NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, APRIL 4, 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

REVISED AGENDA

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

REVISED AGENDA

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Whole-Child Model Network Certification
   b. Homeless Health Initiatives
   c. State Audit of Medi-Cal Services for Children
   d. State-Based Individual Mandate
   e. Governor's Pharmacy Carve-Out Order
   f. Cal MediConnect Program Extension

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 March 7, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the January 10, 2019 Meeting of the CalOptima Board of Directors' Member Advisory Committee, the August 23, 2018 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee, and the February 14, 2019 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Appointment of CalOptima Treasurer

CLOSED SESSION

CS 1 CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
   a. Significant exposure to litigation pursuant to Government Code section 54956.9, subdivision (d)(2): Three Cases.
   b. Initiation of litigation pursuant to Government Code section 54956.9, subdivision (d)(4): One Case.

REPORTS

4. Consider Actions Related to Delivery of Care for Homeless CalOptima Members

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

REVISED AGENDA

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model Program

8. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

9. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

10. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated with Children's Hospital of Orange County, the University of California, Irvine and St. Joseph Health and its Affiliates

11. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Associated with St. Joseph Health and its Affiliates

12. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with St. Joseph Health and its Affiliates

13. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with St. Joseph Health and its Affiliates

14. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with the University of California, Irvine

15. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with the University of California, Irvine

16. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Associated with the University of California, Irvine

17. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with Children's Hospital of Orange County

18. Consider Authorizing New Contracts with the Direct Contracted, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospitals to Increase Rates in Support of Hospital Discharge Obligations and to Incorporate Changes Related to the Department of Health Care Services (DHCS) Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of Orange County

REVISED AGENDA

19. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2019-20

20. Consider Approval of Proposed Changes to CalOptima Contracting Policy EE.1135: Long Term Care Facility Contracting

21. Consider Approval of Proposed Changes to CalOptima Contracting Policy EE.1141: CalOptima Provider Contracts

22. Consider Approval of Proposed Revisions to CalOptima Information Services Policy IS.1306: Shared Drives Authorization and Classification

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

24. Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly Services in Orange County Independent of CalOptima

25. Consider Authorizing Contract with Vendor for Consulting Services Related to CalOptima's Strategic Plan 2020-2022

26. Consider Appointment to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

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

ADVISORY COMMITTEE UPDATES

28. Provider Advisory Committee Update

29. Member Advisory Committee Update

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

INFORMATION ITEMS

31. Introduction to the FY 2019-20 CalOptima Budget: Part 1

32. February 2019 Financial Summary

33. Compliance Report

34. Federal and State Legislative Advocates Reports

35. CalOptima Community Outreach and Program Summary

REVISED AGENDA

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

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

MEMORANDUM

DATE:	April 4, 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

Whole-Child Model (WCM) Networks Meet Certification Standards for July Launch
On March 15, the Department of Health Care Services (DHCS) certified that CalOptima's 12 delegated health networks and our direct network, CalOptima Community Network, meet the requirements for WCM participation. Therefore, the transition of California Children's Services to WCM in Orange County is officially approved for July 1, 2019. Thank you to our health networks for their partnership in this effort to provide access to more coordinated care for children with medically complex conditions. We look forward to a successful launch. Further, CalOptima continues to engage with stakeholder groups at the local and state levels to ensure awareness and work toward a smooth transition. Our WCM Family Advisory Committee is meeting bimonthly and offering valuable feedback to staff, and CalOptima was asked to make a presentation to the California Children's Services Advisory Group this month in Sacramento. Chief Medical Officer David Ramirez, M.D., will be sharing the information about our delegated model, members' access to out-of-network care, the role of CalOptima Direct and CalOptima Community Network, and auto-assignment processes.

Ad Hoc on Homeless Health to Recommend Major Commitment to Additional Programs
CalOptima's focus on Orange County's homeless health crisis is evident in actions the past few months. Not only was there a special meeting for the full Board in February resulting in approval of our clinical field teams and CalOptima Homeless Response Team, a newly appointed ad hoc committee amplified their work in March, issuing a set of recommendations for significant financial support to homeless health initiatives. Your April Board materials include a presentation and three Report Items that collectively reflect CalOptima's commitment to partnering with Orange County and community organizations to make a difference in the lives of CalOptima members who are homeless.

Audit Finds Medi-Cal Services for Children Lacking; Regulators and Legislators Respond
On March 14, the California State Auditor issued a report about DHCS oversight of preventive care for children in Medi-Cal. The report cites deficiencies in utilization of preventive care, based in part on provider access issues due to low reimbursement. Fortunately, CalOptima is included somewhat favorably in the report. While all plans can do more to ensure delivery of preventive care for children, CalOptima's 60.7 percent utilization rate is second only to San Francisco Health Plan's 64.2 percent. The lowest rate among the 23 plans listed was 39.9 percent. As a result of the audit's largely negative findings, DHCS announced a series of stricter

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quality oversight measures, including new performance benchmarks and sanctions for noncompliance. Further, Assemblyman Jim Wood also introduced legislation to implement similar controls. We are carefully monitoring this regulatory and legislative activity to ensure that CalOptima continues to serve our youngest members according to high quality standards.

Governor Introduces Individual Mandate as Part of Budget Trailer Bill
Reflecting his focus on California health care issues, Gov. Gavin Newsom introduced a state-based requirement to obtain health care coverage, known as an individual mandate, with the release of FY 2019–20 budget trailer bill language in mid-March. The language includes a tax penalty of $695 per adult and $348 per child that would be collected by the state and deposited into the General Fund. The money would then be used to provide subsidies for coverage purchased through Covered California and expand subsidies to people between 400 percent to 600 percent of the federal poverty level. Experts predict that an individual mandate may also have the effect of driving more enrollment into Medi-Cal as eligible individuals seek coverage rather than pay penalties.

State Requests Pharmacy Data to Gauge Impact of Governor's Carve-Out Order
Gov. Newsom's executive order to carve out pharmacy services from Medi-Cal managed care took another step forward this past month. On March 26, CalOptima participated in a statewide call with DHCS, which has now requested data on pharmacy costs and utilization for our Medi-Cal and OneCare Connect programs. Officials are working to get a sense of the size of transition driven by the governor's order. Our industry associations continue to prioritize work on this issue by suggesting alternatives that may offer the desired result of lower overall drug costs without jeopardizing the care coordination inherent in managed care.

