for reallocation.

Fiscal Impact
The fiscal impact for this recommended action is budget neutral. Unspent budgeted funds from Cultural & Linguistic Services – Member Communications approved in the CalOptima FY 2018-19 Operating Budget on June 7, 2018, will fund the total cost of $190,000 for this action.

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Rationale for Recommendation

CalOptima is obligated to provide members with appropriate and timely translations in all threshold languages and face to face and telephonic interpreting services in any language upon request. The recommendation will ensure CalOptima remains compliant with contractual and statutory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

2/27/2019 — **Date**

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Board of Directors Meeting
March 7, 2019

Whole-Child Model Family Advisory Committee (WCM FAC) Update

February 26, 2019 Regular WCM FAC Meeting

The WCM FAC Nominations Ad Hoc Committee recommended Cathleen Collins to the WCM FAC to be submitted to the Board of Directors for consideration at its April meeting. WCM FAC Members were also reminded that the terms for three Authorized Family Representatives and two Community Based Organization seats will be coming up for renewal and that they must reapply for their seats between March 1 and April 1, 2019.

Ladan Khamseh, Chief Operating Officer, provided the Committee with a Health Homes Program (HHP) update and noted that CalOptima is discussing with the Department of Health Care Services the possibility of having the HHP start on January 1, 2020 instead of the current target date of July 1, 2019. Ms. Khamseh also reported that staff continues to explore options and opportunities for members when it comes to dental care.

David Ramirez, M.D., Chief Medical Officer, discussed how the Medical Management team's goal is to provide transitioning California Children's Services (CCS) members with a positive experience by providing an overview of what steps are being taken to ensure a smooth transition on July 1, 2019. Dr. Ramirez invited Committee members to provide input on areas of concern, which led to a robust discussion among the members and management.

Candice Gomez, Executive Director, Program Implementation, provided a Whole-Child Model update. Michelle Laughlin, Executive Director, Network Operations provided a Network Operations update on provider contracting.

The Committee received presentations on WCM pharmacy information and dental initiatives.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities. The next meeting is scheduled for April 30, 2019.

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Board of Directors Meeting
March 7, 2019

Provider Advisory Committee (PAC) Update

February 14, 2019 PAC Meeting

Eight PAC members were in attendance at the February PAC meeting.

PAC received an update from Ladan Khamseh, Chief Operating Officer, who reported on the Whole-Child Model (WCM) postponement by the Department of Health Care Services (DHCS). She noted that CalOptima will be providing the DHCS with copies of the signed provider contracts before the March 1, 2019 deadline and that it is anticipated that the DHCS will make its determination on the WCM network adequacy after March 15, 2019.

Ms. Khamseh also discussed the Health Homes Program (HHP) and noted that CalOptima continues to discuss with the DHCS flexibility around the start date for the HHP with the hope of postponing the start date until January 1, 2020 to allow CalOptima to concentrate their efforts on the rollout of the important WCM on July 1, 2019. Currently, HHP is scheduled to begin at the same time as the WCM.

David Ramirez, M.D., Chief Medical Officer, provided an update on the Homeless Health Initiative and how CalOptima can support this mission by improving services for Orange County's homeless population. He also noted that CalOptima had received a 4.0 rating by Medi-Cal as a result of their latest audit. He also discussed areas he would like to focus on in the upcoming year, particularly looking at member and provider incentives as well as looking at telehealth as an option for CalOptima members. Dr. Ramirez also updated the members on the Opioid crisis with an in-depth presentation on how CalOptima has reduced the use of Opioids and Benzodiazepines among Medi-Cal members.

PAC also received a Medi-Cal enrollment update from Michelle Laughlin, Executive Director, Network Operations, a presentation on what we might see in the 2019/20 State Budget and a Dental Initiatives presentation from Arif Shaikh, Director, Government Affairs. Candice Gomez, Executive Director, Program Implementation also discussed the latest information on the Health Homes Program.

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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CalOptima Board of Directors

Supplemental to
March 7, 2019 Board of Directors Meeting Agenda

INFORMATION ITEMS

20. Homeless Health Update

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Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

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Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

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Clinical Field Team Pilot

- Board approved up to $1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
  - Partner with up to five interested FQHCs that will:
    - Establish regular hours at high-volume shelters
    - Deploy to community locations on short notice
    - Coordinate to arrange for coverage with extended hours
    - Deliver urgent-care-type services to homeless individuals in need
      - Bill CalOptima for current CalOptima members
      - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

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Homeless Response Team

- Board authorized CalOptima Homeless Response Team
  - Eight new positions in Case Management department
  - Primary point of contact at CalOptima for homeless health services for CalOptima members
    - Dedicated phone line
    - Extended hours
  - Coordinate scheduling and dispatch of CFTs
  - Work closely with County, shelters and providers
    - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

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Expanded Service Options Under Consideration

- Embedded clinics at shelters
  - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
  - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
  - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

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Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
  - Set up a post-WPC recuperative care program
  - Reallocate part of $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
    - From WPC recuperative care funds
    - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
  - Coordinate with County to explore possibilities of:
    - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
    - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Back to Agenda

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
  - CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
    - WPC
      - Link clients to other programs that provide housing supportive services
      - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
    - Health Homes Program
      - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
      - Members must elect to participate
      - Care management includes housing navigation

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Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
  - Obtaining legal opinion
  - Seeking guidance from the Department of Health Care Services

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Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
  - WPC hospital navigators
  - Increased access to skilled nursing services
  - Recuperative care beyond 90 days
  - Recuperative care with behavioral health focus
  - Housing supportive services
  - Housing development and rental assistance

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Health Homes Program (HHP): Update

Board of Directors Meeting

March 7, 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

Background: Authorization

- Federal: Authorized under Section 2703 of the Affordable Care Act (ACA)
  - State option to implement
  - 90 percent funding for eight quarters and 50 percent thereafter
  - Must be available to dual eligible
- State: California's AB 361 (2013) authorizes HHP participation
  - Implementation permitted if no General Funds used
  - Requires Department of Health Care Services (DHCS) evaluation within two years of state's initial implementation
- CalOptima currently scheduled to go-live
  - July 1, 2019: Members with chronic conditions
  - January 1, 2020: Members with serious mental illnesses or serious emotional disturbance (SMI)

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California Model

Department of Health Care Services

Lead Entities

Qualifying Medi-Cal managed care plans (MCP)
Orange County: CalOptima

Community-Based Care Management Entities (CB-CMEs)

Sample organizations include primary care providers, Federally Qualified Health Centers, physician groups, hospitals and behavioral health entities or MCP

Community and Social Support Services

Sample organizations include supportive housing providers, food banks, employment assistance and social services

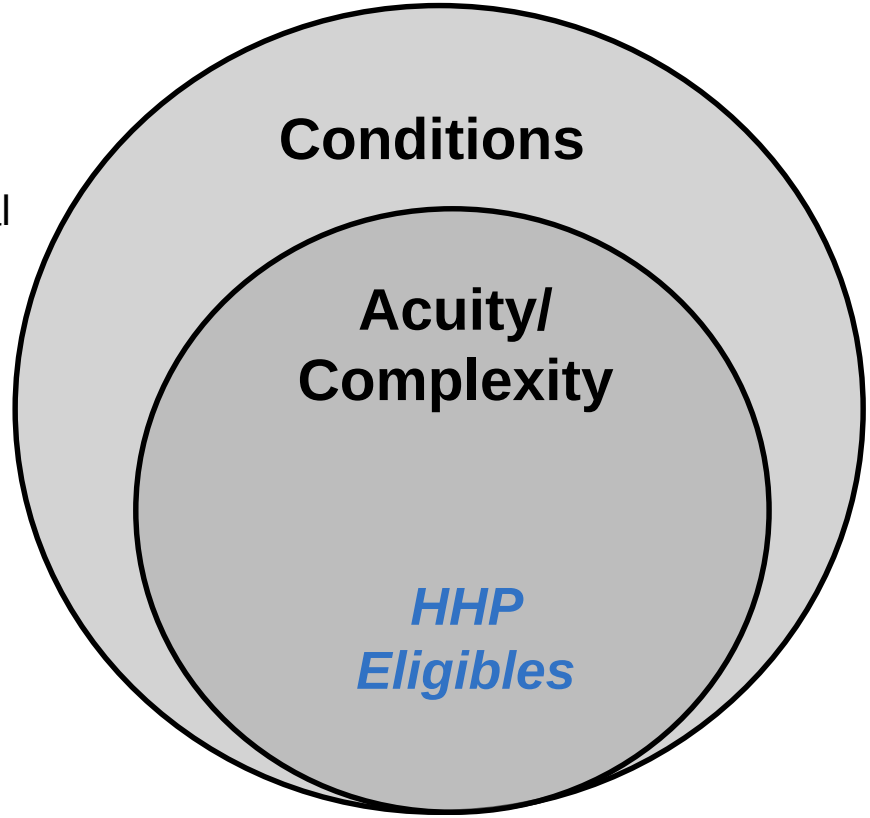
Back to Agenda

Member Eligibility

- Medi-Cal members eligible for HHP

1. Conditions/combination of conditions specified by DHCS
   - Chronic physical conditions, including substance use disorder or
   - Serious mental illness/serious emotional disturbance

2. Acuity/complexity (**one** of the below):
   - Three specified conditions; or
   - One inpatient (IP) stay in last year; or
   - Three Emergency Department (ED) visits in last year; or
   - Chronic homelessness



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Member Exclusions

- Residing in nursing facility (NF)
- Enrolled in hospice
- Participating in other programs (member must choose as they cannot participate in both)
  - Most county-operated Targeted Case Management (TCM), not Mental Health TCM
  - 1915(c) Waiver programs including HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Cal MediConnect

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Member Identification

- DHCS will provide data to determine potentially eligible members
  - Will include most eligible conditions, inpatient stays and emergency department visits and most exclusion criteria
  - Will not include data to identify chronic homelessness or substance use disorder diagnoses
- CalOptima will validate data received from DHCS based on information in its own records and gathered from others
  - Information will be used to develop list of members eligible for progressive engagement
- Members must consent to participate

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Six Core Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referrals to community and social support services, including;
   - Individual Housing Transition Services to support and prepare member for transition to housing
   - Individual Housing and Tenancy Sustaining Services to support member to be a successful tenant in their housing arrangement and thus able to sustain tenancy

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Coordination Opportunities

- Expand reach of CalOptima Special Populations Personal Care Coordinators
  - Currently making visits to shelters and recuperative care sites, such as Courtyard and Illumination Foundation

- Participation in new initiatives
  - Clinic Field Teams — to provide mobile health care in the community for members who are homeless
  - Be Well Wellness Hub — to provide access to broad range of supportive services for members with mental health conditions
    - More than 40% of HHP potentially eligible members may qualify based on their serious mental illness or serious emotional disturbance diagnosis

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Coordination Opportunities (cont.)

- Members may receive services from HHP and County programs
- Examples of these programs include:
  - Whole-Person Care (WPC)
    - Members may be enrolled in both WPC and HHP only if member agrees to receive care coordination services through HHP only
  - Housing Coordinated Entry
  - Comprehensive Health Assessment Team — Homeless (CHAT–H)
  - County Homeless Outreach and Engagement Team (blue shirts team)
  - Members in county shelters
  - County Mental Health
  - Drug Medi-Cal — Organized Delivery System

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Coordination Opportunities (cont.)

- Collaboration activities on existing programs will focusing on
  - Educate staff on programs
    - Eligibility criteria
    - Referral process
    - Services
  - Bi-directional information sharing and care coordination
    - Identify chronically homeless members to support possible enrollment in HHP
    - Identify homeless members known to CalOptima or County
    - Joint care planning
    - Service referrals

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DHCS Deliverables

- CalOptima submitted DHCS defined deliverables by the January 1, 2019 due date, including:
  - Policy and procedures
  - Network delivery model including roles and responsibilities
  - Engagement strategy
  - Member materials
- DHCS provided feedback
  - Plan cannot require member to change PCP or health network
  - Plan must strengthen service delivery model to:
    - Support care management at point of care in the community
    - Ensure face-to-face care coordination in the community, where appropriate
    - Maintain strong direct connection and coordination with member's PCP

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Next Steps

- CalOptima and health networks continue collaboration to implement HHP for their assigned members
  - Address concerns raised by DHCS
  - Policies and procedures
  - Systems enhancements, as applicable
  - Contracts and rates for health networks and others
  - Readiness, reporting and monitoring requirements
  - Budget and staffing
  - Training and tools development

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Financial Summary

January 2019

Board of Directors Meeting

March 7, 2019

Nancy Huang

Interim Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

- January 2019 MTD:
  - Overall enrollment was 763,906 member months
    - Actual lower than budget 19,896 or 2.5%
      - Medi-Cal: unfavorable variance of 19,449 members
        - Whole Child Model (WCM) unfavorable variance of 12,502 members
        - Medi-Cal Expansion (MCE) unfavorable variance of 6,594 members
        - Temporary Assistance for Needy Families (TANF) unfavorable variance of 1,716 members
        - Seniors and Persons with Disabilities (SPD) favorable variance of 1,462 members
        - Long-Term Care (LTC) unfavorable variance of 99 members
      - OneCare Connect: unfavorable variance of 569 members
    - 2,288 decrease from December
      - Medi-Cal: decrease of 2,297 from December
      - OneCare Connect: decrease of 14 from December
      - OneCare: increase of 18 from December
      - PACE: increase of 5 from December

FY 2018-19: Consolidated Enrollment (cont.)

- January 2019 YTD:
  - Overall enrollment was 5,400,977 member months
    - Actual lower than budget 89,986 members or 1.6%
      - Medi-Cal: unfavorable variance of 88,476 members or 1.6%
        - TANF unfavorable variance of 40,300 members
        - MCE unfavorable variance of 34,478 members
        - WCM unfavorable variance of 12,502 members
        - SPD unfavorable variance of 685 members
        - LTC unfavorable variance of 511 members
      - OneCare Connect: unfavorable variance of 2,105 members or 2.0%
      - OneCare: favorable variance of 596 members or 6.4%
      - PACE: unfavorable variance of 1 member or 0.0%

FY 2018-19: Consolidated Revenues

- January 2019 MTD:
  - ➢ Actual lower than budget $17.3 million or 5.8%
    - Medi-Cal: unfavorable to budget $13.7 million or 5.1%
      - Unfavorable volume variance of $6.8 million
      - Unfavorable price variance of $6.9 million
    - OneCare Connect: unfavorable to budget $3.6 million or 13.4%
      - Unfavorable volume variance of $1.0 million
      - Unfavorable price variance of $2.6 million
    - OneCare: Unfavorable to budget $10.3 thousand or 0.6%
      - Favorable volume variance of $162.1 thousand
      - Unfavorable price variance of $172.4 thousand
    - PACE: Unfavorable to budget $789 or 0.0%
      - Unfavorable volume variance of $51.0 thousand
      - Favorable price variance of $50.2 thousand

FY 2018-19: Consolidated Revenues (cont.)

- January 2019 YTD:
  - Actual lower than budget $41.3 million or 2.1%
    - Medi-Cal: unfavorable to budget $38.8 million or 2.2%
      - Unfavorable volume variance of $28.9 million
      - Unfavorable price variance of $9.9 million due to:
        - $22.9 million of WCM revenue
        - $9.5 million of FY19 non-LTC revenue from non-LTC aid codes
        - $4.9 million of Proposition 56 revenue
        - $2.0 million of FY19 Behavioral Health Treatment (BHT) revenue
        - Offset by favorable variance due to:
          - $16.0 million due to favorable rates
          - $3.1 million of Coordinated Care Initiative (CCI) revenue
          - $2.8 million of Hepatitis C revenue
          - $4.5 million of prior year (PY) non-LTC revenue from non-LTC aid codes
          - $1.5 million of PY CCI revenue
          - $1.1 million of PY BHT revenue

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FY 2018-19: Consolidated Revenues (cont.)