Cal MediConnect Poised for a Three-Year Extension That Brings Program Changes
The Cal MediConnect (CMC) program, including CalOptima OneCare Connect, is awaiting state and federal approval of a three-year extension that would authorize CMC through 2023 and introduce key changes. The extension includes new rules for financial penalties based on high rates of disenrollment starting in 2019, an increase in the quality withhold of 4 percent starting in 2020, and an experience rebate that would require plans to share with DHCS and the Centers for Medicare & Medicaid (CMS) any profit over a threshold. The California Association of Health Plans provided feedback in response to a DHCS request, suggesting certain enhancements, including passive enrollment of newly Medicare-eligible and a pilot to integrate In-Home Supportive Services, which was a component of the original CMC program. I will keep your Board apprised of CMC status as the extension will add further stability to OneCare Connect.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

March 7, 2019

A Regular Meeting of the CalOptima Board of Directors was held on March 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 Penrose led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: All Members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim 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

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that the Office of Administrative Law recently approved the General Licensure regulation proposed by the Department of Managed Health Care (DMHC) effective July 1, 2019. In discussions with the DMHC director and general counsel regarding the impact of the regulation to CalOptima and its health networks, the DMHC confirmed that CalOptima is a full-service health care service plan and continues to have the ability to delegate global risk to limited and restricted health care service plans. CalOptima health networks currently operating under limited and/or restricted licenses, including those with CalOptima HMO agreements, would be grandfathered under the new regulation. Additional communications with DMHC will be held in the coming weeks, and staff will keep the Board and stakeholders informed.

PUBLIC COMMENT

There were no requests for public comment.

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 (Measurement Year 2018) Pay for Value Program for Medi-Cal and OneCare Connect Lines of Business

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

Based on his affiliation with CHOC as an anesthesiologist physician, Chair Yost did not vote on this item. Supervisor Do did not vote on this item due to potential conflicts of interest under the Levine Act. Director Schoeffel did not vote on this item due to potential conflicts of interest.

Agenda Items 3 and 6 were pulled for discussion and separate action.

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 the CalOptima 2019 Quality Improvement (QI) Program and 2019 QI Work Plan

Supervisor Do inquired about CalOptima's Member Experience score as it relates to other health plans in the state and nationally, and he suggested adding a measurable goal to the 2019 QI Program on improving access to homeless members. Staff will provide additional information to the Board on Member Experience measures. Chair Yost added that the Board of Directors' Quality Assurance Committee (QAC) will consider an additional goal related to improving access to homeless members at a future QAC meeting.

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Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved the recommended revisions to the 2019 Quality Improvement Program and 2019 Quality Improvement Work Plan. (Motion carried 9-0-0)***

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

Supervisor Steel inquired about awarding gift cards as member incentives related to the Shape Your Life program, as well as any other CalOptima member incentive programs. Staff responded that this incentive program for members and providers has been approved by the Department of Health Care Services, and a summary of CalOptima member incentive programs will be provided to the Board.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors authorized 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 authorized 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-approved member and provider incentive program. (Motion carried 9-0-0)***

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

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

Michelle Laughlin, Executive Director, Network Operations, reported that after further discussions with Kaiser, contract language has been added to address internal pharmacy claims, which are to be reimbursed at the equivalent of 100% of the CalOptima contracted pharmacy network rate. The "lesser of" language for external providers has been removed, and all external claims including pharmacy are to be paid at 100% of Kaiser's contracted negotiated rates, or the rates that Kaiser must pay to non-contracted providers.

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 a contract amendment with Kaiser Foundation Health Plan, Inc., to establish the payment methodology for Kaiser Foundation Health Plan, Inc., under CalOptima's Whole-Child Model Program. (Motion carried 8-0-0; Director Schoeffel absent)***

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

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

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After discussion of the matter, Supervisor Do commented on the importance of presenting recommended Alternative Care Setting (ACS) sites to the Board of Directors for approval, and suggested the following revision to the 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."

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized 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. (Motion carried 8-0-0; Director Schoeffel absent)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer 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). (Motion carried 9-0-0)***

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors: Authorized 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.5004: Travel Policy; 2) Authorized 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) Made a finding that such expenditures are for a public purpose and in the furtherance of CalOptima's mission and statutory purpose. (Motion carried 9-0-0)***

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15. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2019-20
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 authorized procurement and renewal of insurance policies for Policy Year 2019-20 at a premium cost not to exceed $2,650,000. (Motion carried 8-0-0; Director Schoeffel absent)***

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized expenditure for CalOptima's participation in the following community events: 1) 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; 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; 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 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) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 9-0-0)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized 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. (Motion carried 9-0-0)***

ADVISORY COMMITTEE UPDATES

18. Whole-Child Model Family Advisory Committee (WCM FAC) Update
Pamela Patterson, WCM FAC Vice Chair, reported on the gaps in physical and medical therapy services for California Children's Services (CCS) members and suggested forming a focus group including key staff and parents to work on issues concerning prescriptions, case management and coordinating authorizations for physical therapy with the County. Mr. Schrader responded that CalOptima will invite County staff to the next WCM FAC meeting to discuss these issues.

19. Provider Advisory Committee (PAC) Update
John Nishimoto, O.D., PAC Chair, reported on the upcoming recruitment for the following seats: Long-Term Services and Support, Non-Physician Medical Practitioner, Pharmacy, and Physician Representatives.

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INFORMATION ITEMS

20. Homeless Health Update

Mr. Schrader presented an update on the clinical field team pilot and the status of the Homeless Response Team approved by the Board at the February 22, 2019 Special meeting. It was reported that further study will be conducted on the following expanded service options for Board consideration: embedded clinics at selected high-volume shelters, increased per-diem and APR-DRG reimbursement for hospital navigators at contracted hospitals for integrating into the Whole-Person Care (WPC) program, increased access to skilled nursing services, development of a post-WPC recuperative care program, and coordination with the County to explore recuperative care with a focus on behavioral health.

After considerable discussion of the matter, Chair Yost formed an ad hoc committee to examine the issues related to homeless health; volunteers to serve on the ad hoc were requested. Additionally, the Board directed staff to include homelessness as a priority issue in the Board's discussion and development of the 2020-2023 Strategic Plan.

21. Health Homes Program Update

Candice Gomez, Executive Director, Program Implementation, reported that CalOptima was recently notified that the DHCS has revised CalOptima's HHP go-live date to January 1, 2020. An overview of the Health Homes Program (HHP), including member identification, eligibility and exclusions, HHP core services, and coordination opportunities was provided. It was noted that CalOptima submitted DHCS defined deliverables by the January 1, 2019 deadline that included policies and procedures, the network delivery model, engagement strategy and member materials. Feedback from DHCS indicated that members cannot be required to change their primary care provider or health network, as well as strengthening the service delivery model in the areas of care management and coordination. CalOptima will continue to collaborate with health networks to implement HHP for their assigned members.