- January 2019 YTD:
  - ➢OneCare Connect: unfavorable to budget $2.1 million or 1.2%
    - Unfavorable volume variance of $3.6 million
    - Favorable price variance of $1.4 million
  - ➢OneCare: unfavorable to budget $0.4 million or 3.8%
    - Favorable volume variance of $0.7 million
    - Unfavorable price variance of $1.2 million due to:
      - $0.3 million calendar year (CY) 2015 risk adjustment
      - $1.0 million CY 2016 Hierarchical Condition Categories (HCC) risk adjustment
  - ➢PACE: favorable to budget $50.0 thousand or 0.3%
    - Unfavorable volume variance of $7.3 thousand
    - Favorable price variance of $57.1 thousand

FY 2018-19: Consolidated Medical Expenses

- January 2019 MTD:
  - ➢ Actual lower than budget $25.7 million or 8.9%
    - ▪ Medi-Cal: favorable variance of $24.7 million
      - Favorable volume variance of $6.6 million
      - Favorable price variance of $18.2 million
        - ➢ Provider Capitation expenses favorable variance of $4.7 million due to Proposition 56 and Child Health and Disability Prevention Program (CHDP) expenses that were budgeted in Professional Claims
        - ➢ Professional Claim expenses favorable variance of $4.6 million due to:
          - CHDP expenses of $2.0 million
          - BHT expenses of $2.5 million
          - Proposition 56 expenses of $2.6 million and Non-Medical Transportation (NMT), offset by Incurred But Not Reported (IBNR) expense of $2.5 million
        - ➢ Prescription Drug expenses favorable variance of $4.2 million
        - ➢ Facilities expenses favorable variance of $3.6 million

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FY 2018-19: Consolidated Medical Expenses (cont.)

- January 2019 MTD:
  - OneCare Connect: favorable variance of $810.0 thousand or 3.2%
    - Favorable volume variance of $974.1 thousand
    - Unfavorable price variance of $164.0 thousand
  - OneCare: favorable variance of $79.3 thousand or 5.0%
  - PACE: favorable variance of $59.5 thousand or 2.8%

FY 2018-19: Consolidated Medical Expenses (cont.)

- January 2019 YTD:
  - Actual lower than budget $66.0 million or 3.5%
    - Medi-Cal: favorable variance of $64.0 million
      - Favorable volume variance of $27.6 million
      - Favorable price variance of $36.4 million
        - Professional Claim expenses favorable variance of $42.5 million
        - Provider Capitation expenses unfavorable variance of $18.0 million
        - Prescription Drug expenses favorable variance of $16.9 million
        - Facilities expenses unfavorable variance of $13.8 million
        - Managed Long Term Services and Supports (MLTSS) expenses favorable variance of $8.1 million
    - OneCare Connect: favorable variance of $0.7 million
      - Favorable volume variance of $3.4 million
      - Unfavorable price variance of $2.8 million
- Medical Loss Ratio (MLR):
  - January 2019 MTD: Actual: 92.9% Budget: 96.1%
  - January 2019 YTD: Actual: 94.0% Budget: 95.4%

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FY 2018-19: Consolidated Administrative Expenses

- January 2019 MTD:
  - Actual lower than budget $0.8 million or 6.0%
    - Salaries, wages and benefits: favorable variance of $0.6 million
    - Other categories: favorable variance of $0.2 million

- January 2019 YTD:
  - Actual lower than budget $15.5 million or 17.5%
    - Salaries, wages & benefits: favorable variance of $7.8 million
    - Other categories: favorable variance of $7.7 million

- Administrative Loss Ratio (ALR):
  - January 2019 MTD: Actual: 4.3% Budget: 4.3%
  - January 2019 YTD: Actual: 3.8% Budget: 4.5%

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FY 2018-19: Change in Net Assets

- January 2019 MTD:
  - $11.9 million surplus
  - $12.9 million favorable to budget
    - Lower than budgeted revenue of $17.3 million
    - Lower than budgeted medical expenses of $25.7 million
    - Lower than budgeted administrative expenses of $0.8 million
    - Higher than budgeted investment and other income of $3.8 million

- January 2019 YTD:
  - $63.0 million surplus
  - $58.3 million favorable to budget
    - Lower than budgeted revenue of $41.3 million
    - Lower than budgeted medical expenses of $66.0 million
    - Lower than budgeted administrative expenses of $15.5 million
    - Higher than budgeted investment and other income of $18.0 million

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Enrollment Summary: January 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
64,506	65,115	(609)	(0.9%)	Aged	448,459	451,101	(2,642)	(0.6%)
596	620	(24)	(3.9%)	BCCTP	4,243	4,340	(97)	(2.2%)
46,213	44,118	2,095	4.7%	Disabled	328,931	326,877	2,054	0.6%
305,194	304,863	331	0.1%	TANF Child	2,167,238	2,197,338	(30,100)	(1.4%)
91,564	93,611	(2,047)	(2.2%)	TANF Adult	653,142	663,344	(10,200)	(1.5%)
3,416	3,515	(99)	(2.8%)	LTC	23,863	24,374	(511)	(2.1%)
236,373	242,967	(6,594)	(2.7%)	MCE	1,661,125	1,695,603	(34,478)	(2.0%)
-	12,502	(12,502)	(100.0%)	WCM	-	12,502	(12,502)	(100.0%)
747,862	**767,311**	**(19,449)**	**(2.5%)**	**Medi-Cal**	**5,287,001**	**5,375,477**	**(88,476)**	**(1.6%)**
14,287	**14,856**	**(569)**	**(3.8%)**	**OneCare Connect**	**102,080**	**104,185**	**(2,105)**	**(2.0%)**
304	**311**	**(7)**	**(2.3%)**	**PACE**	**2,032**	**2,033**	**(1)**	**(0.0%)**
1,453	**1,324**	**129**	**9.7%**	**OneCare**	**9,864**	**9,268**	**596**	**6.4%**
763,906	**783,802**	**(19,896)**	**(2.5%)**	**CalOptima Total**	**5,400,977**	**5,490,963**	**(89,986)**	**(1.6%)**

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CalOptima A Public Agency Better. Together.

Financial Highlights: January 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
763,906	783,802	(19,896)	-2.5%	Member Months	5,400,977	5,490,963	(89,986)	-1.6%
282,356,609	299,659,541	(17,302,931)	-5.8%	Revenues	1,919,123,046	1,960,439,140	(41,316,094)	-2.1%
262,370,973	288,061,736	25,690,763	8.9%	Medical Expenses	1,804,071,969	1,870,090,834	66,018,866	3.5%
12,226,927	13,001,814	774,887	6.0%	Administrative Expenses	73,054,159	88,573,258	15,519,100	17.5%
7,758,709	**(1,404,009)**	**9,162,718**	**652.6%**	**Operating Margin**	**41,996,918**	**1,775,047**	**40,221,872**	**2266.0%**
4,183,226	416,667	3,766,559	904.0%	Non Operating Income (Loss)	20,959,745	2,916,667	18,043,079	618.6%
11,941,934	**(987,342)**	**12,929,277**	**1309.5%**	**Change in Net Assets**	**62,956,664**	**4,691,714**	**58,264,950**	**1241.9%**
92.9%	96.1%	3.2%		Medical Loss Ratio	94.0%	95.4%	1.4%	
4.3%	4.3%	0.0%		Administrative Loss Ratio	3.8%	4.5%	0.7%	
2.7%	-0.5%	3.2%		Operating Margin Ratio	2.2%	0.1%	2.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: January 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
11.0	(0.7)	11.7	Medi-Cal	47.9	9.2	38.8
(3.3)	(0.6)	(2.7)	OCC	(7.0)	(7.0)	(0.0)
0.0	(0.0)	0.1	OneCare	(0.4)	(0.5)	0.1
0.0	(0.0)	0.1	PACE	1.5	0.0	1.4
7.8	**(1.4)**	**9.2**	**Operating**	**42.0**	**1.8**	**40.2**
4.2	0.4	3.8	Inv./Rental Inc, MCO tax	21.0	2.9	18.0
4.2	**0.4**	**3.8**	**Non-Operating**	**21.0**	**2.9**	**18.0**
11.9	**(1.0)**	**12.9**	**TOTAL**	**63.0**	**4.7**	**58.3**

Consolidated Revenue & Expense: January 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	511,489	236,373	747,862	14,287	1,453	304	763,906
REVENUES							
Capitation Revenue	$ 145,620,329	$ 109,655,200	$ 255,275,529	$ 23,164,191	$ 1,653,636	$ 2,263,254	$ 282,356,609
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	145,620,329	109,655,200	255,275,529	23,164,191	1,653,636	2,263,254	282,356,609
MEDICAL EXPENSES							
Provider Capitation	37,039,406	50,179,231	87,218,637	11,106,778	459,414		98,784,829
Facilities	19,863,002	22,046,572	41,909,574	4,366,250	408,804	538,043	47,222,671
Ancillary	-	-	-	611,315	11,451	-	622,766
Professional Claims	17,001,935	7,044,057	24,045,992	-	-	508,229	24,554,221
Prescription Drugs	18,978,651	21,370,752	40,349,402	5,618,682	519,563	200,769	46,688,416
MLTSS	32,670,939	2,835,555	35,506,494	1,224,594	5,807	(1,532)	36,735,362
Medical Management	2,206,114	1,070,898	3,277,012	1,249,973	86,356	664,989	5,278,331
Quality Incentives	759,431	408,704	1,168,135	269,600			1,437,735
Reinsurance & Other	421,754	286,720	708,474	174,329	6,000	157,839	1,046,642
Total Medical Expenses	128,941,233	105,242,488	234,183,721	24,621,520	1,497,395	2,068,337	262,370,973
Medical Loss Ratio	88.5%	96.0%	91.7%	106.3%	90.6%	91.4%	92.9%
GROSS MARGIN	**16,679,096**	**4,412,712**	**21,091,808**	**(1,457,330)**	**156,241**	**194,917**	**19,985,636**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,812,348	860,958	44,461	108,568	7,826,334
Professional fees			192,637	34,500	14,666	170	241,972
Purchased services			1,053,706	188,768	19,080	3,950	1,265,505
Printing & Postage			439,595	100,003	21,367	26,415	587,380
Depreciation & Amortization			383,366			2,068	385,434
Other expenses			1,572,234	42,098	113	2,168	1,616,613
Indirect cost allocation & Occupancy			(333,078)	589,123	44,020	3,624	303,689
Total Administrative Expenses			10,120,808	1,815,450	143,708	146,962	12,226,927
Admin Loss Ratio			4.0%	7.8%	8.7%	6.5%	4.3%
INCOME (LOSS) FROM OPERATIONS			10,971,000	(3,272,779)	12,533	47,955	7,758,709
INVESTMENT INCOME							4,186,441
TOTAL GRANT INCOME			(3,263)				(3,263)
OTHER INCOME			47				47
CHANGE IN NET ASSETS			**$ 10,967,784**	**$ (3,272,779)**	**$ 12,533**	**$ 47,955**	**$ 11,941,934**
BUDGETED CHANGE IN NET ASSETS			(721,019)	(588,423)	(46,136)	(48,431)	(987,342)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 11,688,804	$ (2,684,356)	$ 58,669	$ 96,386	$ 12,929,277

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CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: January 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,625,876	1,661,125	5,287,001	102,080	9,864	2,032	5,400,977
REVENUES							
Capitation Revenue	$ 947,244,806	$ 772,640,871	$ 1,719,885,676	$ 173,661,596	$ 10,781,848	$ 14,793,926	$ 1,919,123,046
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	947,244,806	772,640,871	1,719,885,676	173,661,596	10,781,848	14,793,926	1,919,123,046
MEDICAL EXPENSES							
Provider Capitation	250,617,021	352,456,760	603,073,780	80,600,630	2,928,993		686,603,402
Facilities	155,920,856	161,585,639	317,506,494	24,312,845	3,069,414	2,722,641	347,611,394
Ancillary	-	-	-	4,488,570	208,812	-	4,697,382
Professional Claims	110,511,858	43,714,631	154,226,488	-	-	3,030,850	157,257,338
Prescription Drugs	120,434,324	136,766,363	257,200,687	37,928,693	3,264,409	1,162,702	299,556,492
MLTSS	223,949,657	19,553,554	243,503,211	9,995,834	443,922	26,948	253,969,915
Medical Management	14,768,603	7,243,876	22,012,478	7,842,823	440,669	4,376,911	34,672,880
Quality Incentives	5,384,701	2,863,430	8,248,131	2,102,200		17,280	10,367,611
Reinsurance & Other	4,102,469	2,472,946	6,575,415	1,580,245	43,095	1,136,800	9,335,556
Total Medical Expenses	885,689,487	726,657,197	1,612,346,685	168,851,839	10,399,314	12,474,131	1,804,071,969
Medical Loss Ratio	93.5%	94.0%	93.7%	97.2%	96.5%	84.3%	94.0%
GROSS MARGIN	**61,555,318**	**45,983,673**	**107,538,992**	**4,809,757**	**382,534**	**2,319,795**	**115,051,077**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			42,329,808	5,315,869	236,029	682,644	48,564,351
Professional fees			1,098,709	214,798	102,667	6,414	1,422,587
Purchased services			4,913,205	1,255,274	104,092	57,212	6,329,783
Printing & Postage			2,256,402	519,911	64,074	47,523	2,887,909
Depreciation & Amortization			2,804,082			14,561	2,818,644
Other expenses			8,305,625	303,776	377	17,526	8,627,305
Indirect cost allocation & Occupancy			(2,100,921)	4,209,300	263,597	31,604	2,403,580
Total Administrative Expenses			59,606,911	11,818,928	770,835	857,485	73,054,159
Admin Loss Ratio			3.5%	6.8%	7.1%	5.8%	3.8%
INCOME (LOSS) FROM OPERATIONS			47,932,081	(7,009,172)	(388,301)	1,462,310	41,996,918
INVESTMENT INCOME							20,959,002
OTHER INCOME			744				744
CHANGE IN NET ASSETS			**$ 47,932,825**	**$ (7,009,172)**	**$ (388,301)**	**$ 1,462,310**	**$ 62,956,664**
BUDGETED CHANGE IN NET ASSETS			9,167,131	(6,962,484)	(467,487)	37,886	4,691,714
VARIANCE TO BUDGET - FAV (UNFAV)			$ 38,765,693	$ (46,688)	$ 79,186	$ 1,424,424	$ 58,264,950

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CalOptima A Public Agency Better. Together.

Balance Sheet:
As of January 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$464,736,693	Accounts Payable	$16,470,762
Investments	396,601,507	Medical Claims liability	713,456,996
Capitation receivable	329,899,166	Accrued Payroll Liabilities	11,494,059
Receivables - Other	21,505,253	Deferred Revenue	85,552,175
Prepaid expenses	6,827,680	Deferred Lease Obligations	76,306
		Capitation and Withholds	122,901,013
Total Current Assets	**1,219,570,299**	**Total Current Liabilities**	**949,951,310**
Capital Assets			
Furniture & Equipment	35,575,437		
Building/Leasehold Improvements	8,311,770		
505 City Parkway West	50,013,815		
	93,901,022		
Less: accumulated depreciation	(45,196,085)		
Capital assets, net	48,704,938	Other (than pensions) post employment benefits liability	25,439,057
Other Assets		Net Pension Liabilities	24,985,897
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	39,485,056	**TOTAL LIABILITIES**	**1,000,376,264**
Long-term Investments	509,100,533		
Total Board-designated Assets	548,585,589	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	548,885,589		
TOTAL ASSETS	**1,817,160,825**	TNE	81,915,494
		Funds in Excess of TNE	742,672,737
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	824,588,231
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,828,293,875**	**TOTAL LIABILITIES & FUND BALANCES**	**1,828,293,875**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis As of January 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	150,062,296				
	Tier 1 - Logan Circle	149,850,498				
	Tier 1 - Wells Capital	149,456,359				
Board-designated Reserve		449,369,153	310,342,744	478,453,417	139,026,409	(29,084,264)
TNE Requirement	Tier 2 - Logan Circle	99,216,436	81,915,494	81,915,494	17,300,941	17,300,941
	Consolidated:	**548,585,589**	**392,258,238**	**560,368,911**	**156,327,351**	**(11,783,323)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

January 2019

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CalOptima - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
763,906	783,802	(19,896)	-2.5%	Member Months	5,400,977	5,490,963	(89,986)	-1.6%
282,356,609	299,659,541	(17,302,931)	-5.8%	Revenues	1,919,123,046	1,960,439,140	(41,316,094)	-2.1%
262,370,973	288,061,736	25,690,763	8.9%	Medical Expenses	1,804,071,969	1,870,090,834	66,018,866	3.5%
12,226,927	13,001,814	774,887	6.0%	Administrative Expenses	73,054,159	88,573,258	15,519,100	17.5%
7,758,709	**(1,404,009)**	**9,162,718**	**652.6%**	**Operating Margin**	**41,996,918**	**1,775,047**	**40,221,872**	**2266.0%**
4,183,226	416,667	3,766,559	904.0%	Non Operating Income (Loss)	20,959,745	2,916,667	18,043,079	618.6%
11,941,934	**(987,342)**	**12,929,277**	**1309.5%**	**Change in Net Assets**	**62,956,664**	**4,691,714**	**58,264,950**	**1241.9%**
92.9%	96.1%	3.2%		Medical Loss Ratio	94.0%	95.4%	1.4%	
4.3%	4.3%	0.0%		Administrative Loss Ratio	3.8%	4.5%	0.7%	
2.7%	-0.5%	3.2%		Operating Margin Ratio	2.2%	0.1%	2.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Seven Months Ended January 31, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	747,862	767,311	(19,449)	(2 5%)
OneCare Connect	14,287	14,856	(569)	(3 8%)
OneCare	1,453	1,324	129	9 7%
PACE	304	311	(7)	(2 3%)
Total	763,906	783,802	(19,896)	(2 5%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,968	$ (721)	$ 11,689	1621 2%
OneCare Connect	(3,273)	(588)	(2,685)	(456 6%)
OneCare	13	(46)	59	128 3%
PACE	48	(48)	96	200 0%
505 Bldg	-	-	-	0 0%
Investment Income & Other	4,186	417	3,769	903 8%
Total	$ 11,942	$ (986)	$ 12,928	1311 2%

MLR

	Actual	Budget	% Point Var
Medi-Cal	91 7%	96 3%	4 5
OneCare Connect	106 3%	95 0%	(11 3)
OneCare	90 6%	94 8%	4 2

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,121	$ 10,764	$ 643	6 0%
OneCare Connect	1,815	1,920	105	5 4%
OneCare	144	133	(10)	(7 7%)
PACE	147	185	38	20 4%
Total	$ 12,227	$ 13,002	$ 775	6 0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	972	1,089	117
OneCare Connect	221	234	13
OneCare	5	6	1
PACE	69	88	19
Total	1,267	1,417	150

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	769	704	65
OneCare Connect	65	63	1
OneCare	280	221	60
PACE	4	4	1
Total	1,119	992	127

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,287,001	5,375,477	(88,476)	(1 6%)
OneCare Connect	102,080	104,184	(2,105	(2 0%)
OneCare	9,864	9,268	596	6 4%
PACE	2,032	2,033	(1)	(0 0%)
Total	5,400,977	5,490,962	(89,986)	(1 6%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 47,933	$ 9,167	$ 38,766	422 9%
OneCare Connect	(7,009)	(6,962)	(47)	(0 7%)
OneCare	(388)	(467)	79	16 9%
PACE	1,462	38	1,424	3747 4%
505 Bldg	-	-	-	0 0%
Investment Income & Other	20,960	2,917	18,043	618 5%
Total	$ 62,958	$ 4,693	$ 58,265	1241 5%

MLR

	Actual	Budget	% Point Var
Medi-Cal	93 7%	95 3%	1 6
OneCare Connect	97 2%	96 4%	(0 8)
OneCare	96 5%	95 9%	(0 5)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 59,607	$ 73,243	$ 13,637	18 6%
OneCare Connect	11,819	13,211	1,392	10 5%
OneCare	771	923	152	16 5%
PACE	857	1,195	338	28 3%
Total	$ 73,054	$ 88,573	$ 15,519	17 5%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	6,629	7,443	814
OneCare Connect	1,541	1,638	97
OneCare	34	42	8
PACE	441	554	113
Total	8,645	9,677	1,032

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	722	75
OneCare Connect	66	64	3
OneCare	289	221	68
PACE	5	4	1
Total	1,157	1,010	147

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended January 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	763,906		783,802		(19,896)	
REVENUE						
Medi-Cal	$ 255,275,529	$ 341.34	$ 268,968,468	$ 350.53	$ (13,692,939)	$ (9.19)
OneCare Connect	23,164,191	1,621 35	26,763,113	1,801.50	(3,598,922)	(180.15)
OneCare	1,653,636	1,138.08	1,663,917	1,256.73	(10,281)	(118.65)
PACE	2,263,254	7,444 92	2,264,043	7,279.88	(789)	165.04
Total Operating Revenue	282,356,609	369.62	299,659,541	382.32	(17,302,931)	(12.70)
MEDICAL EXPENSES						
Medi-Cal	234,183,721	313.14	258,925,648	337.45	24,741,927	24.31
OneCare Connect	24,621,520	1,723 35	25,431,579	1,711.87	810,059	(11.48)
OneCare	1,497,395	1,030 55	1,576,657	1,190.83	79,262	160.28
PACE	2,068,337	6,803.74	2,127,852	6,841.97	59,515	38.23
Total Medical Expenses	262,370,973	343.46	288,061,736	367.52	25,690,763	24.06
GROSS MARGIN	19,985,636	26.16	11,597,805	14.80	8,387,831	11.36
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,826,334	10.25	8,395,897	10.71	569,563	0.46
Professional fees	241,972	0.32	412,958	0.53	170,986	0.21
Purchased services	1,265,505	1.66	1,238,936	1.58	(26,569)	(0.08)
Printing & Postage	587,380	0.77	533,146	0.68	(54,235)	(0.09)
Depreciation & Amortization	385,434	0.50	464,167	0.59	78,733	0.09
Other expenses	1,616,613	2.12	1,584,478	2.02	(32,135)	(0.10)
Indirect cost allocation & Occupancy expense	303,689	0.40	372,233	0.47	68,544	0.07
Total Administrative Expenses	12,226,927	16.01	13,001,814	16.59	774,887	0.58
INCOME (LOSS) FROM OPERATIONS	7,758,709	10.16	(1,404,009)	(1.79)	9,162,718	11.95
INVESTMENT INCOME						
Interest income	2,366,261	3.10	416,667	0.53	1,949,594	2.57
Realized gain/(loss) on investments	(431,862)	(0.57)	-	-	(431,862)	(0.57)
Unrealized gain/(loss) on investments	2,252,041	2.95	-	-	2,252,041	2.95
Total Investment Income	4,186,441	5.48	416,667	0.53	3,769,774	4.95
TOTAL GRANT INCOME	(3,263)	-	-	-	(3,263)	-
OTHER INCOME	47	-	-	-	47	-
CHANGE IN NET ASSETS	**11,941,934**	**15.63**	**(987,342)**	**(1.26)**	**12,929,277**	**16.89**
MEDICAL LOSS RATIO	**92.9%**		**96.1%**		**3 2%**	
ADMINISTRATIVE LOSS RATIO	**4.3%**		**4.3%**		**0.0%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	5,400,977		5,490,962		(89,985)	
REVENUE						
Medi-Cal	$ 1,719,885,676	$ 325.30	$ 1,758,716,704	$ 327.17	$ (38,831,027)	$ (1.87)
OneCare Connect	173,661,596	1,701.23	175,766,551	1,687.08	(2,104,955)	14.15
OneCare	10,781,848	1,093.05	11,211,822	1,209.73	(429,974)	(116.68)
PACE	14,793,926	7,280.48	14,744,063	7,252.37	49,863	28.11
Total Operating Revenue	1,919,123,046	355.33	1,960,439,140	357.03	(41,316,094)	(1.70)
MEDICAL EXPENSES						
Medi-Cal	1,612,346,685	304.96	1,676,306,150	311.84	63,959,466	6.88
OneCare Connect	168,851,839	1,654.11	169,517,716	1,627.10	665,877	(27.01)
OneCare	10,399,314	1,054.27	10,756,140	1,160.57	356,826	106.30
PACE	12,474,131	6,138.84	13,510,828	6,645.76	1,036,697	506.92
Total Medical Expenses	1,804,071,969	334.03	1,870,090,834	340.58	66,018,866	6.55
GROSS MARGIN	115,051,077	21.30	90,348,305	16.45	24,702,772	4.85
ADMINISTRATIVE EXPENSES						
Salaries and benefits	48,564,351	8.99	56,369,531	10.27	7,805,180	1.28
Professional fees	1,422,587	0.26	2,888,208	0.53	1,465,621	0.27
Purchased services	6,329,783	1.17	8,655,438	1.58	2,325,655	0.41
Printing & Postage	2,887,909	0.53	3,732,018	0.68	844,109	0.15
Depreciation & Amortization	2,818,644	0.52	3,249,164	0.59	430,520	0.07
Other expenses	8,627,305	1.60	11,073,267	2.02	2,445,962	0.42
Indirect cost allocation & Occupancy expense	2,403,580	0.45	2,605,634	0.47	202,054	0.02
Total Administrative Expenses	73,054,159	13.53	88,573,258	16.13	15,519,100	2.60
INCOME (LOSS) FROM OPERATIONS	41,996,918	7.78	1,775,047	0.32	40,221,872	7.46
INVESTMENT INCOME						
Interest income	18,190,397	3.37	2,916,667	0.53	15,273,730	2.84
Realized gain/(loss) on investments	(1,839,137)	(0.34)	-	-	(1,839,137)	(0.34)
Unrealized gain/(loss) on investments	4,607,742	0.85	-	-	4,607,742	0.85
Total Investment Income	20,959,002	3.88	2,916,667	0.53	18,042,335	3.35
OTHER INCOME	744	-	-	-	744	-
CHANGE IN NET ASSETS	**62,956,664**	**11.66**	**4,691,714**	**0.85**	**58,264,950**	**10.81**
MEDICAL LOSS RATIO	**94.0%**		**95.4%**		**1.4%**	
ADMINISTRATIVE LOSS RATIO	**3.8%**		**4.5%**		**0.7%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	511,489	236,373	747,862	14,287	1,453	304	763,906
REVENUES							
Capitation Revenue	$ 145,620,329	$ 109,655,200	$ 255,275,529	$ 23,164,191	$ 1,653,636	$ 2,263,254	$ 282,356,609
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	145,620,329	109,655,200	255,275,529	23,164,191	1,653,636	2,263,254	282,356,609
MEDICAL EXPENSES							
Provider Capitation	37,039,406	50,179,231	87,218,637	11,106,778	459,414		98,784,829
Facilities	19,863,002	22,046,572	41,909,574	4,366,250	408,804	538,043	47,222,671
Ancillary	-	-	-	611,315	11,451	-	622,766
Professional Claims	17,001,935	7,044,057	24,045,992	-	-	508,229	24,554,221
Prescription Drugs	18,978,651	21,370,752	40,349,402	5,618,682	519,563	200,769	46,688,416
MLTSS	32,670,939	2,835,555	35,506,494	1,224,594	5,807	(1,532)	36,735,362
Medical Management	2,206,114	1,070,898	3,277,012	1,249,973	86,356	664,989	5,278,331
Quality Incentives	759,431	408,704	1,168,135	269,600			1,437,735
Reinsurance & Other	421,754	286,720	708,474	174,329	6,000	157,839	1,046,642
Total Medical Expenses	128,941,233	105,242,488	234,183,721	24,621,520	1,497,395	2,068,337	262,370,973
Medical Loss Ratio	88 5%	96 0%	91 7%	106 3%	90 6%	91 4%	92 9%
GROSS MARGIN	**16,679,096**	**4,412,712**	**21,091,808**	**(1,457,330)**	**156,241**	**194,917**	**19,985,636**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,812,348	860,958	44,461	108,568	7,826,334
Professional fees			192,637	34,500	14,666	170	241,972
Purchased services			1,053,706	188,768	19,080	3,950	1,265,505
Printing & Postage			439,595	100,003	21,367	26,415	587,380
Depreciation & Amortization			383,366			2,068	385,434
Other expenses			1,572,234	42,098	113	2,168	1,616,613
Indirect cost allocation & Occupancy			(333,078)	589,123	44,020	3,624	303,689
Total Administrative Expenses			10,120,808	1,815,450	143,708	146,962	12,226,927
Admin Loss Ratio			4 0%	7 8%	8 7%	6 5%	4 3%
INCOME (LOSS) FROM OPERATIONS			10,971,000	(3,272,779)	12,533	47,955	7,758,709
INVESTMENT INCOME							4,186,441
TOTAL GRANT INCOME			(3,263)				(3,263)
OTHER INCOME			47				47
CHANGE IN NET ASSETS			**$ 10,967,784**	**$ (3,272,779)**	**$ 12,533**	**$ 47,955**	**$ 11,941,934**
BUDGETED CHANGE IN NET ASSETS			(721,019)	(588,423)	(46,136)	(48,431)	(987,342)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 11,688,804	$ (2,684,356)	$ 58,669	$ 96,386	$ 12,929,277

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,625,876	1,661,125	5,287,001	102,080	9,864	2,032	5,400,977
REVENUES							
Capitation Revenue	$ 947,244,806	$ 772,640,871	$ 1,719,885,676	$ 173,661,596	$ 10,781,848	$ 14,793,926	$1,919,123,046
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	947,244,806	772,640,871	1,719,885,676	173,661,596	10,781,848	14,793,926	1,919,123,046
MEDICAL EXPENSES							
Provider Capitation	250,617,021	352,456,760	603,073,780	80,600,630	2,928,993		686,603,402
Facilities	155,920,856	161,585,639	317,506,494	24,312,845	3,069,414	2,722,641	347,611,394
Ancillary	-	-	-	4,488,570	208,812	-	4,697,382
Professional Claims	110,511,858	43,714,631	154,226,488	-	-	3,030,850	157,257,338
Prescription Drugs	120,434,324	136,766,363	257,200,687	37,928,693	3,264,409	1,162,702	299,556,492
MLTSS	223,949,657	19,553,554	243,503,211	9,995,834	443,922	26,948	253,969,915
Medical Management	14,768,603	7,243,876	22,012,478	7,842,823	440,669	4,376,911	34,672,880
Quality Incentives	5,384,701	2,863,430	8,248,131	2,102,200		17,280	10,367,611
Reinsurance & Other	4,102,469	2,472,946	6,575,415	1,580,245	43,095	1,136,800	9,335,556
Total Medical Expenses	885,689,487	726,657,197	1,612,346,685	168,851,839	10,399,314	12,474,131	1,804,071,969
Medical Loss Ratio	93 5%	94 0%	93 7%	97 2%	96 5%	84 3%	94 0%
GROSS MARGIN	**61,555,318**	**45,983,673**	**107,538,992**	**4,809,757**	**382,534**	**2,319,795**	**115,051,077**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			42,329,808	5,315,869	236,029	682,644	48,564,351
Professional fees			1,098,709	214,798	102,667	6,414	1,422,587
Purchased services			4,913,205	1,255,274	104,092	57,212	6,329,783
Printing & Postage			2,256,402	519,911	64,074	47,523	2,887,909
Depreciation & Amortization			2,804,082			14,561	2,818,644
Other expenses			8,305,625	303,776	377	17,526	8,627,305
Indirect cost allocation & Occupancy			(2,100,921)	4,209,300	263,597	31,604	2,403,580
Total Administrative Expenses			59,606,911	11,818,928	770,835	857,485	73,054,159
Admin Loss Ratio			3 5%	6 8%	7 1%	5 8%	3 8%
INCOME (LOSS) FROM OPERATIONS			47,932,081	(7,009,172)	(388,301)	1,462,310	41,996,918
INVESTMENT INCOME							20,959,002
OTHER INCOME			744				744
CHANGE IN NET ASSETS			**$ 47,932,825**	**$ (7,009,172)**	**$ (388,301)**	**$ 1,462,310**	**$ 62,956,664**
BUDGETED CHANGE IN NET ASSETS			9,167,131	(6,962,484)	(467,487)	37,886	4,691,714
VARIANCE TO BUDGET - FAV (UNFAV)			$ 38,765,693	$ (46,688)	$ 79,186	$ 1,424,424	$ 58,264,950

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CalOptima
A Public Agency
Better. Together.