The following Information Items were accepted as presented:
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

Director Penrose reported that at the February 21, 2019 Board of Directors' Finance and Audit Committee (FAC) meeting, the FAC reviewed the County's Quarterly Budget Actual Review (QBAR) process with the goal to streamline the communication of budget allocation changes or transfer of funds, including the review of any recommended changes by the FAC on a quarterly basis before presentation to the Board of Directors for approval, except in emergency cases.

Chair Yost reported on the appointment of Supervisor Do and Director DiLuigi to serve on the IGT 6 and 7 Ad Hoc to review proposals related to the Board approved IGT 6 and 7 expenditure plan and make community grant recommendations to the Board of Directors for approval. Dr. Yost also requested that in addition to the provision of information to the Board of Directors' Quality Assurance

Committee (QAC) on homeless deaths in the County, that staff present proposed measures for the homeless population for review at the next QAC meeting; the QAC will provide a report for discussion at a future Board meeting.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 4:53 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: April 4, 2019

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MINUTES

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

January 10, 2019

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on January 10, 2019, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Molnar called the meeting to order at 2:40 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Sandy Finestone (2:45 PM); Diana Cruz-Toro; Connie Gonzalez; Jaime Munoz (2:54 PM); Ilia Rolon; Jacquelyn Ruddy; Sr. Mary Therese Sweeney; Christine Tolbert;

Members Absent: Donna Grubaugh; Mallory Vega

Others Present: Ladan Khamseh, Chief Operating Officer; Dr. David Ramirez, Chief Medical Officer; Thanh-Tam Nguyen, Medical Director; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, MD, Medical Director; Michelle Laughlin, Executive Director, Network Operations; Sesha Mudunuri, Executive Director, Operations; Betsy Ha, Executive Director, Quality Analytics, Belinda Abeyta, Director, Customer Service; Mauricio Flores, Manager Customer Service; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Specialist

MINUTES

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

Action: ***On motion of Member Sr. Mary Therese Sweeney, seconded and carried, the MAC approved the minutes as submitted. (8-0-0, Members Grubaugh and Vega absent)***

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

Action: ***On motion of Member Christine Tolbert, seconded and carried, the MAC approved the minutes as submitted. (8-0-0, Members Grubaugh and Vega absent)***

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PUBLIC COMMENT

There were no requests for Public Comment.

REPORTS

Chief Medical Officer (CMO) Update

Dr. David Ramirez, CMO, introduced Dr. Thanh-Tam Nguyen, as the new Medical Director for the Whole-Child Model program. Dr. Ramirez also spoke of his goal to improve member experience that would help improve the Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores as well as improve access and remove barriers for members as the three major areas CalOptima would be focusing on this year.

Chief Operating Officer (COO) Update

Ladan Khamseh, COO, provided an update on the changes to CalOptima's Non-Emergency Transportation Service (NEMT) and noted that CalOptima had contracted with Veyo and that this change in vendor should have a minimal impact if any to CalOptima members. Ms. Khamseh also told the MAC that CalOptima is currently conducting a customer service community outreach project which is being provided to qualified members for Medi-Cal's Part A and Part B plans. She noted that 1200 eligible members received mailings and customer service is following up the mailing with phone calls. Ms. Khamseh also noted that CalOptima's current strategic plan ends in 2019 and a Request for Proposal (RFP) will be used to find a vendor to assist with the development of the new strategic plan.

Executive Director Network Operations Update

Michelle Laughlin, Executive Director, provided an update on the results of the Medi-Cal Provider Enrollment initiative. The Department of Health Care Services (DHCS) had required that as of January 1, 2019 any provider providing services to Medi-Cal members must be enrolled in Medi-Cal to receive payment. The CalOptima Board agreed to a six-month extension for payments to Primary Care Physicians (PCPs) provided that they show proof that they had enrolled with the DHCS by December 31, 2019.

INFORMATION ITEMS

MAC Member Updates

Chair Molnar noted that nominations open on January 15, 2019 until February 15, 2019 for the two open seats, Children and Long-Term Services and Supports Representatives. Applications are posted on the CalOptima website under the About Us section and then Board and Advisory Committees. Chair Molnar and Members Finestone and Tolbert agreed to participate in an ad hoc committee to review applications for the two seats and to make recommendations at the next MAC meeting.

Whole-Child Model Update

Candice Gomez, Executive Director, Program Implementation presented a comprehensive update on the Whole-Child Model (WCM) implementation. DHCS notified CalOptima of the delayed implementation which is in Phase 3 and is to begin no sooner than July 1, 2019. The basis for the

delay is the size of CalOptima's California Children's Services (CCS) population within Orange County, along with the complexity of CalOptima's delegated health network model. Ms. Gomez noted that until the WCM implementation begins, children that are currently enrolled in CalOptima and CCS will continue to receive CCS services through the Orange County Health Care Agency (OCHCA).

Vision Care Presentation

Provider Advisory Committee (PAC) Chair, John Nishimoto, O.D., Professor and Sr. Associate Dean for Professional Affairs and Clinical Education, Marshall B. Ketchum University Southern California College of Optometry gave an informative presentation on Optometry's role in patient care, early detection and prevention.

ADJOURNMENT

Chair Molnar announced that the next MAC meeting is scheduled for Thursday, March 14, 2019 at 2:30 p.m.

Hearing no further business, Chair Molnar adjourned the meeting at 4:15 p.m.

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

Approved: March 14, 2019

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MINUTES

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

August 23, 2018

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on August 23, 2018 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Gio Corzo called the meeting to order at 3:01 p.m. and led the Pledge of Allegiance.

Chair Corzo welcomed Keiko Gamez as the Member/Family Member Representative.

ESTABLISH QUORUM

Members Present: Gio Corzo, Chair; Patty Mouton, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, Keiko Gamez

Members Absent: George Crits (non-voting), Erin Ulibarri (non-voting), Jyothi Atluri (non-voting), Richard Santana, Kristin Trom

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Sesha Mudunuri, Executive Director, Operations; Dr. Emily Fonda, Medical Director, Medical Management; Betsy Ha, Executive Director, Quality Analytics; Albert Cardenas, Director, Customer Service (Medicare); Cheryl Simmons, Provider Relations; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the June 28, 2018 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Sandy Finestone, seconded and carried, the Committee approved the minutes of the June 28, 2018 meeting. (Motion carried 8-0-0, voting members Santana and Trom absent.)***

PUBLIC COMMENT

There were no requests for public comment.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, noted that the National Committee for Quality Assurance (NCQA) conducted its tri-annual audit of CalOptima in July. The preliminary report indicates that CalOptima achieved a near perfect score, which will allow CalOptima to extend its accreditation. Mr. Schrader provided an update on the transition of the California Children's Services (CCS) to the Whole-Child Model (WCM) effective January 1, 2019, and an update on PACE Alternative Care Setting (ACS) sites located in Garden Grove and Laguna Woods. Additional ACS sites will open in the Fall in the cities of Anaheim and Santa Ana, and CalOptima anticipates that a fifth ACS site will open in 2019.

Chief Medical Officer (CMO) Update

Emily Fonda, M.D., Medical Director, provided an update on the PACE expansion transition to alternative care settings, and noted that. PACE members can keep their primary care physician (PCP) if the PCP chooses to participate in the PACE program.

Dr. Fonda reported on the Whole Person Care (WPC) program designed to increase access and help with navigation of services for the homeless. The program is a collaborative effort between CalOptima and the Orange County Health Care Agency (OCHCA). OCHCA also manages a recuperative care program, which has expanded to three facilities and has increased the maximum length of stay from 15 to 90 days as part of the WPC program. Several Committee members inquired about touring these recuperative care facilities. Staff will provide the members with available dates for tours of these facilities.

Dr. Fonda also noted that CalOptima's Long Term Services and Support (LTSS) Department will be collaborating the University of California Irvine (UCI) in developing the LTSS plan that would be instrumental in helping reduce admissions to the hospital.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Corzo reported that the Member Advisory Committee (MAC) is hosting a joint advisory committee meeting on November 8, 2018. Member Gamez volunteered to serve on an ad hoc committee with Chair Corzo to help develop the joint advisory committee meeting agenda with the ad hoc members from the other committees.

Vice Chair Mouton announced that the 29th Annual Alzheimer's Research Conference, in collaboration with Alzheimer's Orange County, the UCI Mind Institute, and The Pacific Hospice and Palliative Care Foundation, will be held on October 6, 2018 in Irvine.th. Vice Chair Mouton also noted that the California Conference of Catholic Bishops have embarked upon a Whole Person Care initiative to improve access and education on Palliative and Hospice Care, and a conference is scheduled at the Christ Cathedral campus in Orange on October 25, 2018.

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Member Chigaros reported that Chief Medical Officer Michelle Eslami, M.D. is now with Rockport Healthcare Services. Dr. Eslami has agreed to present at a future OCC MAC meeting.

Intergovernmental Transfer (IGT) Funds 5, 6 &7 Update

Cheryl Meronk, Director, Strategic Planning, provided an overview of the approved Intergovernmental Transfer (IGT) Funds for IGT 5, 6 and 7. IGT 5 has $14.4 million available for community grants, and eight Requests for Information (RFI) generated 93 responses. Staff is currently reviewing these responses and recommendations regarding the proposals will be presented for consideration at a future Board meeting. CalOptima received an additional $8 million of unanticipated funds related to IGT 6 and 7. On August 2, 2018, the Board approved an allocation of $10 million in IGT funds from IGT 6 and 7 to the OCHCA for recuperative care services under the Whole-Person Care pilot program. A recommendation for expenditure plans for the remaining $21.1 million will be presented to the Board for consideration in September.

Health Homes Program (HHP) Update

Candice Gomez, Executive Director, Program Implementation reported that HHP was authorized at the Federal level through Affordable Care Act (ACA) and is available for eligible members in CalOptima's OneCare and OneCare Connect programs. The HHP program is scheduled to take effect July 1, 2019.

Annual Healthcare Effectiveness Data and Information Set (HEDIS) Update and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Update

Irma Munoz, Lead Project Manager, Quality Analytics, and Marsha Choo, Manager, Quality Analytics, presented the 2018 HEDIS and CAHPS results, and reported that CalOptima improved its performance levels from the previous year.

ADJOURNMENT

Chair Corzo announced that the next OCC MAC Meeting will be held on Thursday, October 25, 2018.

Hearing no further business, the meeting adjourned at 4:27 p.m.

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

Approved: February 28, 2019

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MINUTES

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

February 14, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, February 14, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

John Nishimoto, O.D., PAC Chair, reordered the agenda to hear CEO and Management Reports until a quorum was reached.

PUBLIC COMMENTS

Pamela Pimentel, MOM's of Orange County, Oral re: Agenda Item VII. D., Update on Dental Initiatives

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), presented an update on the Whole-Child Model (WCM) contracting initiative and noted that CalOptima will be providing the Department of Health Care Services (DHCS) with copies of signed provider contracts before March 1, 2019. She noted that member noticing is still required, and members will receive both a 90-day and a 60-day letter as well as outreach calls. Ms. Khamseh also updated the PAC on the Health Homes Program and noted that CalOptima is working with the DHCS to see if there is flexibility in pushing out the roll out of this program to January 1, 2020. Ms. Khamseh also updated the PAC on the Board approved process for considering requests for letters of support from organizations seeking to offer Program of All-Inclusive Care for the Elderly (PACE) services in the Orange County area and noted that there were two letters of support being reviewed as per the Board's directive at the September 2018 meeting.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer (CMO), provided an update on medical management and pharmacy management's plan to reduce barriers for the WCM families and members to receive care. He noted that these departments are working diligently to ensure that the roll out on July 1, 2019 goes smoothly. Dr. Ramirez also discussed Homeless Health and ways CalOptima could help support members who are homeless by trying to identify gaps in care with the homeless population. He also updated the PAC on the Be Well OC Center and how the Center could assist members in such areas as dementia and eating disorders.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, noted that the DHCS is slated to certify the provider network for the WCM by March 15, 2019. She noted that ten networks were using Children's Hospital of Orange County (CHOC) to create their WCM network. Ms. Laughlin also noted that physicians who had applied for their Medi-Cal enrollment were being notified by DHCS of their acceptance into the Medi-Cal program.