January 31, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $11.9 million, $12.9 million favorable to budget
- Operating surplus is $7.8 million, with a surplus in non-operating income of $4.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $63.0 million, $58.3 million favorable to budget
- Operating surplus is $42.0 million, with a surplus in non-operating of $21.0 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
11.0	(0.7)	11.7	Medi-Cal	47.9	9.2	38.8
(3.3)	(0.6)	(2.7)	OCC	(7.0)	(7.0)	(0.0)
0.0	(0.0)	0.1	OneCare	(0.4)	(0.5)	0.1
0.0	(0.0)	0.1	PACE	1.5	0.0	1.4
7.8	**(1.4)**	**9.2**	**Operating**	**42.0**	**1.8**	**40.2**
4.2	0.4	3.8	Inv./Rental Inc, MCO tax	21.0	2.9	18.0
4.2	**0.4**	**3.8**	**Non-Operating**	**21.0**	**2.9**	**18.0**
11.9	**(1.0)**	**12.9**	**TOTAL**	**63.0**	**4.7**	**58.3**

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CalOptima - Consolidated
Enrollment Summary
For the Seven Months Ended January 31, 2019

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
64,506	65,115	(609)	(0.9%)	Aged	448,459	451,101	(2,642)	(0.6%)
596	620	(24)	(3.9%)	BCCTP	4,243	4,340	(97)	(2.2%)
46,213	44,118	2,095	4.7%	Disabled	328,931	326,877	2,054	0.6%
305,194	304,863	331	0.1%	TANF Child	2,167,238	2,197,338	(30,100)	(1.4%)
91,564	93,611	(2,047)	(2.2%)	TANF Adult	653,142	663,344	(10,200)	(1.5%)
3,416	3,515	(99)	(2.8%)	LTC	23,863	24,374	(511)	(2.1%)
236,373	242,967	(6,594)	(2.7%)	MCE	1,661,125	1,695,603	(34,478)	(2.0%)
-	12,502	(12,502)	(100.0%)	WCM	-	12,502	(12,502)	(100.0%)
747,862	**767,311**	**(19,449)**	**(2.5%)**	**Medi-Cal**	**5,287,001**	**5,375,477**	**(88,476)**	**(1.6%)**
14,287	**14,856**	**(569)**	**(3.8%)**	**OneCare Connect**	**102,080**	**104,185**	**(2,105)**	**(2.0%)**
304	**311**	**(7)**	**(2.3%)**	**PACE**	**2,032**	**2,033**	**(1)**	**(0.0%)**
1,453	**1,324**	**129**	**9.7%**	**OneCare**	**9,864**	**9,268**	**596**	**6.4%**
763,906	**783,802**	**(19,896)**	**(2.5%)**	**CalOptima Total**	**5,400,977**	**5,490,963**	**(89,986)**	**(1.6%)**

				Enrollment (By Network)				
165,097	167,433	(2,336)	(1.4%)	HMO	1,167,612	1,175,836	(8,224)	(0.7%)
214,028	221,981	(7,953)	(3.6%)	PHC	1,522,267	1,555,212	(32,945)	(2.1%)
191,926	189,310	2,616	1.4%	Shared Risk Group	1,350,525	1,342,109	8,416	0.6%
176,811	188,587	(11,776)	(6.2%)	Fee for Service	1,246,597	1,302,320	(55,723)	(4.3%)
747,862	**767,311**	**(19,449)**	**(2.5%)**	**Medi-Cal**	**5,287,001**	**5,375,477**	**(88,476)**	**(1.6%)**
14,287	**14,856**	**(569)**	**(3.8%)**	**OneCare Connect**	**102,080**	**104,185**	**(2,105)**	**(2.0%)**
304	**311**	**(7)**	**(2.3%)**	**PACE**	**2,032**	**2,033**	**(1)**	**(0.0%)**
1,453	**1,324**	**129**	**9.7%**	**OneCare**	**9,864**	**9,268**	**596**	**6.4%**
763,906	**783,802**	**(19,896)**	**(2.5%)**	**CalOptima Total**	**5,400,977**	**5,490,963**	**(89,986)**	**(1.6%)**

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CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	MMs
HMO													
Aged	3,844	3,866	3,841	3,841	3,854	3,842	3,837						26,925
BCCTP	1	1	1	1	1	1	1						7
Disabled	6,744	6,789	6,789	6,811	6,838	6,813	6,807						47,591
TANF Child	58,435	58,267	58,162	58,110	57,723	56,929	56,504						404,130
TANF Adult	29,473	29,373	29,404	29,529	29,392	29,131	28,926						205,228
LTC	2	2	3	4	1	1	2						15
MCE	68,597	68,602	68,919	69,646	69,547	69,385	69,020						483,716
WCM	-	-	-	-	-	-	-						-
	167,096	**166,900**	**167,119**	**167,942**	**167,356**	**166,102**	**165,097**						**1,167,612**
PHC													
Aged	1,600	1,621	1,620	1,673	1,673	1,645	1,593						11,425
BCCTP	-	-	-	-	-	-	-						-
Disabled	7,243	7,239	7,230	7,212	7,226	7,231	7,190						50,571
TANF Child	157,157	156,755	157,444	158,169	157,483	156,497	155,299						1,098,804
TANF Adult	12,731	12,684	12,787	12,785	12,596	12,476	12,049						88,108
LTC	-	1	-	-	-	1	1						3
MCE	39,060	38,992	39,234	39,568	39,402	39,204	37,896						273,356
WCM	-	-	-	-	-	-	-						
	217,791	**217,292**	**218,315**	**219,407**	**218,380**	**217,054**	**214,028**						**1,522,267**
Shared Risk Group													
Aged	3,593	3,605	3,621	3,642	3,610	3,589	3,635						25,295
BCCTP	-	-	-	-	-	-	-						-
Disabled	7,626	7,554	7,486	7,473	7,493	7,463	7,409						52,504
TANF Child	67,471	67,226	67,159	67,251	66,739	66,119	65,717						467,682
TANF Adult	30,936	30,567	30,622	30,670	30,417	30,217	29,947						213,376
LTC	2	-	1	1	-	2	-						6
MCE	83,554	83,443	84,008	85,253	85,270	84,916	85,218						591,662
WCM	-	-	-	-	-	-	-						-
	193,182	**192,395**	**192,897**	**194,290**	**193,529**	**192,306**	**191,926**						**1,350,525**
Fee for Service (Dual)													
Aged	49,903	50,943	50,657	50,741	51,018	51,265	51,130						355,657
BCCTP	16	15	18	14	13	11	11						98
Disabled	20,706	20,863	20,741	20,761	20,812	20,921	20,739						145,543
TANF Child	2	3	2	2	1	2	2						14
TANF Adult	1,081	1,083	1,064	1,055	1,038	1,029	1,028						7,378
LTC	3,025	3,019	3,007	3,077	3,079	3,096	3,062						21,365
MCE	2,327	2,367	2,416	2,388	2,237	2,141	2,086						15,962
WCM	-	-	-	-	-	-	-						-
	77,060	**78,293**	**77,905**	**78,038**	**78,198**	**78,465**	**78,058**						**546,017**
Fee for Service (Non-Dual)													
Aged	4,702	3,727	4,153	4,118	4,018	4,128	4,311						29,157
BCCTP	613	596	601	581	589	574	584						4,138
Disabled	4,802	4,672	4,617	4,678	5,209	4,676	4,068						32,722
TANF Child	30,166	31,801	28,765	26,649	25,545	26,010	27,672						196,608
TANF Adult	20,308	20,588	20,198	19,628	19,315	19,401	19,614						139,052
LTC	353	360	367	347	356	340	351						2,474
MCE	44,399	44,410	43,161	40,810	40,393	41,103	42,153						296,429
WCM	-	-	-	-	-	-	-						-
	105,343	**106,154**	**101,862**	**96,811**	**95,425**	**96,232**	**98,753**						**700,580**
MEDI-CAL TOTAL													
Aged	63,642	63,762	63,892	64,015	64,173	64,469	64,506						448,459
BCCTP	630	612	620	596	603	586	596						4,243
Disabled	47,121	47,117	46,863	46,935	47,578	47,104	46,213						328,931
TANF Child	313,231	314,052	311,532	310,181	307,491	305,557	305,194						2,167,238
TANF Adult	94,529	94,295	94,075	93,667	92,758	92,254	91,564						653,142
LTC	3,382	3,382	3,378	3,429	3,436	3,440	3,416						23,863
MCE	237,937	237,814	237,738	237,665	236,849	236,749	236,373						1,661,125
WCM	-	-	-	-	-	-	-						-
	760,472	**761,034**	**758,098**	**756,488**	**752,888**	**750,159**	**747,862**						**5,287,001**
PACE	273	286	286	289	295	299	304						2,032
OneCare	1,390	1,384	1,375	1,404	1,423	1,435	1,453						9,864
OneCare Connect	16,399	13,137	14,681	14,665	14,610	14,301	14,287						102,080
TOTAL	**778,534**	**775,841**	**774,440**	**772,846**	**769,216**	**766,194**	**763,906**						**5,400,977**

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ENROLLMENT:

Overall January enrollment was 763,906

- Unfavorable to budget 19,896 or 2.5%
- Decreased 2,288 or 0.3% from prior month (December 2018)
- Decreased 31,051 or 3.9% from prior year (January 2018)

Medi-Cal enrollment was 747,862

- Unfavorable to budget 19,449
    - Whole Child Model (WCM) unfavorable 12,502
    - Medi-Cal Expansion (MCE) unfavorable 6,594
    - Temporary Assistance for Needy Families (TANF) unfavorable 1,716
    - Seniors and Persons with Disabilities (SPD) favorable 1,462
    - Long-Term Care (LTC) unfavorable 99
- Decreased 2,297 from prior month

OneCare Connect enrollment was 14,287

- Unfavorable to budget 569
- Decreased 14 from prior month

OneCare enrollment was 1,453

- Favorable to budget 129
- Increased 18 from prior month

PACE enrollment was 304

- Unfavorable to budget 7
- Increased 5 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
747,862	**767,311**	**(19,449)**	**(2.5%)**	**Member Months**	**5,287,001**	**5,375,477**	**(88,476)**	**(1.6%)**
				Revenues				
255,275,529	268,968,468	(13,692,939)	(5 1%)	Capitation revenue	1,719,885,676	1,758,716,704	(38,831,027)	(2 2%)
-	-	-	0 0%	Other income	-	-	-	0 0%
255,275,529	**268,968,468**	**(13,692,939)**	**(5.1%)**	**Total Operating Revenue**	**1,719,885,676**	**1,758,716,704**	**(38,831,027)**	**(2.2%)**
				Medical Expenses				
88,386,772	95,456,901	7,070,129	7 4%	Provider capitation	611,321,911	603,253,891	(8,068,020)	(1 3%)
41,909,574	46,661,630	4,752,056	10 2%	Facilities	317,506,494	308,808,051	(8,698,443)	(2 8%)
24,045,992	29,401,268	5,355,275	18 2%	Professional Claims	154,226,488	200,038,911	45,812,422	22 9%
40,349,402	45,713,381	5,363,978	11 7%	Prescription drugs	257,200,687	278,735,739	21,535,052	7 7%
35,506,494	37,143,353	1,636,858	4 4%	MLTSS	243,503,211	255,824,460	12,321,249	4 8%
3,277,012	4,018,482	741,470	18 5%	Medical management	22,012,478	25,930,661	3,918,183	15 1%
708,474	530,634	(177,840)	(33 5%)	Reinsurance & other	6,575,415	3,714,438	(2,860,977)	(77 0%)
234,183,721	**258,925,648**	**24,741,927**	**9.6%**	**Total Medical Expenses**	**1,612,346,685**	**1,676,306,150**	**63,959,466**	**3.8%**
21,091,808	**10,042,820**	**11,048,988**	**110.0%**	**Gross Margin**	**107,538,992**	**82,410,553**	**25,128,438**	**30.5%**
				Administrative Expenses				
6,812,348	7,306,002	493,654	6 8%	Salaries, wages & employee benefits	42,329,808	49,076,253	6,746,445	13 7%
192,637	350,275	157,638	45 0%	Professional fees	1,098,709	2,449,425	1,350,716	55 1%
1,053,706	949,069	(104,638)	(11 0%)	Purchased services	4,913,205	6,626,371	1,713,165	25 9%
439,595	423,310	(16,286)	(3 8%)	Printing and postage	2,256,402	2,963,167	706,765	23 9%
383,366	462,076	78,710	17 0%	Depreciation and amortization	2,804,082	3,234,529	430,447	13 3%
1,572,234	1,496,700	(75,534)	(5 0%)	Other operating expenses	8,305,625	10,458,817	2,153,192	20 6%
(333,078)	(223,592)	109,486	49 0%	Indirect cost allocation, Occupancy Expense	(2,100,921)	(1,565,139)	535,782	34 2%
10,120,808	**10,763,839**	**643,031**	**6.0%**	**Total Administrative Expenses**	**59,606,911**	**73,243,422**	**13,636,511**	**18.6%**
				Operating Tax				
11,330,315	10,940,770	389,545	3 6%	Tax Revenue	80,088,526	75,593,346	4,495,180	5 9%
11,330,315	10,940,770	(389,545)	(3 6%)	Premium tax expense	80,088,526	64,809,208	(15,279,318)	(23 6%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
(0)	-	0	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
21,061	249,874	(228,813)	(91 6%)	Grant Revenue	311,217	1,749,118	(1,437,901)	(82 2%)
5,738	223,107	217,370	97 4%	Grant expense - Service Partner	204,638	1,561,749	1,357,112	86 9%
18,586	26,767	8,181	30 6%	Grant expense - Administrative	106,580	187,369	80,789	43 1%
(3,263)	-	(3,263)	**0.0%**	**Total Grant Income**	-	-	-	**0.0%**
(0)	**-**	**(0)**	**0.0%**	**QAF and IGT - Net**	**-**	**-**	**-**	**0.0%**
47	**-**	**47**	**0.0%**	**Other income**	**744**	**-**	**744**	**0.0%**
47	-	47	0 0%	MC Other income	744	-	744	0 0%
10,967,784	**(721,019)**	**11,688,804**	**1621.1%**	**Change in Net Assets**	**47,932,825**	**9,167,131**	**38,765,693**	**422.9%**
91.7%	***96.3%***	***4.5%***	***4.7%***	***Medical Loss Ratio***	***93.7%***	***95.3%***	***1.6%***	***1.6%***
4.0%	***4.0%***	***0.0%***	***0.9%***	***Admin Loss Ratio***	***3.5%***	***4.2%***	***0.7%***	***16.8%***

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MEDI-CAL INCOME STATEMENT– JANUARY MONTH:

REVENUES of $255.3 million are unfavorable to budget $13.7 million, driven by:

- Unfavorable volume related variance of $6.8 million
- Unfavorable price related variance of $6.9 million due to:
    - $22.9 million of WCM revenue, offset by
    - $6.3 million Coordinated Care Initiative (CCI) revenue
    - $4.0 million prior year (PY) CCI revenue
    - $2.3 million due to favorable rates

MEDICAL EXPENSES are $234.2 million, favorable to budget $24.7 million due to:

- **Provider Capitation** expense is favorable to budget $7.1 million due to the delay of WCM, resulting in $12.0 million favorable variance, offset by capitation expenses for Proposition 56 of $2.3 million and Child Health and Disability Prevention Program (CHDP) of $2.0 million that were budgeted in Professional Claims
- **Prescription Drug** expense is favorable to budget $5.4 million
- **Professional Claims** expense is favorable to budget $5.4 million due to CHDP expenses of $2.0 million, Behavioral Health Treatment (BHT) expenses of $2.5 million, Proposition 56 expenses of $2.6 million and Non-Medical Transportation (NMT), offset by increased Incurred But Not Reported claims (IBNR) liability
- **Facilities** expense is favorable to budget $4.8 million due to WCM expenses of $2.7 and IBNR

ADMINISTRATIVE EXPENSES are $10.1 million, favorable to budget $0.6 million, driven by:

- **Salary & Benefits**: $0.5 million favorable to budget due to open positions
- **Other Non-Salary**: $0.1 million favorable to budget

CHANGE IN NET ASSETS is $11.0 million for the month, $11.7 million favorable to budget