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CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:20 a.m. Vice Chair Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D. (at 8:20 a.m.); Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.
Members Absent:	Theodore Caliendo, M.D., Junie Lazo-Pearson, Ph.D., Brian Lee, Ph.D. and Jacob Sweidan, M.D.
Others Present:	Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Arif Shaikh, Director, Government Affairs; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the December 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 December 13, 2018 meeting. (Motion carried 8-0-0; Members Caliendo, Lazo-Pearson, Lee and Sweidan absent)***

INFORMATION ITEMS

Opioid Crisis Update

Dr. Ramirez presented an update on the opioid crisis in Orange County. He noted that CalOptima had instituted some formulary restriction that required prior authorization for drugs with the highest risk of overdose such as Methadone and extended-release high-dose morphine as well as require a prior authorization for short-acting opioid analgesic combinations exceeding formulary quantity limits. Dr. Ramirez noted that CalOptima's pharmacy management team currently works with members who have been prescribed opioids and the physicians who are prescribing them by providing member and physician education.

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Health Homes Program Update
Candice Gomez, Executive Director, Program Implementation, provided an update on the Health Homes Program (HHP) and noted that the required DHCS readiness documents and deliverables have been submitted to DHCS for review and approval Ms. Gomez informed the committee that CalOptima has requested the HHP be effective January 1, 2020 not July 1, 2019. DHCS has not yet responded to the request.

State Budget Update
Arif Shaikh, Director, Government Affairs, provided an update on newly elected Governor Newsom's budget proposals. He noted that the proposed budget would carve-out pharmacy services and return it to fee-for-service no sooner than July 1, 2021, in an effort to control drug costs. The Senate Budget Committee is holding an informational hearing on February 14, 2019. Mr. Shaikh also discussed the Managed Care Organization (MCO) Tax, which is due to end on June 30, 2019. He noted that there is interest in extending the MCO tax, which brings in approximately $1 billion/year for Medi-Cal. Mr. Shaikh also discussed the State's intent to expand full scope Medi-Cal to undocumented individuals up to age 25.

Update on Dental Initiatives
Mr. Shaikh presented an update on the Denti-Cal Initiative and provided the PAC with a brief background on the program. Mr. Shaikh noted that at the November 1, 2018 Board of Directors meeting, the Board authorized CalOptima to explore policy opportunities to carve-in dental benefits for Orange County Medi-Cal members. He noted that CalOptima will start to engage local stakeholders, regulators and statewide advocacy organizations, including DHCS and the California Dental Association, to determine their level of support. CalOptima is seeking letters of support from organizations that share CalOptima's interest in the integration of the dental program into Medi-Cal. Letters of support are due by March 1, 2019.

PAC Member Updates
On behalf of the PAC, Chair Nishimoto recognized former member Pamela Pimentel for her nine years of service on the PAC. Ms. Pimentel thanked the PAC members, CalOptima leadership and staff for their support during her tenure.

Chair Nishimoto noted that the recruitment for the hospital and nurse representatives will close on Friday, February 15, 2019. Chair Nishimoto requested volunteers for a Recruitment Ad Hoc Committee to review the applicants for the hospital and nurse representatives' seats, and Vice Chair Miranti and Members Myers and Sweidan volunteered to serve. The ad hoc will present recommendations for consideration at the March 14, 2019 meeting.

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ADJOURNMENT
There being no further business, Chair Nishimoto adjourned the meeting at 9:38 a.m.

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

Approved: March 14, 2019

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
3. Consider Appointment of CalOptima Treasurer

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

Recommended Action
Appoint Nancy Huang, CalOptima Interim Chief Financial Officer, as Interim Treasurer.

Background
At the September 10, 1996, Special Meeting, the CalOptima Board of Directors (Board) authorized the creation of the CalOptima Investment Advisory Committee (IAC), and stipulated that CalOptima's Chief Financial Officer (CFO) would automatically serve on the IAC by virtue of his or her position.

At its June 2, 1998, meeting, the Board approved the substitution of the title "Treasurer," in place of "CFO" as the CalOptima staff person appointed to the IAC.

Discussion
In accordance with CalOptima's Annual Investment Policy, the Treasurer is responsible for oversight of the management of CalOptima's investment program. Section V. of the Annual Investment Policy provides that "The Treasurer shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board approved investment managers."

The proposed action is to appoint CalOptima Interim CFO, Nancy Huang, to serve as Interim Treasurer, effective upon Board approval.

Fiscal Impact
None

Rationale for Recommendation
Appointment CalOptima's Interim CFO as the CalOptima Treasurer will ensure stability and continuity in the oversight of CalOptima's treasury functions, and activities of investment managers, consistent with the requirements of CalOptima's Annual Investment Policy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

3/27/2019 — **Date**

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

Back to Agenda

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

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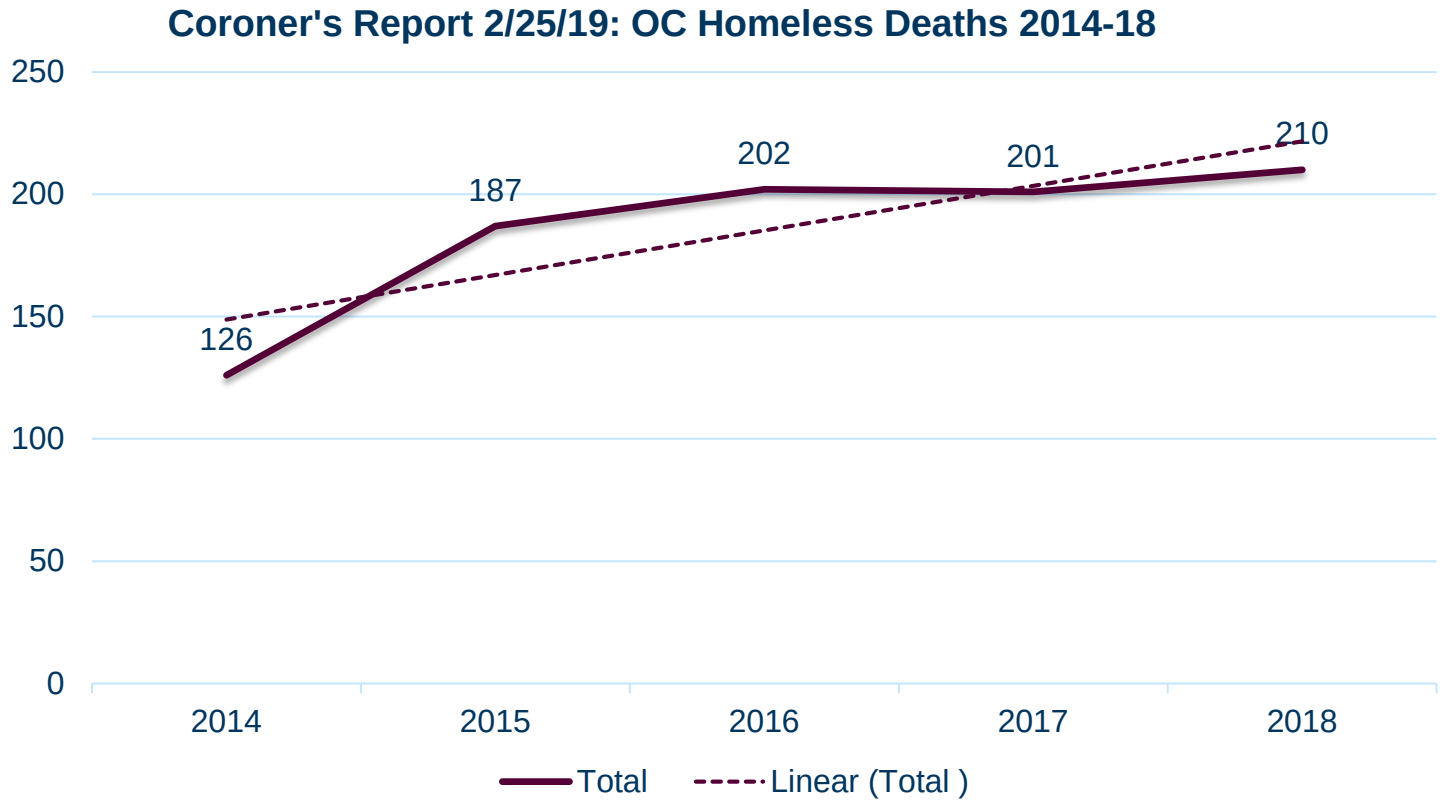
Homeless Deaths