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Seven Months Ending January 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,287	**14,856**	**(569)**	**(3.8%)**	**Member Months**	**102,080**	**104,185**	**(2,105)**	**(2.0%)**
				Revenues				
2,074,682	3,223,952	(1,149,270)	(35 6%)	Medi-Cal Capitation revenue	17,880,881	23,103,023	(5,222,142)	(22 6%)
16,450,648	18,697,528	(2,246,880)	(12 0%)	Medicare Capitation revenue part C	120,108,193	119,659,216	448,977	0 4%
4,638,862	4,841,633	(202,771)	(4 2%)	Medicare Capitation revenue part D	35,672,522	33,004,312	2,668,210	8 1%
-	-	-	0 0%	Other Income	-	-	-	0 0%
23,164,191	**26,763,113**	**(3,598,922)**	**(13.4%)**	**Total Operating Revenue**	**173,661,596**	**175,766,551**	**(2,104,955)**	**(1.2%)**
				Medical Expenses				
11,376,378	12,428,489	1,052,111	8 5%	Provider capitation	82,702,830	80,566,608	(2,136,222)	(2 7%)
4,366,250	3,779,522	(586,728)	(15 5%)	Facilities	24,312,845	25,303,492	990,647	3 9%
611,315	711,943	100,628	14 1%	Ancillary	4,488,570	4,616,124	127,554	2 8%
1,224,594	1,631,123	406,529	24 9%	Long Term Care	9,995,834	11,678,282	1,682,448	14 4%
5,618,682	5,403,534	(215,148)	(4 0%)	Prescription drugs	37,928,693	37,238,461	(690,232)	(1 9%)
1,249,973	1,345,054	95,081	7 1%	Medical management	7,842,823	9,100,581	1,257,758	13 8%
174,329	131,914	(42,415)	(32 2%)	Other medical expenses	1,580,245	1,014,168	(566,077)	(55 8%)
24,621,520	**25,431,579**	**810,059**	**3.2%**	**Total Medical Expenses**	**168,851,839**	**169,517,716**	**665,877**	**0.4%**
(1,457,330)	**1,331,534**	**(2,788,864)**	**(209.4%)**	**Gross Margin**	**4,809,757**	**6,248,835**	**(1,439,078)**	**(23.0%)**
				Administrative Expenses				
860,958	904,993	44,035	4 9%	Salaries, wages & employee benefits	5,315,869	6,106,572	790,702	12 9%
34,500	42,917	8,417	19 6%	Professional fees	214,798	300,417	85,619	28 5%
188,768	251,415	62,647	24 9%	Purchased services	1,255,274	1,759,906	504,631	28 7%
100,003	86,202	(13,802)	(16 0%)	Printing and postage	519,911	603,412	83,501	13 8%
-	-	-	0 0%	Depreciation & amortization	-	-	-	0 0%
42,098	77,036	34,939	45 4%	Other operating expenses	303,776	539,255	235,479	43 7%
589,123	557,394	(31,729)	(5 7%)	Indirect cost allocation	4,209,300	3,901,758	(307,542)	(7 9%)
1,815,450	**1,919,957**	**104,507**	**5.4%**	**Total Administrative Expenses**	**11,818,928**	**13,211,319**	**1,392,391**	**10.5%**
				Operating Tax				
-	-	-	0 0%	Tax Revenue	-	-	-	0 0%
-	-	-	0 0%	Premium tax expense	-	-	-	0 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
(3,272,779)	**(588,423)**	**(2,684,356)**	**(456.2%)**	**Change in Net Assets**	**(7,009,172)**	**(6,962,484)**	**(46,688)**	**(0.7%)**
106.3%	***95.0%***	***(11.3%)***	***(11.9%)***	***Medical Loss Ratio***	***97.2%***	***96.4%***	***(0.8%)***	***(0.8%)***
7.8%	***7.2%***	***(0.7%)***	***(9.2%)***	***Admin Loss Ratio***	***6.8%***	***7.5%***	***0.7%***	***9.5%***

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ONECARE CONNECT INCOME STATEMENT – JANUARY MONTH:

REVENUES of $23.2 million are unfavorable to budget $3.6 million due to:

- Unfavorable volume related variance of $1.0 million
- Unfavorable price related variance of $2.6 million due to lower than projected rates

MEDICAL EXPENSES of $24.6 million are favorable to budget $0.8 million

ADMINISTRATIVE EXPENSES of $1.8 million are favorable to $0.1 million

CHANGE IN NET ASSETS is ($3.3) million, $2.7 million unfavorable to budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,453	**1,324**	**129**	**9.7%**	**Member Months**	**9,864**	**9,268**	**596**	**6.4%**
				Revenues				
1,262,396	1,156,554	105,843	9.2%	Medicare Part C revenue	6,907,859	7,710,558	(802,699)	(10.4%)
391,239	507,363	(116,124)	(22.9%)	Medicare Part D revenue	3,873,989	3,501,264	372,725	10.6%
1,653,636	**1,663,917**	**(10,281)**	**(0.6%)**	**Total Operating Revenue**	**10,781,848**	**11,211,822**	**(429,974)**	**(3.8%)**
				Medical Expenses				
459,414	458,662	(752)	(0.2%)	Provider capitation	2,928,993	3,148,976	219,984	7.0%
408,804	536,756	127,953	23.8%	Inpatient	3,069,414	3,640,363	570,949	15.7%
11,451	59,639	48,188	80.8%	Ancillary	208,812	391,967	183,155	46.7%
5,807	26,857	21,051	78.4%	Skilled nursing facilities	443,922	186,269	(257,653)	(138.3%)
519,563	450,498	(69,066)	(15.3%)	Prescription drugs	3,264,409	3,100,670	(163,739)	(5.3%)
86,356	34,481	(51,875)	(150.4%)	Medical management	440,669	238,748	(201,921)	(84.6%)
6,000	9,763	3,763	38.5%	Other medical expenses	43,095	49,147	6,052	12.3%
1,497,395	**1,576,657**	**79,262**	**5.0%**	**Total Medical Expenses**	**10,399,314**	**10,756,140**	**356,826**	**3.3%**
156,241	**87,260**	**68,981**	**79.1%**	**Gross Margin**	**382,534**	**455,682**	**(73,148)**	**(16.1%)**
				Administrative Expenses				
44,461	41,317	(3,144)	(7.6%)	Salaries, wages & employee benefits	236,029	278,614	42,585	15.3%
14,666	19,600	4,934	25.2%	Professional fees	102,667	137,200	34,533	25.2%
19,080	17,425	(1,655)	(9.5%)	Purchased services	104,092	121,975	17,883	14.7%
21,367	13,206	(8,161)	(61.8%)	Printing and postage	64,074	92,441	28,368	30.7%
113	6,883	6,770	98.4%	Other operating expenses	377	48,183	47,807	99.2%
44,020	34,965	(9,055)	(25.9%)	Indirect cost allocation, occupancy expense	263,597	244,755	(18,842)	(7.7%)
143,708	**133,396**	**(10,312)**	**(7.7%)**	**Total Administrative Expenses**	**770,835**	**923,169**	**152,334**	**16.5%**
12,533	**(46,136)**	**58,669**	**127.2%**	**Change in Net Assets**	**(388,301)**	**(467,487)**	**79,186**	**16.9%**
90.6%	***94.8%***	***4.2%***	***4.4%***	***Medical Loss Ratio***	***96.5%***	***95.9%***	***(0.5%)***	***(0.5%)***
8.7%	***8.0%***	***(0.7%)***	***(8.4%)***	***Admin Loss Ratio***	***7.1%***	***8.2%***	***1.1%***	***13.2%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
304	**311**	**(7)**	**(2.3%)**	**Member Months**	**2,032**	**2,033**	**(1)**	**0.0%**
				Revenues				
1,741,918	1,742,118	(200)	(0 0%)	Medi-Cal capitation revenue	11,214,746	11,381,062	(166,316)	(1 5%)
409,796	421,410	(11,614)	(2 8%)	Medicare Part C revenue	2,830,966	2,709,210	121,756	4 5%
111,540	100,515	11,025	11 0%	Medicare Part D revenue	748,213	653,791	94,422	14 4%
2,263,254	**2,264,043**	**(789)**	**(0.0%)**	**Total Operating Revenue**	**14,793,926**	**14,744,063**	**49,863**	**0.3%**
				Medical Expenses				
664,989	805,482	140,493	17 4%	Medical Management	4,376,911	4,992,963	616,052	12 3%
538,043	477,020	(61,023)	(12 8%)	Claims payments to hospitals	2,722,641	3,061,995	339,354	11 1%
508,229	501,668	(6,561)	(1 3%)	Professional claims	3,030,850	3,260,573	229,723	7 0%
157,839	138,641	(19,198)	(13 8%)	Patient transportation	1,136,800	906,291	(230,509)	(25 4%)
200,769	181,834	(18,935)	(10 4%)	Prescription drugs	1,162,702	1,177,312	14,610	1 2%
(1,532)	20,207	21,739	107 6%	MLTSS	26,948	91,744	64,796	70 6%
-	3,000	3,000	100 0%	Other Expenses	17,280	19,950	2,670	13 4%
2,068,337	**2,127,852**	**59,515**	**2.8%**	**Total Medical Expenses**	**12,474,131**	**13,510,828**	**1,036,697**	**7.7%**
194,917	**136,191**	**58,726**	**43.1%**	**Gross Margin**	**2,319,795**	**1,233,235**	**1,086,560**	**88.1%**
				Administrative Expenses				
108,568	143,585	35,018	24 4%	Salaries, wages & employee benefits	682,644	908,092	225,448	24 8%
170	167	(3)	(2 0%)	Professional fees	6,414	1,167	(5,248)	(449 8%)
3,950	21,027	17,076	81 2%	Purchased services	57,212	147,187	89,975	61 1%
26,415	10,428	(15,986)	(153 3%)	Printing and postage	47,523	72,998	25,476	34 9%
2,068	2,091	23	1 1%	Depreciation & amortization	14,561	14,635	73	0 5%
2,168	3,859	1,691	43 8%	Other operating expenses	17,526	27,011	9,484	35 1%
3,624	3,466	(158)	(4 6%)	Indirect cost allocation, Occupancy Expense	31,604	24,260	(7,344)	(30 3%)
146,962	**184,622**	**37,660**	**20.4%**	**Total Administrative Expenses**	**857,485**	**1,195,349**	**337,864**	**28.3%**
				Operating Tax				
4,511	-	4,511	0 0%	Tax Revenue	28,634	-	28,634	0 0%
4,511	-	(4,511)	0 0%	Premium tax expense	28,634	-	(28,634)	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
47,955	**(48,431)**	**96,386**	**199.0%**	**Change in Net Assets**	**1,462,310**	**37,886**	**1,424,424**	**3759.7%**
91.4%	***94.0%***	***2.6%***	***2.8%***	***Medical Loss Ratio***	***84.3%***	***91.6%***	***7.3%***	***8.0%***
6.5%	***8.2%***	***1.7%***	***20.4%***	***Admin Loss Ratio***	***5.8%***	***8.1%***	***2.3%***	***28.5%***

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CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
39,605	22,981	(16,624)	(72.3%)	Purchase services	238,520	160,871	(77,649)	(48.3%)
162,251	162,935	684	0.4%	Depreciation & amortization	1,138,235	1,140,542	2,307	0.2%
15,816	15,917	101	0.6%	Insurance expense	110,711	111,417	706	0.6%
70,232	173,136	102,904	59.4%	Repair and maintenance	694,684	1,211,952	517,268	42.7%
35,111	1,635	(33,476)	(2047.5%)	Other Operating Expense	333,547	11,445	(322,102)	(2814.3%)
(323,015)	(376,604)	(53,589)	(14.2%)	Indirect allocation, Occupancy	(2,515,697)	(2,636,227)	(120,530)	(4.6%)
(1)	**-**	**1**	**0.0%**	**Total Administrative Expenses**	**(0)**	**-**	**0**	**0.0%**
1	**-**	**1**	**0.0%**	**Change in Net Assets**	**0**	**-**	**0**	**0.0%**

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OTHER STATEMENTS – JANUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $12.5 thousand, $58.7 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $48.0 thousand, $96.4 thousand favorable to budget

CalOptima
Balance Sheet
January 31, 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$464,736,693	Accounts Payable	$16,470,762
Investments	396,601,507	Medical Claims liability	713,456,996
Capitation receivable	329,899,166	Accrued Payroll Liabilities	11,494,059
Receivables - Other	21,505,253	Deferred Revenue	85,552,175
Prepaid expenses	6,827,680	Deferred Lease Obligations	76,306
		Capitation and Withholds	122,901,013
Total Current Assets	**1,219,570,299**	**Total Current Liabilities**	**949,951,310**
Capital Assets			
Furniture & Equipment	35,575,437		
Building/Leasehold Improvements	8,311,770		
505 City Parkway West	50,013,815		
	93,901,022		
Less: accumulated depreciation	(45,196,085)		
Capital assets, net	48,704,938	Other (than pensions) post	
		employment benefits liability	25,439,057
Other Assets		Net Pension Liabilities	24,985,897
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	39,485,056	**TOTAL LIABILITIES**	**1,000,376,264**
Long-term Investments	509,100,533		
Total Board-designated Assets	548,585,589	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	548,885,589		
TOTAL ASSETS	**1,817,160,825**	TNE	81,915,494
		Funds in Excess of TNE	742,672,737
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	824,588,231
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,828,293,875**	**TOTAL LIABILITIES & FUND BALANCES**	**1,828,293,875**

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CalOptima
Statement of Cash Flows
January 31, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	11,941,934	62,956,664
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	547,684	3,956,879
Changes in assets and liabilities:		
Prepaid expenses and other	(1,374,161)	(530,333)
Catastrophic reserves		
Capitation receivable	(14,777,915)	(30,253,403)
Medical claims liability	4,678,218	(119,162,616)
Deferred revenue	(126,733)	(28,150,775)
Payable to providers	6,093,946	26,452,122
Accounts payable	(21,371,121)	9,307,729
Other accrued liabilities	132,630	614,622
Net cash provided by/(used in) operating activitie	(14,255,518)	(74,809,111)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	24,088,445	183,697,441
Change in Property and Equipment	(548,181)	(1,903,567)
Change in Board designated reserves	(2,342,400)	(10,337,916)
Net cash provided by/(used in) investing activitie	21,197,864	171,455,958
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALEN	6,942,347	96,646,846
CASH AND CASH EQUIVALENTS, beginning of period	457,794,347	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**464,736,693**	**464,736,693**

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CalOptima
Board Designated Reserve and TNE Analysis
as of January 31, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	150,062,296				
	Tier 1 - Logan Circle	149,850,498				
	Tier 1 - Wells Capital	149,456,359				
Board-designated Reserve		449,369,153	310,342,744	478,453,417	139,026,409	(29,084,264)
TNE Requirement	Tier 2 - Logan Circle	99,216,436	81,915,494	81,915,494	17,300,941	17,300,941
	Consolidated:	**548,585,589**	**392,258,238**	**560,368,911**	**156,327,351**	**(11,783,323)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

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BALANCE SHEET:

ASSETS increased $1.3 million from December or 0.1%

- **Capitation Receivables** increased $12.4 million due to timing of Department of Healthcare Services (DHCS) capitation payments
- **Investments** decreased $24.1 million or 5.7% due to the quarterly Managed Care Organization (MCO) tax payment and transfer timing requirements for operating cash funding
- **Operating Cash** increased by $6.9 million or 1.5% for routine operating requirements and variable month end cut-off dates

LIABILITIES decreased $10.6 million from December or 1.0%

- **Accounts Payable** decreased $22.9 due to the quarterly MCO tax payment of $34.2 million
- **Claims Liability** increased $4.7 million due to an increase in overpayments made by DHCS
- **Capitation and Withholds** increased $6.1 million due shared risk pool

NET ASSETS are $824.6 million, an increase of $11.9 million from December

CalOptima Foundation
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2019

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	43,289	43,289	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	20,894	20,894	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%
917	229,840	228,923	99.6%	Other	6,417	1,608,878	1,602,461	99.6%
917	239,009	238,092	99.6%	**Total Operating Expenditures**	6,417	1,673,061	1,666,644	99.6%
0	0	0	0.0%	**Investment Income**	305	0	(305)	0.0%
(917)	**(239,009)**	**(238,092)**	**(99.6%)**	**Program Income**	**(6,112)**	**(1,673,061)**	**(1,666,949)**	**(99.6%)**

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CalOptima Foundation
Balance Sheet
January 31, 2019

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,860,195	Accounts payable-Current	6,417
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	16,751
Total Current Assets	**2,860,195**	Grants-Foundation	0
		Total Current Liabilities	**23,168**
		Total Liabilities	**23,168**
		Net Assets	**2,837,028**
TOTAL ASSETS	**2,860,195**	**TOTAL LIABILITIES & NET ASSETS**	**2,860,195**

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CalOptima Foundation- Consolidated
Narrative Explanations for Budget Variances
January 31, 2019

Overview:
CalOptima Foundation was formed as a not-for-profit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. The activities of the Foundation are presented in the financial statements attached.
CalOptima Foundation wind down FY19

Income Statement:
Operating Revenue
HITEC Grant - No activity

Operating Expenses
CalOptima Foundation operating expenses were $6,417 for audit fees YTD.
* Major Actual to Budget variance was in "Other" category - $1.6 million favorable variance YTD.
  - FY19 budget was allocated monthly based on the remaining $2.9 million fund balance.
  - Actual recognized expenses were much lower than budgeted anticipated CalOptima support activities.

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.
* Grant Receivable - $0 current month receivable for ONC draw down of HITEC grant.
Liabilities
Payable to CalOptima - $16.8 thousand for audit fees - Foundation.

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Budget Allocation Changes
Reporting Changes for January 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
November	Medi-Cal	Facilities - Capital Project (8th Floor HR Remodel)	Facilities - Capital Project (Replace Master Control Center)	$22,500	Reallocate $22,500 from Capital Project (8th Floor hr. Remodel) to Capital Project (Replace Master Control Center)	2019
December	Medi-Cal	Facilities - Office Supplies	Facilities - Computer Supply/Minor Equipment	$60,000	Supplies to Computer Supplies/Minor Equipment to furniture needs of the staff	2019
December	Medi-Cal	Strategic Development - Professional Fees (Covered CA Consulting)	Strategic Development - Professional Fees (Strategic Planning Consulting)	$50,000	Repurpose $50,000 from Professional Fees (Covered CA Consulting) to Professional Fees (Strategic Planning Consulting)	2019
January	Medi-Cal	IS Application Development - Training & Seminars	IS Application Development - Maintenance HW/SW	$11,000	Reallocate $11,000 from training & seminars to maintenance HW/SW to pay for additional Tableau licenses	2019

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

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Board of Directors Meeting
March 7, 2019

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare

- CMS Timeliness Monitoring Project:

  On December 21, 2018, the Centers for Medicare & Medicaid Services (CMS) announced its efforts to collect data for organization determinations, appeals and grievances (ODAG) and coverage determinations, appeals and grievances (CDAG) for the review period of February 1, 2018 – April 30, 2018. CMS will be conducting this collection in three waves, with the first wave of letters requesting for data to be issued in January 2019. CMS will run a timeliness analysis on all validated universes and determine a rate of timeliness for each case type. Any findings may result in compliance actions, if necessary, and may have implications for the Star Ratings data integrity reviews for the four appeals measures. Although CalOptima's OneCare program has not been formally notified of its submission date yet for the 2019 Timeliness Monitoring Project, its Regulatory Affairs & Compliance department is currently working with impacted departments to compile the ODAG/CDAG universes to ensure readiness.

  On a related note, on January 30, 2019, CMS notified CalOptima that there were no compliance issues with the Timeliness Monitoring Project conducted last year for data from 2017 dates of service; therefore, no further action is required.

- CY 2017 Medicare Part C National Risk Adjustment Data Validation (RADV) Audit:

  On December 28, 2018, CMS notified CalOptima that its OneCare program has been selected to participate in the CY 2017 Medicare Part C National Risk Adjustment Data Validation (RADV) Audit. CMS is in the process of coordinating a teleconference with CalOptima, which will provide more information on the logistics of the audit.

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- Notification of Three-Year Provider Network Adequacy Review:

  On January 15, 2019, CMS notified CalOptima that its OneCare program has been selected for its three-year provider network adequacy review. In the next few weeks, CMS will allow plan sponsors to upload their networks into the Health Plan Management System (HPMS) Network Management Module (NMM) for an informal review and technical assistance prior to the formal review in June 2019. In June 2019, CalOptima will receive instructions on how to upload the entire network for its OneCare program into the NMM for CMS to begin the formal review.

- Medicare Data Validation Audit (OneCare and OneCare Connect):

  In preparation for the annual Medicare Data Validation Audit, CalOptima is in the process of collecting the required Parts C and D reporting data and working with all impacted business areas to ensure the accuracy of the data prior to submission in February 2019. The audit is scheduled to occur from April through June 2019.

2. OneCare Connect

- Medicare Part D Prescription Drug Event Validation:

  On January 10, 2019, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the Calendar Year (CY) 2017 Medicare Part D Prescription Drug Event Validation. CMS will validate the accuracy of PDE data submitted by Medicare Part D sponsors for CY 2017 payments. On January 31, 2019, CMS hosted a training teleconference in preparation for the validation audit. CMS requires that all documentation be submitted by April 19, 2019.

3. Medi-Cal

- 2019 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima from February 4, 2019 through February 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019, and consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. CalOptima expects to receive a preliminary report and an exit conference in the coming months.

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B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the months of December 2018 and January 2019.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2018	100%	100%	100%	97%
October 2018	90%	93%	100%	100%
November 2018	97%	100%	100%	100%

➢ No significant trends to report.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
September 2018	93%	100%	98%	97%	100%
October 2018	98%	98%	100%	100%	100%
November 2018	100%	83%	100%	100%	100%

➢ The lower compliance score of 83% for resolution of PDRs for November 2018 was due to untimely resolutions for multiple PDRs.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to --- staff training, process development,

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system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of PDRs within regulatory requirements.

- Medi-Cal Pharmacy: Pharmacy Standard Appeals

Month	Timeliness	Clinical Decision Making	Categorization/ Classification	Language Preference	Member Notice	Provider Notice	Authorization
September 2018	100%	100%	100%	100%	100%	100%	100%
October 2018	100%	100%	100%	100%	100%	100%	100%
November 2018	100%*	100%*	100%*	100%*	100%*	100%*	100%*

➢ No significant trends to report.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2018	100%	90%	100%	100%
October 2018	100%	100%	100%	100%
November 2018	100%	100%	100%	90%

➢ The lower compliance score of 90% for denied claims accuracy of PDRs for November 2018 was due to an error in denial for a single claim.

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- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
September 2018	Nothing to Report	Nothing to Report	Nothing to Report
October 2018	100%	100%	100%
November 2018	Nothing to Report	Nothing to Report	Nothing to Report

  - No significant trends to report.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Timeliness	Paid Accuracy Accuracy	Denied Timeliness	Denied Accuracy
September 2018	100%	100%	100%	90%
October 2018	90%	90%	100%	100%
November 2018	100%	100%	100%	100%

  - The lower compliance score of 90% for paid claims timeliness of PDRs for October 2018 was due to a single misclassified claim.

  - The lower compliance score of 90% for paid claims accuracy of PDRs for October 2018 was due to a single misclassified claim.

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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Timeliness	Letter Accuracy	Check Lag
September 2018	100%	90%	100%	100%
October 2018	100%	67%	100%	N/A
November 2018	100%	100%	100%	N/A

  - ➢ No significant trends to report.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
September 2018	90%	100%	100%	100%
October 2018	100%	100%	100%	100%
November 2018	100%	100%	100%	100%

  - ➢ No significant trends to report.

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- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Timeliness	Check Lag
September 2018	100%	100%	100%	100%
October 2018	100%	100%	100%	N/A
November 2018	100%	100%	100%	N/A

  - ➢ No significant trends to report.

5. Health Network Monitoring: Medi-Cal

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

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
September 2018	54%	84%	85%	50%	64%	82%	89%	93%	83%	82%	70%	75%	78%
October 2018	42%	84%	82%	67%	55%	79%	87%	64%	86%	88%	63%	67%	72%
November 2018	55%	78%	80%	73%	70%	75%	90%	83%	83%	85%	42%	60%	66%

  - ➢ The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (routine - 5 business days)
    - Failure to meet timeframe for member notification (2 business days)
    - Failure to meet timeframe for provider written notification (2 business days)
    - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
    - Failure to meet timeframe for deferred decision (14 calendar days)
    - Failure to meet timeframe for member delay notification (5 business days)
    - Failure to meet timeframe for provider delay notification (5 business days)

  - ➢ The lower scores for clinical decision making were due to the following reasons:

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- Failure to obtain adequate clinical information
- Failure to have appropriate professional make decision
- Failure to cite criteria for decision

➢ The lower letter scores were due to the following reasons:
- Failure to describe why the request did not meet criteria in lay language
- Failure to provide language assistance program (LAP) insert in approved threshold languages
- Failure to provide member with information on how to file a grievance
- Failure to provide letter in member's primary language
- Failure to provide letter with description of services in lay language
- Failure to provide peer-to-peer discussion of the decision with medical reviewer
- Failure to provide referral back to primary care provider (PCP) on denial letter
- Failure to include name and contact information for health care professional responsible for the decision to deny or modify
- Failure to provide notification to enrollee of delayed decision and anticipated final decision date
- Failure to provide notification to provider of delayed decision and anticipated final decision date

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

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2018	94%	84%	100%	96%
October 2018	100%	83%	97%	93%
November 2018	100%	87%	100%	91%

➢ The compliance rate for denied claims accuracy decreased from 93% in October 2018 to 91% in November 2018 due to missing documents that are required for processing accurate payment on claims.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work

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with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

6. Health Network Monitoring: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
September 2018	93%	100%	92%	100%	96%	100%	83%	92%
October 2018	90%	100%	95%	100%	83%	100%	89%	93%
November 2018	93%	67%	91%	100%	98%	100%	75%	89%

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision
  - Failure to cite criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to use approved CMS template
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

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

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- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2018	100%	100%	100%	93%
October 2018	89%	100%	97%	100%
November 2018	89%	100%	100%	94%

- The compliance rate for denied claims accuracy decreased from 100% in October 2018 to 94% in November 2018 due to missing documents that are required for processing accurate payment on claims.

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

7. Health Network Monitoring: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
September 2018	86%	87%	90%	75%	86%	50%	74%	79%	63%	63%	81%
October 2018	55%	73%	81%	77%	92%	69%	69%	80%	63%	88%	71%
November 2018	75%	84%	82%	63%	95%	43%	72%	77%	38%	89%	69%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (routine -5 Business Days)
  - Failure to meet timeframe for member notification (2 business days)

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  - 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 letter scores were due to the following reasons:
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member's primary language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to include name and contact information for health care professional responsible for the decision to deny
  - Failure to provide referral back to primary care provider (PCP) on denial letter

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

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

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2018	92%	100%	95%	86%
October 2018	82%	96%	95%	98%
November 2018	81%	96%	98%	90%

- The compliance rate for paid claims timeliness decreased from 82% in October 2018 to 81% in November 2018 due to untimely processing of multiple claims.

- The compliance rate for denied claims accuracy decreased from 98% in October 2018 to 90% in November 2018 due to missing documents that are required for processing accurate payment on claims.

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

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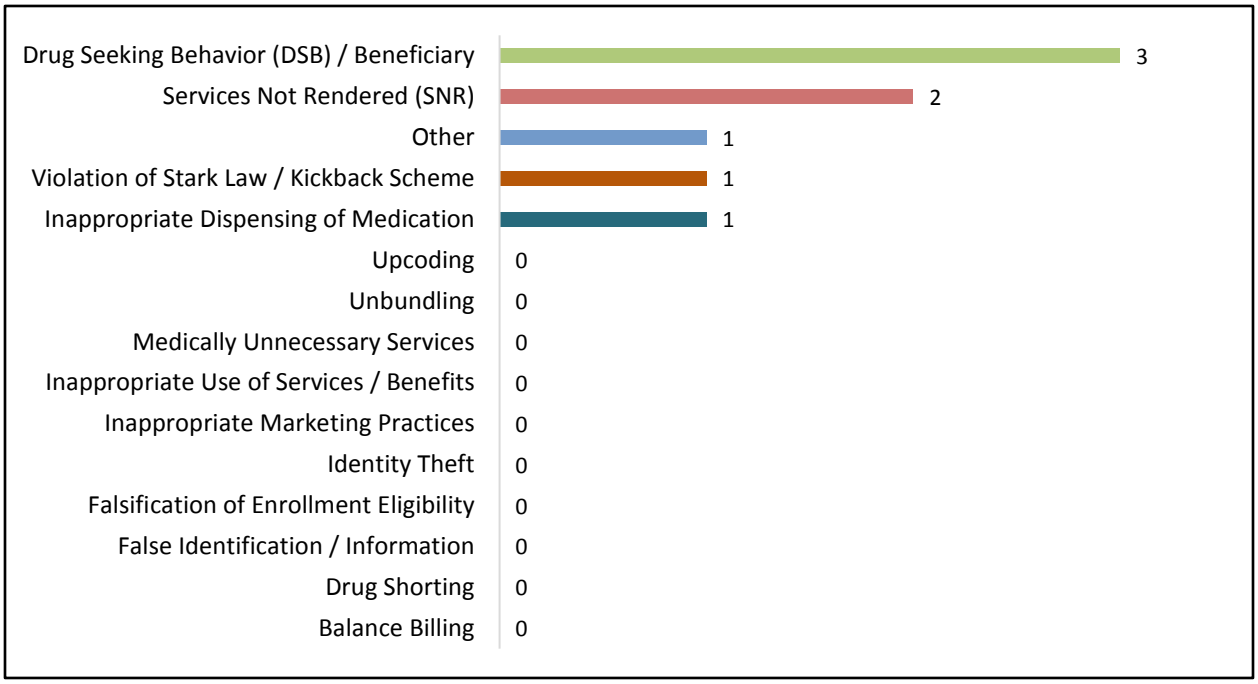
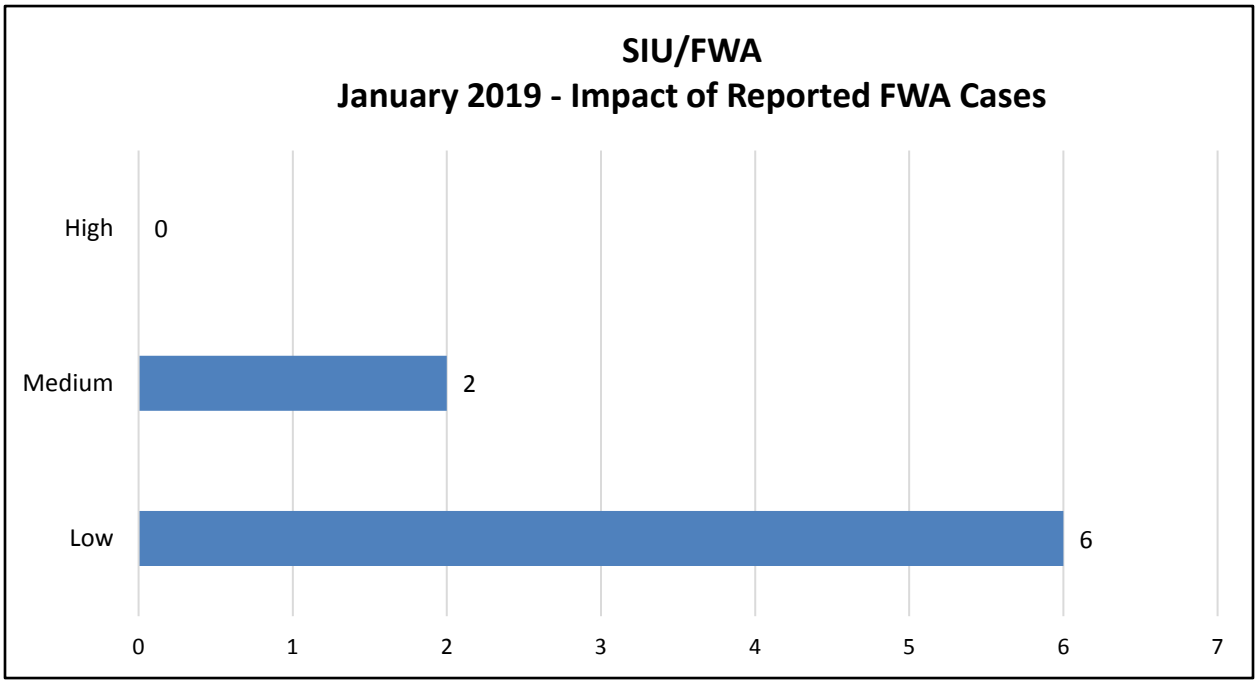
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in January 2019)





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. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

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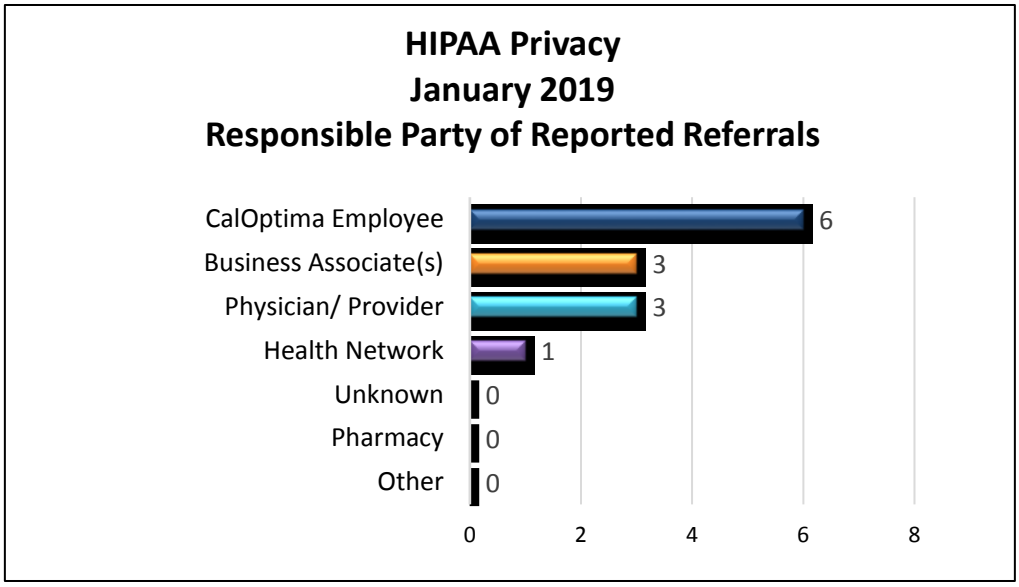
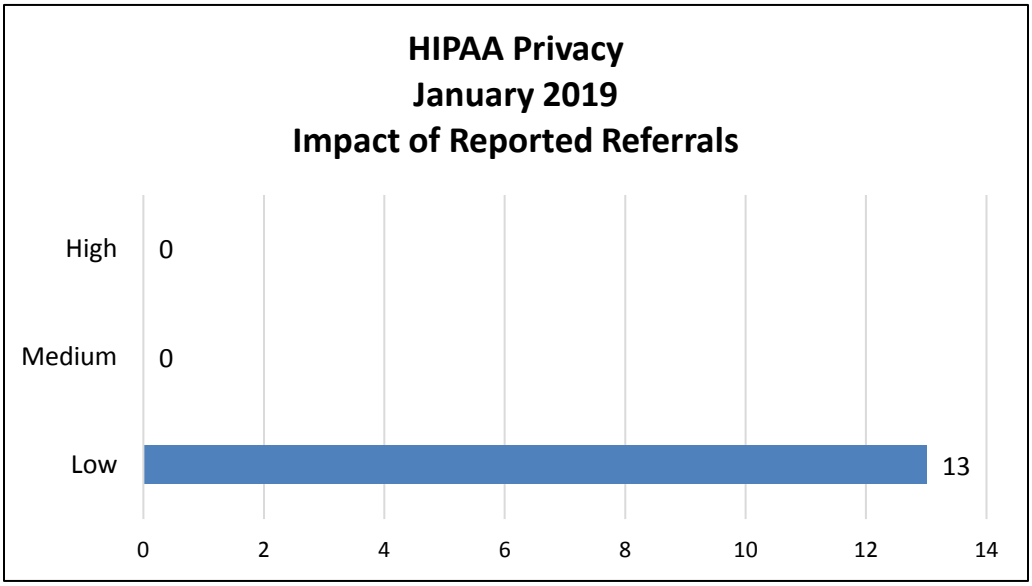
E. Privacy Update (January 2019)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	13
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**13**

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. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

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CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
March 7, 2019

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

February 15, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: February Board of Directors Report

With the recent 35-day government shutdown fresh on their minds, lawmakers raced to finish a spending package over the previous two weeks, finally sending a bill to the President that finishes up last year's appropriations bill and avoids another lapse in funding. Meanwhile, congressional committees are ramping up work on key legislative priorities including drug pricing, ACA issues, and surprise medical billing. This report provides an update on legislative activity through February 15, 2019.