Back to Agenda

Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

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Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

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Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

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Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

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Better System of Care

Back to Agenda

Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

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Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

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Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

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Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

Back to Agenda

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

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Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Back to Agenda

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Back to Agenda

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

Back to Agenda

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

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WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

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Better System of Care: Future Planning

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Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

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Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services Health Center
- Serve the People Community Health Center

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Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

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Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

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Current System of Care

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

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Current System of Care (Cont.)

- Services available to Medi-Cal members through CalOptima
  - Physician services – primary and specialty care
  - Hospital services and tertiary care
  - Palliative care and hospice
  - Pharmacy
  - Behavioral health (mild to moderate)
- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
  - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
  - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

- Access issues for homeless individuals
  - Difficulty with scheduled appointments
  - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
  - Individuals may qualify for Medi-Cal but are not enrolled

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Immediate Response

- In 2018, more than 200 reported homeless deaths in Orange County
  - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
  - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
    - Percentage that were CalOptima members
    - Demographics
    - Causes of death
    - Prior access to medical care
  - Identify opportunities for improvement

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Strengthened System of Care

- Vision
  - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
  - Reasons for partnering with FQHCs
    - Receive CalOptima reimbursement for Medi-Cal members
    - Receive federal funding for uninsured
    - Enrollment assistance into Medi-Cal
    - Offer members education on choosing FQHC as their PCP
  - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
    - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
    - Available with extended hours
    - Go to parks, riverbeds and shelters
    - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

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Federal and State Guidance

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
  - Intensive case management services
    - Section 1915(c) Home and Community Based Services waiver
      - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
  - Housing navigation and supports
    - Section 1115 waiver
      - e.g., Whole-Person Care Pilot

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Federal and State Guidance (Cont.)

- Medicaid funds cannot be used for rent or room and board
  - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
  - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

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Activities in Other Counties

- Los Angeles County
  - LA County administers a flexible housing subsidy pool
  - L.A. Care provided a $4 million grant (total commitment of $20 million over 5 years) for rent subsidies to house 300 individuals
    - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
  - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
  - Housing pool not in existence today under WPC Pilot
  - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

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Considerations

- Establish CalOptima Homeless Response Team
  - Dedicated CalOptima resources
  - Coordinate with clinical field teams
  - Interact with Blue Shirts, health networks, providers, etc.
  - Work in the community
  - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
  - On-site in shelters
  - On the streets through clinical field teams

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Additional Considerations

- Look at opportunities to support CalOptima members who are homeless
  - ➢ Contribute to a housing pool
    - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
    - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

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Recommended Actions

- Authorize establishment of a clinical field team pilot program
  - Contract with any willing FQHC that meets qualifications
  - ~~CalOptima financially responsible for services regardless of health network eligibility~~
  - ~~One year pilot program~~
  - ~~Fee for service reimbursement based on CalOptima Medi-Cal fee schedule~~
- Authorize reallocation of up to $1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
  - ~~Vehicle, equipment and supplies~~
  - ~~Staffing~~

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Recommended Actions (Cont.)

- Authorize establishment of the CalOptima Homeless Response Team
  - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed $1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

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pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact
The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

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

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

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Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

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

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

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- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

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These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

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IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

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Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

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IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

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Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

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Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

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Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

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Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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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
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

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

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

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- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model (WCM) Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions

Approve modifications to the following Policies and Procedures in connection with Whole-Child Model program as follows:

1. DD.2006: Enrollment In/Eligibility with CalOptima [Medi-Cal]
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process [Medi-Cal]
3. GG.1125: Cancer Clinical Trials [Medi-Cal, OneCare, OneCare Connect]
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices [Medi-Cal]

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. 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.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. On November 21, 2018 and December 18, 2018, DHCS provided updated WCM provider network adequacy standards that all CalOptima health networks must meet in order to participate in the WCM. Additionally, on December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model, which superseded the APL originally published on June 7, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

On December 6, 2018, the CalOptima Board of Directors authorized modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program to no sooner than July 1, 2019. Additional policies and procedure require

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modification due to the delayed WCM implementation date, provider network adequacy standards and regulatory guidance.

Discussion

DHCS released updated network adequacy standards for 27 identified provider types and specialties on November 21, 2018, which was further updated on December 18, 2018. CalOptima's health networks are required to contract with 23 of the 27 identified provider types and CalOptima is responsible for contracting with the remaining four on behalf of the entire network. The remaining four specialty types are considered rare specialties and include, Pediatric Dermatology, Pediatric Developmental and Behavioral Medicine, Oral and Maxillofacial Surgery and Transplant Hepatology. Health networks must meet the adequacy standards as certified by DHCS to participate in WCM. Members may only receive CCS services through a participating health network.

All health networks are expected to meet applicable network adequacy requirements; final evidence of network adequacy was submitted to DHCS on March 1, 2019. Network adequacy will be evaluated, at a minimum, on an annual basis. While not expected, CalOptima has modified its policy and procedures to ensure that members eligible for CCS are not assigned to a health network not participating in WCM. Additionally, processes were established to notify members assigned to a health network that is later determined to not meet WCM provider network adequacy standards.