Fiscal Year (FY) 2019 Appropriations

On January 25, President Trump signed a spending bill (H.J. Res. 28) that ended the longest government shutdown in U.S. history, funding the previously closed federal agencies through February 15. The resolution left unresolved the dispute over border security funding, however, and lawmakers soon faced another deadline to provide legislation that addressed the President's demand for a border wall. Following work by a bipartisan conference committee, Senate Appropriations Committee Chairman Richard Shelby (R-AL) announced that negotiators had reached an agreement on a deal to close out Fiscal Year (FY) 2019 funding, including the Homeland Security spending measure. On February 14, the Senate adopted the $333 billion package by a vote of 83-16; the House passed the measure by a 300-128 vote soon after and sent it to the President.

The final package (H.J. Res. 31) provides about $1.38 billion for border barrier construction, significantly less than the $5.7 billion the President had demanded. The White House confirmed the President would sign the bill on February 15. Still dissatisfied with the level of border security funding, however, President Trump also signed a national emergency declaration in order to reprogram $6.6 billion in Department of Defense and Treasury funds for border wall construction. The move is almost certain to face legal challenges. Indeed, House Speaker Nancy Pelosi (D-CA) has said that Democrats are reviewing their options on the matter, including a potential lawsuit and a privileged resolution of disapproval.

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Drug Pricing

Lawmakers have kicked off the year with a laser focus on prescription drug pricing, reflecting the priorities of the Trump Administration, the Democrat-controlled House and new Senate Finance Committee Chairman. House Oversight and Reform Committee Chairman Elijah Cummings (D-MD) announced the launch of a new investigation on January 14, sending letters to a dozen drugmakers to request detailed information and documents about their pricing practices. The Committee held the first of several hearings on drug pricing on January 29, with experts calling on Congress to improve price transparency. Members from both sides of the aisle emphasized the need to reevaluate the rules around drug patents and exclusivities, while several Democratic lawmakers made more pointed observations about rising insulin prices.

Insulin prices were also highlighted at a Senate Finance Committee hearing on January 29, with Chairman Charles Grassley (R-IA) pledging to "get to the bottom" of why prices continue to increase. Chairman Grassley also noted that a number of manufacturers had declined his invitation to testify before the Committee. Indicating that he would be "more insistent" going forward, he has invited seven brand-drug manufacturers to testify at a February 26 hearing.

Notably, Sen. Grassley has introduced legislation with Sen. Amy Klobuchar (D-MN) that would permit individuals to import prescription drugs from Canada. Other bipartisan efforts include the Right Rebate Act, which aims to prevent the misclassification of drugs under the Medicaid drug rebate program; and proposals to bolster generic competition by targeting "pay-for-delay" tactics and abuse of the Risk Evaluation and Mitigation Strategy program. Democrats have also offered several bills to allow Medicare to negotiate directly with manufacturers. These bills were highlighted at a February 12 House Ways and Means Committee hearing on prescription drug pricing. Overall the hearing had a very bipartisan tone, with Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) even releasing a joint statement before the hearing on the importance of the issue.

Finally, President Trump touched on drug pricing in his State of the Union address on February 5, highlighting high prices in the United States and asking Congress to address "global freeloading." He also called for requiring that drugmakers, insurers and hospitals disclose "real prices" to patients.

ACA Protection

House Democrats, having made clear that strengthening the Affordable Care Act (ACA) is a priority, have held several hearings so far on the health law and what they are characterizing as

Republican efforts to "sabotage" the ACA. The House Ways and Means Committee held a January 29 on pre-existing conditions, during which Democrats highlighted Republican efforts to repeal the ACA. Ranking Member Brady, meanwhile, insisted that protections for individuals with pre-existing conditions were not in danger. On February 6, the House Energy and Commerce Committee Health Subcommittee held a hearing to examine *Texas v. United States*, the lawsuit challenging the ACA, and its potential impact on Americans with pre-existing conditions. Republicans downplayed the impact of the recent ruling in the case, noting it had been stayed, while Democrats cast the lawsuit as part of a broader GOP strategy to attack the health law. The Subcommittee held a related hearing on February 13 to consider Democratic legislative proposals "to reverse ACA sabotage" by the Trump Administration.

Surprise Billing

Support is building in Congress for a bipartisan effort to address so-called surprise medical bills. The White House held a recent roundtable discussion with patients on surprise billing, earning the President praise from Democrats for highlighting the issue. Speaker Pelosi (D-CA) has made clear that addressing surprise medical bills is a key part of Democrats' health care agenda.

Sen. Lamar Alexander (R-TN), Chairman of the Health, Education, Labor and Pensions (HELP) Committee, has met with other Committee leaders on the matter and expects to see bipartisan legislation in the coming months. The details of such legislation is uncertain, and the various proposals floated by several lawmakers advance their own solutions to the problem. A draft bill released by Sen. Bill Cassidy (R-LA), for instance, would cap patients' out-of-pocket costs and prohibit balance billing. In most cases, the amount a health plan must pay would be set by the state. A bill introduced by Sen. Maggie Hassan (D-NH) last session would set up a "binding arbitration" process in a surprise out-of-network billing situation. A reintroduced bill from House Ways and Means Committee Health Subcommittee Chairman Lloyd Doggett (D-TX) would require hospitals to notify patients whether the providers they would receive care from are in-network. Without sufficient notice and the patient's consent, hospitals could charge patients no more than the in-network cost.

Most recently, a bipartisan group of senators including Sens. Cassidy, Hassan, Michael Bennet (D-CO), Todd Young (R-IN), Tom Carper (D-DE), and Lisa Murkowski (R-AK) sent a letter to plans and providers seeking information about their billing practices and costs of care.

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CalOptima Legislative Report
By Don Gilbert and Trent Smith
February 11, 2019

The deadline to introduce new legislation is February 22. So far newly introduced bills are trickling in with approximately two dozen bills introduced every day. However, that number will grow significantly as we get closer to the deadline. In fact, we customarily see a majority of the new bills introduced in the final few days before the deadline.

So far there are a handful of bills that may be of interest to CalOptima. As we see most years, there are several proposals to add new services under the Medi-Cal program. While Governor Brown vetoed most of these bills, Governor Newsom may have a different perspective on expanding Medi-Cal to cover new services and treatments.

AB 166 by Assemblyman Gabriel proposes adding violence prevention counseling services to the Medi-Cal program, while SB 207 by Senator Hurtado would include asthma preventive services as a covered benefit under the Medi-Cal program. We expect to see many other bills introduced during this Legislative Session seeking to expand services provided under Medi-Cal, with the authors hopeful that Governor Newsom will overlook the potential costs of these new coverage mandates and instead focus on the positive health outcomes such services could provide.

Assemblyman Chu has introduced AB 318, which would commence on January 1, 2020, and would require the Department of Health Care Services (DHCS) and managed care plans to require field testing of all translated materials provided to Medi-Cal beneficiaries. The bill defines “field testing” as a review of translations for accuracy, cultural appropriateness, and readability. Assemblyman Chu introduced a similar bill last year that was vetoed by the Governor.

SB 165 by Senate Pro Tem Atkins focuses on interpretation services in the Medi-Cal program. DHCS is already working with stakeholders to establish a pilot project based on the recommendations of a study mandated by previous legislation. The study will make recommendations intended to improve interpretation services in the Medi-Cal program. This bill would require DHCS to establish a pilot project concurrent with the study.

AB 414 by Assemblyman Bonta and SB 175 by Senator Pan both require a California resident to ensure that they and any of their dependents maintain minimum essential healthcare coverage for each month beginning after 2019. The bill would impose a penalty, established by the Exchange, for the failure to maintain minimum essential coverage. These bills are intended to implement a policy put forth by Governor Newsom as part of his goal to provide health care coverage for all California residents.

SB 66 by Senate Pro Tem Atkins authorizes reimbursement for a maximum of two visits taking place on the same day at a single Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). This applies if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment. An additional "same day" appointment would also be permitted if the patient has a medical visit as well as a mental health or dental visit. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit. This establishes the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate. This measure was unsuccessfully pursued last year.

We know CalOptima has an interest in providing dental care as a benefit for its members. Therefore, we want to highlight AB 316 by Assemblyman Ramos. This measure would require DHCS to implement a payment adjustment to Medi-Cal providers who render dental services to Medi-Cal beneficiaries.

Finally, we have begun working with CalOptima's senior staff on a lobbying effort against the Department of Managed Health Care's (DMHC) proposed regulations, which would mandate new licensure requirements for certain providers that assume delegation risk from a health plan such as CalOptima. In short order, we have arranged for CalOptima to meet with a majority of their legislative delegation in Sacramento. We will also participate in a meeting in the Governor's office with other concerned parties. At the direction of CalOptima staff, we will continue to work with coalition partners in further lobbying against these proposed regulations.

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2019–20 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 652 Blumenauer	**Programs of All-Inclusive Care for the Elderly (PACE) Final Rule:** Directs the Secretary of Health and Human Services (HHS) to release the final PACE rule (81 Fed. Reg. 54666) no later than April 1, 2019, which would implement the first update to PACE regulations in more than ten years. The proposed changes include allowing PACE organizations (POs) to, (1) include community-based physicians as part of their interdisciplinary teams (IDTs); (2) use nurse practitioners and physician assistants as primary care providers; (3) provide services in settings other than the PACE Center, and; (4) configure the IDT to meet the needs of individual participants. Taken together these changes are likely to enable POs to accommodate more participants and expand their programs without compromising quality of care. CalOptima PACE has been an early adopter of many of the PACE innovations reflected in the final rule, applying for Centers for Medicare & Medicaid Services (CMS) exemptions to utilize community-based physicians, nurse practitioners, and the Alternative Care Setting (ACS) model to deliver PACE care outside of the PACE center. Updating the PACE regulations to allow these innovations to be part of the program will facilitate growth and sustainability for the PACE model.	**01/17/2019** Introduced; Referred to Ways and Means; Energy and Commerce	NPA – Support

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula SB 29 (Lara/Durazo)	**Medi-Cal Eligibility Expansion:** Extends eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Department of Health Care Services (DHCS) projects this expansion would cost approximately $1.6 billion General Fund (GF) each year; $1.5 billion by expanding full-scope Medical up to age 64 and $115 million by expanding to adults 65 years of age and older. Additionally, the cost of In-Home Supportive Services (IHSS) for undocumented young adults with disabilities would cost $2.2 million GF each year. The cost of IHSS for undocumented seniors has yet to be calculated. Under the terms of SB 75, signed into California state law in 2015, children under 19 years of age, regardless of their immigration status, became eligible for full-scope Medi-Cal benefits, as long as they meet all other eligibility requirements. This change in state policy brought approximately 9,000 new members in to CalOptima. Similarly, AB 4/SB 29 would likely increase CalOptima's Medi-Cal membership. Of note, the Governor's 2019-20 Budget Proposal includes a provision to expand full-scope Medi-Cal to undocumented individuals, but only for ages 19 to 25. According to a DHCS analysis, the Governor's proposed expansion would result in an estimated 138,000 newly eligible individuals receiving full-scope benefits at a cost of $194 million to the state's GF ($260 million total) in fiscal year 2019-20. A similar analysis of AB 4/SB 29's impact is likely to be produced as these bills are heard in their respective committees of jurisdiction.	**12/03/2018** Introduced	Watch
AB 316 Ramos/Rivas	**Medi-Cal Dental Services Reimbursement:** Would increase the fee-for-service reimbursement rate for Denti-Cal providers that provide services to individuals with special needs. Pending approval from the Centers for Medicare & Medicaid Services (CMS), the increase in reimbursement rates to Denti-Cal providers would allow the provider to be reimbursed for the additional time and resources required to treat a patient with special needs. Providers are currently not receiving additional funds if a patient with specials needs uses more time and resources than originally allocated. The increase in reimbursement rate has yet to be defined. Since Denti-Cal is a Medi-Cal managed care "carve-out," CalOptima does not provide dental benefits to our Medi-Cal members. However, CalOptima is tracking this bill due to its potential impact on our members who access dental benefits on a fee-for-service basis as part of the Denti-Cal program.	**01/30/2019** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 318 Chu	**Materials for Medi-Cal Members:** Similar to AB 2299, introduced and vetoed by the Governor in 2018, requires all Medi-Cal managed care plans' (MCPs) written health education and information materials to be reviewed through "field testing" to ensure all materials meet readability and suitability standards. Field testing may be conducted internally by the MCP or by an external entity. The findings of the field testing will then be reported to the Department of Health Care Services (DHCS). Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. The timeline to complete the field test report has yet to be defined. Currently, CalOptima's Health Education and Cultural Linguistic Services departments review all informational materials released to members in all threshold languages. To ensure the quality of the translation, CalOptima and its Health Networks participate in a robust process to ensure cultural and linguistic appropriateness, including: qualified translators, editor for translated documents, and having the translated documents translated back to English to check the accuracy of the translation, as necessary. This bill proposes to add an additional step—field test reports to DHCS—in addition to the current process.	**01/30/2019** Introduced	Watch
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement:** Similar to SB 1125, introduced and vetoed by the Governor in 2018, would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow for reimbursable mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Although there is no direct impact to CalOptima given that the FQHC "wrap around" prospective payment system (PPS) reimbursement is administered by the state, the policy change would impact access to services that our members receive at FQHCs. LHPC supported SB 1125 in 2018.	**01/08/2019** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 163 Portantino	**Qualifications for Autism Spectrum Disorder (ASD) Providers:** Similar to SB 399, introduced and vetoed by the Governor in 2018, would revise and expand the definitions of those providing care and support to individuals with Autism Spectrum Disorder (ASD) and redefine the minimum qualifications of autism service professionals. Additionally, ASD treatment would be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider and the authorization of ASD treatment services would not be declined if a parent or caregiver is unable to participate. This would significantly limit CalOptima's ability to determine medically necessary services. Furthermore, without parent or caregiver participation, the ability to manage the child's behavior as well as the success of the treatment would be limited. CAHP and LHPC opposed SB 399 in 2018, asserting that the provisions resulted in a disregard of current medical recommendations and evidence-based practice guidelines.	**02/06/2019** Referred to Committees on Health and Human Services **01/24/2019** Introduced	Watch
SB 175 Pan	**State-Based Individual Mandate:** Would create a state-based individual mandate, to require all California residents to be enrolled in a health insurance plan. A fine would be charged to each resident for each month that person is not insured. The bill language does not currently define the penalty fee amount. H.R. 1 (P.L. No: 115-97), passed by Congress in 2017, eliminated the penalty associated with the Affordable Care Act's individual mandate, effective January 1, 2019; therefore, there is currently a zero-dollar fine if a California resident is not insured. As a result, the California Legislative Analyst's Office (LAO) reported that 24 percent fewer people enrolled in Covered California in 2019 when compared to 2018 enrollment data. While there is no direct impact to CalOptima, since it does not operate in the individual market, the provisions would have a wide-ranging impact on the health care system as a whole. Individuals who are just above the Medi-Cal eligibility threshold often "churn" back and forth between Covered California and CalOptima and SB 175 could potentially impact this population.	**02/06/2019** Referred to Committees on Health and Governance & Finance **01/28/2019** Introduced	Watch