Below is additional information regarding the modified policies which include revisions related to WCM as well as clarification related to existing operations:

1. ***DD.2006: Enrollment In/ Eligibility with CalOptima*** defines the criteria by which CalOptima enrolls a member in CalOptima Direct. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. Revisions include modifications to the process for members undergoing a transplant to transition from a health network to CalOptima Community Network (CCN). With respect to WCM, the revisions clarify that transitioning members with select chronic conditions from delegated health networks to CalOptima Community Network will be effective on and after the WCM implementation date.

2. ***DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process*** describes the process in which a health network eligible member shall select CalOptima Community Network (CCN) or a health network, and CCN or the health network's responsibilities for such member. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. With respect to WCM, the revisions address requirements that a member may only receive services through a WCM participating network that has met DHCS network adequacy requirements.

3. ***GG.1125: Cancer Clinical Trials*** outlines coverage guidelines for routine health care services provided in connection with a member's participation in a cancer clinical trial. CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory

requirements including the WCM program. With respect to WCM, the revisions address CalOptima's expanded responsibility for Cancer Clinical Trials for CCS members under WCM.

4. ***GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices*** outlines the durable medical equipment (DME) guidelines and medical necessity criteria for reimbursement of medically necessary automobile orthopedic positioning devices (AOPD). CalOptima revised the policy to ensure policy alignment with current operational processes and regulatory requirements including the WCM program. With respect to WCM, the revisions address CalOptima's expanded responsibility for AOPD for CCS members under WCM.

Additional policies are expected to be submitted for Board approval at a later time.

Fiscal Impact
The recommended action to modify existing policies and procedures, DD.2006, DD.2008, GG.1125 and GG.1515 in connection with the WCM program is not expected to have an additional fiscal impact beyond CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks, approved by the Board on October 4, 2018. Management will include all projected revenues and expenses associated with the WCM program in the Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation
To ensure CalOptima meets all requirements of the Whole-Child Model program, approval of the requested actions is recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DD.2006: Enrollment In/ Eligibility with CalOptima (redline and clean versions)
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process (redline and clean versions)
3. GG.1125: Cancer Clinical Trials (redline and clean versions)
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices (redline and clean versions)
5. Board Action 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
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. DHCS All Plan Letter 18-011 California Children's Services Whole-Child Model Program

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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Policy #:	DD.2006
Title:	**Enrollment In/Eligibility with CalOptima Direct**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	10/01/1995
Revision Date:	04/04/2019

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a **Member** in **CalOptima Direct**.

II. POLICY

A. CalOptima may enroll a **Member** in **CalOptima Direct**, in accordance with this Policy.

B. CalOptima shall enroll the following **Members** in **CalOptima Direct Administrative (COD-A)** subject to the provisions of this Policy:

1. A **Member** who has Medicare coverage and is not enrolled in OneCare or OneCare Connect~~:~~.

~~1. For a Member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this policy, CalOptima shall not be required to assign such Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).~~
A **member**
~~2. For a Member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this policy, CalOptima shall assign such Member to a Medi-Cal PCP in accordance with DHCS policy(s).~~

2. ~~A Member~~ who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and ~~is~~ placed outside of Orange County.

3. A **Member** with a **Share of Cost (SOC) Aid Code**.

4. A **Member** who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County zZip cCode, or invalid address information from the State.

   a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the **Member** select a **Health Network** or **CalOptima Community Network (CCN)**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

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***** Terms in **bold** are defined in the Glossary.

C. CalOptima shall enroll a **Member** in **CCN in the following circumstances**, unless eligible for enrollment in **COD-A** ~~as described above, subject to the following provisions of this Policy:~~under Section II.B.:

1. A **Member** with Long Term Care (LTC) **Aid Code**;

2. A **Member** with a Breast and Cervical Cancer Treatment Program (BCCTP) primary **Aid Code**;

3. A **Health Network Eligible Member**, except as otherwise identified in this Policy~~:~~, who is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program, and:

   a. Is diagnosed with hemophilia;

   b. Is listed for a **Solid Organ Transplant** or approved for a Bone Marrow Transplant (BMT). ~~identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a **California Children's Services (CCS)** paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or is approved for a Bone Marrow Transplant (BMT), except if the Member is listed as **Status 7**;~~

   c. Has received a **Solid Organ Transplant** or BMT within one hundred twenty (120) calendar days prior to the **Member's** effective date of enrollment in CalOptima; or

   d. Is diagnosed with **End Stage Renal Disease (ESRD)**.

~~Notwithstanding Section II.C.3., **members** under the age of twenty-one (21) years shall not be assigned to CCN. This provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program.~~

D. If a **Member** is no longer required to be enrolled in **COD-A** or **CCN** as described in Sections II.B or II.C, such **Member**:

1. Is a **Health Network Eligible Member**;

2. May select **CalOptima Community Network** or any other **Health Network** in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a **Health Network Eligible Member** from the provisions of this P~~p~~olicy if such **Member** is enrolled in a **Health Maintenance Organization (HMO)** that, pursuant to the **Health Network's** Contract, is responsible for all **Covered Services** for the **Member**.

F. **COD-A** is responsible for a **Health Network Eligible Member** until such **Member** selects a **Health Network** or is assigned to a **Health Network**, pursuant to CalOptima Policies DD.2008:

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Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment~~.~~, respectively.

G. **CalOptima Direct** is not responsible for **Covered Services** provided to a **Member** outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a **Member** with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such **Member** shall not be auto-assigned by CalOptima, and the **Member** shall remain in **COD-A**.

B. If a **Member** assigned to **COD-A** due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the **Member** select a **Health Network** or **CCN**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto-assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

~~B.~~

C. If a current **Member** assigned to a **Health Network** has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the **Member** may remain with their assigned **Health Network** unless **Member** makes a different **Health Network** choice or meets the criteria for **COD-A** or **CCN** enrollment as stated in Section II.B or II.C.

D. If a **Health Network Eligible Member** becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The ~~**Member's Public**~~**Member's** Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the **Member** in **COD-A**.

   a. If CalOptima receives such request to enroll the **Member** in **COD-A** by the tenth (10^{th}) calendar day of the month, **CalOptima Direct** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1^{st}) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10^{th}) calendar day of the month, **COD-A** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1^{st}) calendar day of the month after the immediately following month.

2. If the **Member's** Public Guardian, ~~or Orange~~or Orange County Children and Family Services does not submit a written request to enroll the **Member** in **CalOptima Direct**, the **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **Division of Financial Responsibility (DOFR)**.

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3. If the **Member** returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the **Member** in a **Health Network** or **CCN**.

E. If a **Health Network Eligible Member** is diagnosed with Hemophilia:

1. The **Member's Health Network** shall notify CalOptima of the **Member's** diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the **Health Network** notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1st) calendar day of the ~~immediate~~immediately following month.

   b. If the **Health Network** notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, to enroll the **Member** in **CalOptima Direct**, and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.~~D~~E.1 of this Policy.

F. If a **Health Network Eligible Member**, is listed for a **Solid Organ Transplant** or approved for a BMT.~~identified by a Provider as a potential candidate for a Solid Organ Transplant at a DHCS-approved Transplant Center or a **CCS** paneled Transplant Special Care Center, and the Provider has requested authorization for Covered Services, or the Member is approved for Bone Marrow Transplant (BMT) at a DHCS-approved Transplant Center or **CCS** paneled Transplant Special Care Center, and is not listed as **Status 7:**~~

1. The **Member's Health Network** shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

   a. Except as set forth in Section III.~~D~~F.1.b of this P~~p~~olicy, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**.

   b. If the **Member** receives a **Solid Organ Transplant** or BMT after the date the **Health Network** notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month of notice.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, and CalOptima transitions such **Member** to **CalOptima Direct** as set forth in Section III.~~D~~F.1. of this P~~p~~olicy.

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3. **CCN** shall be responsible for all **Covered Services** for the **Member** for three- hundred sixty-five (365) calendar days after the **Member** receives a **Solid Organ Transplant** or BMT. After three-hundred sixty-five (365) calendar days after the date the **Member** receives a **Solid Organ Transplant** or BMT, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the **CCS**-paneled Transplant Special Care Center, determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT:

   a. If it has been less than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT; or

   b. If it has been more than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a **Health Network Eligible Member**, except a Kaiser **Member**, is identified as a potential candidate for ~~received~~ a **Solid Organ Transplant** or a BMT: ~~within one hundred twenty (120) calendar days prior to their effective date of enrollment in CalOptima:~~

1. The **Member's Health Network** shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**, for a period of not less than three hundred sixty-five (365) calendar days after the date the **Member** received such Transplant.

3. CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the **Member** received a **Solid Organ Transplant** or BMT.

4. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member** until the **Health Network** submits written notice and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.~~E~~G.1 and III.~~E~~G.2 of this Policy.

H. If a **Health Network Eligible Member** is diagnosed with **ESRD** and is not already assigned to **CCN**:

1. The **Member's Health Network** shall notify CalOptima, in writing, of the **Member** by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

    a. If a **Health Network** submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the ~~immediate~~immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 15, **CCN** shall assume responsibility for the **Member** effective August 1.

    b. If a **Health Network** submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 16, **CCN** shall assume responsibility for the **Member** effective September 1.

    c. CalOptima shall provide the **Member** with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a **Member** who meets the requirements specified in Sections II.B and II.C, of this P~~p~~olicy, CalOptima shall transition the **Member** to **COD-A**, or **CCN**, and notify the **Member's Health Network** of such transition. CalOptima shall provide the **Member**, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until CalOptima enrolls the **Member** in **COD-A** or **CCN**.

J. If CalOptima identifies a **Member** who meets the requirements specified in Section II.B.1.~~b~~ of this P~~p~~olicy, CalOptima shall assign the **Member** a **PCP** as follows:

1. For a **member** who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in **CalOptima Direct** pursuant to this P~~p~~olicy, CalOptima shall not be required to assign such **members** who are eligible for services through Medicare to a Medi-Cal **Primary Care Provider (PCP)** or require them to select a Medi-Cal **PCP** in accordance with the policy of the Department of Health Care Services (DHCS).

2. For a **member** who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in **CalOptima Direct**, pursuant to this P~~p~~olicy, CalOptima shall assign such **member** to a Medi-Cal **PCP** in accordance with DHCS policy(s).

3. For an existing **Member** assigned to a **Health Network**, who gains Part A-only Dual status, CalOptima shall transition the **Member** to **COD-A** in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

    a. CalOptima shall assign the **Member** a **PCP** in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

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4. For a newly enrolled **Member** who is also Medicare Part A-only Dual eligible, CalOptima shall assign the **Member** to a **PCP** in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A **Member** may request to change his or her participating **PCP** every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~H.~~I. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
~~I.~~J. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
~~J.~~K. California Health and Safety Code, §§ 104160 through 104163
~~K.~~L. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
~~L.~~M. Department of Health Care Services All Plan Letter (APL) 18-~~011~~023: California Children's Services Whole Child Model Program
~~M.~~N. Title 22, California Code of Regulations, §51006
~~N.~~O. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services
C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTION(S)

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 09/06/18: Regular Meeting of the CalOptima Board of Directors

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~~B.~~C. 08/06/15: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 03/06/14: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 03/04/10: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 11/05/09: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 06/03/08: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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~~X.~~IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a ~~Member~~member is eligible to receive Medi-Cal ~~Covered Services~~covered services.
California Children's Services Program	~~For the purposes of this policy, the~~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 (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	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 ~~Member~~member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~Members~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A ~~Member~~member who receives all ~~Covered Services~~covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for ~~Members~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division ~~of~~Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of ~~Covered Services.~~covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide ~~Covered Services~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
Health Network Eligible Member	A ~~Member~~member who is eligible to choose a CalOptima ~~Health Network~~health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to ~~Members~~members and serves as the medical home for ~~Members~~members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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Policy #:	DD.2006
Title:	**Enrollment In/Eligibility with CalOptima Direct**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	10/01/1995
Revision Date:	04/04/2019

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a **Member** in **CalOptima Direct**.

II. POLICY

A. CalOptima may enroll a **Member** in **CalOptima Direct**, in accordance with this Policy.

B. CalOptima shall enroll the following **Members** in **CalOptima Direct Administrative (COD-A)** subject to the provisions of this Policy:

1. A **Member** who has Medicare coverage and is not enrolled in OneCare or OneCare Connect.

2. A **member** who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and placed outside of Orange County.

3. A **Member** with a **Share of Cost (SOC) Aid Code**.

4. A **Member** who resides at the Fairview Developmental Center.

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County zip code, or invalid address information from the State.

    a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the **Member** select a **Health Network** or **CalOptima Community Network (CCN)**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. CalOptima shall enroll a **Member** in **CCN in the following circumstances**, unless eligible for enrollment in **COD-A** under Section II.B.:

1. A **Member** with Long Term Care (LTC) **Aid Code**;

2. A **