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

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

Last Updated: February 20, 2019

Legislative & Regulatory Policy/Technical Feedback

Date	Proposed Regulation	Summary of CalOptima Feedback
2/12/2019	**Request for Information on Modifying HIPAA Rules to Improve Coordinated Care** The U.S. Department of Health and Human Services (HHS), Office for Civil Rights published a Request for Information seeking feedback on whether and how Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules should be revised to better promote coordinated care.	CalOptima provided feedback to HHS via ACAP. In our feedback, CalOptima highlighted the potential to improve care coordination between behavioral and physical health services provided to people with Substance Use Disorders (SUD) by aligning the SUD-specific privacy requirements in 42 CFR part 2 with the privacy requirements in HIPAA, among other comments.
12/13/2018	**Draft Model Enrollee Handbook/Evidence of Coverage** DHCS released a Draft Model Enrollee Handbook/ Evidence of Coverage as a template to be used by MCPs, as required by the Medicaid Managed Care Final Rule (also known as the "Mega Reg"). DHCS requested MCPs to review and provide feedback regarding the model handbook.	CalOptima provided feedback to DHCS via CAHP. CalOptima requested clarification regarding technical definitions included in the handbook and suggested edits related to the implementation of the California Children's Services Whole Child Model and the Health Homes Program.
11/20/2018	**Network Certification Requirements** DHCS released an edited version of an APL, 18-005, which would make changes to the annual network certification process. DHCS will be making network adequacy determinations using provider data submitted by MCPs in January or February 2019, instead of data submitted via the Annual Network Certification reporting template, which plans will no longer be required to submit. Accordingly, DHCS also made proposed changes to the Network Certification Taxonomy Crosswalk.	CalOptima provided feedback to DHCS via CAHP. CalOptima requested clarification regarding provider codes in the edited version of the taxonomy crosswalk as well as technical guidance from DHCS regarding provider counts. CalOptima also requested further clarification from DHCS regarding the timely access survey timeline.
11/19/2018	**Medi-Cal Informing Materials** DHCS released a proposed APL, 18-XXX, concerning informing materials provided to Medi-Cal beneficiaries in an electronic format. According to the proposed guidance, MCPs have the option to send members a DHCS–approved insert in member welcome packets and/or annual informational mailings to inform members of how to obtain the Provider Directory, Formulary, and Member Handbook electronically in lieu of sending a physical copy. MCPs interested in using an insert must submit a proposal to DHCS with an example of the insert, among other details.	CalOptima provided feedback to DHCS via CAHP. CalOptima requested clarification regarding the types of written member information that are required to be distributed initially and annually to members. CalOptima also requested further clarification from DHCS regarding the required elements of the insert.

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11/19/2018	**Medicaid Drug Rebate Program** DHCS released a proposed APL, 18-XXX, regarding the reporting and oversight responsibilities for MCPs, to ensure compliance with federal law, which prohibits duplicate discounts for a single drug. According to the proposed guidance, MCPs must have a mechanism in place to identify drugs that were purchased under the 340B program, so that DHCS can exclude those drugs from its submission as part of the Medicaid Drug Rebate Program. Of note, according to the proposed guidance, MCPs are also required to identify drugs purchased as part of the 340B program, even if dispensed at a pharmacy that a covered entity (e.g., Federally Qualified Health Center) contracts with.	CalOptima provided feedback to DHCS via CAHP and LHPC. In our feedback, CalOptima specifically highlighted significant challenges for MCPs to identify 340B drugs that are dispensed at covered entities' contract pharmacies. In response to our feedback, CAHP and LHPC recommended to DHCS that the covered entity that dispenses 340B drugs to MCP members should retain the responsibility for establishing and maintaining both in-house, and contract pharmacy arrangements, that comply with all 340B program requirements.
11/1/2018	**Risk Adjustment Data Validation (RADV) Audits** CMS published a proposed rule that would change, among other things, the methodology for Risk Adjustment Data Validation (RADV) audits for Calendar Years 2020 and 2021. The changes that CMS has proposed to the RADV audit methodology have the potential to impact Medicare plans. Contract-level RADV audits are one method by which CMS recoups overpayments by examining the accuracy of enrollee diagnoses submitted by Medicare plans for risk-adjusted payment. Risk adjustment discrepancies can be aggregated to determine an overall level of payment error, and CMS is proposing to formalize its ability to do so in this rule change.	CalOptima provided feedback to CMS via ACAP and NPA regarding this proposed rule change. We requested technical guidance and further clarification from CMS regarding coding intensity adjustment that related to the Hierarchical Condition Category/Risk Adjustment Factor (HCC/RAF) point system, among other requests for technical guidance.
10/25/18	**Telehealth Services** DHCS released a proposed APL, 18-XXX, to provide clarification to MCPs on the DHCS policy on telehealth services, as well as edits to relevant sections of the provider manual. DHCS intends to clarify that Medi-Cal providers have increased flexibility to make medically necessary decisions for their patients on the use of telehealth as well as to provide clarification and more detailed guidance regarding coverage and reimbursement requirements.	CalOptima provided feedback to DHCS via CAHP and LHPC. In our feedback, CalOptima requested greater clarification regarding the E-consult definition as well as what services are encompassed in the new definition. We also requested clarification related to the ability of various types of providers to utilize specific types of telehealth modalities.
10/15/2018	**General Licensure Requirements for Health Care Service Plans** DMHC opened a fourth comment period for its proposed regulation, Section 1300.49 of Title 28 of the California Code of Regulations, which establishes new requirements for health care service plan licensure, including "restricted health care service plans." Under the proposed regulation, entities that assume "global risk," as defined in the regulation, must either apply for a DMHC "Knox-Keene" license or apply for and	CalOptima provided feedback to DMHC via LHPC. The LHPC comment letter requested clarification regarding two areas of the proposed regulation. LHPC requested that DMHC confirm its understanding that entities acting as subcontractors of Full-Service Health Care Service Plans can be granted a restricted health care service plan license or an exemption, regardless of whether the Full-Service Health Care Service Plan has a Knox-Keene license, or, is exempt from licensure.

	receive an exemption from the requirement to obtain a license. While the proposed regulation does not directly impact CalOptima, it may impact some of CalOptima's health networks, depending on their contracting models and DMHC's assessment of whether those models meet the definition of global risk.	Also, LHPC requested clarification to find out if entities that assume global risk from MCPs are exempt from Knox-Keene licensure for Medi-Cal services (like CalOptima) and are also covered by the MCP's statutory exemption from licensure for Medi-Cal.

Last Updated: February 11, 2019

Acronym Key:	
APL	All Plan Letter
CAHP	California Association of Health Plans
CMS	Centers for Medicare & Medicaid Services
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
HHS	Department of Health and Human Services
LHPC	Local Health Plans of California
MCP	Medi-Cal Managed Care Plan
NPA	National PACE Association

Board of Directors Meeting
March 7, 2019

CalOptima Community Outreach Summary — February 2019

Background

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

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

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

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

CalOptima Community Events Update

Community Relations and Case Management hosted the bi-annual Community Resource Fair at CalOptima on January 23, 2019 from 9 a.m. to 12 p.m. The purpose of the event was to increase the knowledge of CalOptima staff and our health network partners of resources available in the community to assist members who need help with meeting basic needs such as housing, food, transportation, employment, utilities assistance, legal aid and child care.

Thirty-five community partners with a total of 53 of their staff were available to share information about their programs and services to CalOptima employees and our health network partners. Participating community partners included non-profit community-based organizations, county agencies and other service providers. From the exhibitor evaluations collected, 100 percent of the exhibitors expressed that the level of attendance and instructions to prepare for the event were either good or excellent. Also, 100 percent of the exhibitors also expressed that they would participate in the resource fair again.

The resource fair is an excellent educational and networking opportunity. All CalOptima staff and the delegated health networks' case managers, personal care coordinators, social workers, referral specialists, and others who help members connect to community resources were invited to attend. Attendees also had an opportunity to win

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several gift baskets. A total of 218 CalOptima internal staff and 43 health network staff attended the resource fair. From the participation evaluations collected, 97 percent of the participants strongly agreed or agreed that they had an overall positive experience at the event. Over 95 percent of the participants strongly agreed or agreed that the information provided during the event was relevant and beneficial to their work and will help them better serve our members.

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During February 2019, CalOptima participated in 41 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
2/04/19	• Orange County Health Care Agency Mental Health Services Act Steering Committee
2/05/19	• Collaborative to Assist Motel Families Meeting
2/06/19	• Orange County Aging Services Collaborative Meeting • Anaheim Human Services Network • Orange County Healthy Aging Initiative Meeting
2/07/19	• Homeless Provider Forum • Cal State Fullerton Healthy Neighborhood Advisory Meeting
2/08/19	• Orange County Strategic Plan for Aging — Healthcare Subcommittee Meeting
2/11/19	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
2/12/19	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting
2/13/19	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting • Orange County Communications Workgroup
2/14/19	• FOCUS Collaborative Meeting • Kid Healthy Community Advisory Committee Meeting • Orange County Women's Health Project Advisory Meeting
2/15/19	• Orange County Strategic Plan on Aging — Orange County Heart to Heart Council Quarterly Meeting (Sponsorship Fee: $500 included speaking opportunity to share information about programs and services) • Orange County Pediatric Mental Health System of Care Task Force Meeting

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2/19/19	• Placentia Community Collaborative Meeting • Orange County Cancer Coalition Meeting
2/20/19	• Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Community Collaborative Meeting • Orange County Communication Workgroup
2/21/19	• 2019 Health Care Forecast Conference hosted by University of California, Irvine Paul Merage School of Business (Sponsorship Fee: $1,000 included opportunity to share information about programs and services) • Orange County Children's Partnership Committee Meeting • Surf City Senior Providers Networking Luncheon • Garden Grove Community Collaborative Meeting
2/25/19	• Community Health Research Exchange Meeting
2/26/19	• Orange County Senior Roundtable
2/28/19	• Orange County Care Coordination for Kids Meeting • Disability Coalition of Orange County Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
2/02/19	1	• Orange County Black History Parade and Cultural Faire hosted by Orange County Heritage Council (Registration Fee: $175 included one exhibit table for outreach at the event.)
	1	• Clinic in the Park hosted by Higher Ground Youth and Family Services
2/08/19	20	• Tet Festival hosted by Vietnamese Community of Southern California (Sponsorship Fee: $10,000 included one exhibit booth in prime location at event, three 3' x 8' banner display, 20 mentions on stage, 25 radio impressions and a full-page advertisement on 10,000 flyers.)
	20	• Tet Festival hosted by the Union of Vietnamese Students Association (Sponsorship Fee: $10,000 included 10' x 20' booth in prime location at event, booth listing in event program book, 60 admission tickets, four VIP 3-day admission badges, six VIP 3-day parking hang tags, banner display near main entrance and main stage, three graphic ad impressions on main stage, social media impression on Facebook event page, and a full page color advertisement in the event program book.)
2/09/19	2	• Health and Wellness Fair hosted by the Wellness and Prevention Coalition (Sponsorship Fee: $500 included one vendor booth, mentioned in press release and e-newsletter, quarter page ad in resource directory, logo on all promotional items, name on attendee bingo card and recognition on website and social media with links.)

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2/23/19	1	• 25th Annual Health and Wellness Fair hosted by Magnolia School District
	1	• ActNOW California Conference hosted by the G.R.E.E.N Foundation (Sponsorship Fee: $1,000 included an exhibit table for outreach)
2/28/19	1	• Clinic in the Park hosted by Centralia Elementary School District

CalOptima organized or convened the following 12 community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
2/04/19	• Community-based Organization Presentation for Bright Future for Kids — Topic: Medi-Cal in Orange County
2/11/19	• Community-based Organization Presentation for Pathways of Hope — Topic: Medi-Cal in Orange County
2/22/19	• Community-based Organization Presentation for Santa Ana Unified School District Wellness Center — Topic: Medi-Cal in Orange County

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
2/06/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
2/08/19	• Community-based Organization Presentation for Heroes Elementary School — Topic: Medi-Cal in Orange County
2/12/19	• Community-based Organization Presentation for Lorin Griset Academy — Topic: Medi-Cal in Orange County
2/13/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
2/20/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
2/22/19	• County Community Service Center Health Seminar — Topic: Medi-Cal Recovery Law (Vietnamese)
2/26/19	• County Community Service Center Health Seminar — Topic: Heart Health (Vietnamese) • Community-based Organization Presentation for Westmont Elementary School — Topic: Medi-Cal in Orange County
2/27/19	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You

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CalOptima Board of Directors
Community Activities

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

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

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

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

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

March

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Friday, 3/1 7am-5pm	+OC Coalition of Community Health Centers 2019 Annual Health Care Symposium	Conference *Registration required.*	Sponsorship $500 1 Staff	Hilton Hotel 777 W. Convention Way Anaheim

+ Exhibitor/Attendee
++ Meeting Attendee

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Saturday, 3/2 7:30am-3pm	+St. Joseph Hospital OC Asian and Pacific Islander Youth and Family Mental Health Summit	Community Presentation Health/Resource Fair Open to the Public	2 Staff	Western High School 501 S. Western Ave. Anaheim
Saturday, 3/2 11am-2pm	*PACE Senior Health and Wellness Event	Community Event Open to the Public		PACE Center 13300 Garden Grove Blvd. Garden Grove
Sunday, 3/3 10am-2pm	+UCLA Vietnamese Community Health Winter 2019 Health Fair	Health/Resource Fair Open to the Public	1 Staff	Westminster Rose Center 14140 All American Way Westminster
Monday, 3/4 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, 3/5 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, 3/6 3-5:30pm	*Health Education Workshop Shape Your Life	Open to the Public *Registration required.*	N/A	360 TurnAround Youth Diversion 708 N. Garfield St. Santa Ana
Thursday, 3/7 8am-4pm	+Alzheimer's Family Center Spirituality Conference	Community Presentation Health/Resource Fair Open to the Public	Sponsorship $750 2 Staff	UCI Pacific Ballroom 311 W. Peltason Dr. Irvine
Thursday, 3/7 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 3/7 9-10:30am	++Refugee Forum of OC	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim

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

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Friday, 3/8 9:30-11am	++Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Sunday-Tuesday 9am-5pm	+Family Voices of California Annual Health Summit and Legislative Day	Conference *Registration required.*	Sponsorship $2,5000 1 WCM FAC member	Holiday Inn Sacramento
Monday, 3/11 1-2:30pm	+OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 3/11 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 3/12 9-10:30am	++OC Strategic Plan for Aging Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 3/13 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 3/13 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 3/13 3-5:30pm	*Health Education Workshop Shape Your Life	Open to the Public *Registration required.*	N/A	360 TurnAround Youth Diversion 708 N. Garfield St. Santa Ana
Wednesday, 3/13 3:30-4:30pm	++OC Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 3/14 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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Thursday, 3/14 12:30-1:30pm	++Kid Health Advisory Committee Mtg	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC 1901 E. Fourth St. Santa Ana
Thursday, 3/14 2:30-4:30pm	++OC Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Thursday, 3/14 3:30-5:30pm	++State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Tuesday, 3/19 8:30-10am	++North OC Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 3/19 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 3/20 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, 3/20 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 3/20 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Thursday, 3/21 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana

Monday, 3/25 12:30-1:30pm	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 3/26 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 3/26 2-4pm	++Susan G. Komen OC Unidos Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen 2817 McGraw Ave. Irvine
Thursday, 3/28 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, 3/28 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana

Monday, 3/25 12:30-1:30pm	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 3/26 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 3/26 2-4pm	++Susan G. Komen OC Unidos Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen 2817 McGraw Ave. Irvine
Thursday, 3/28 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, 3/28 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana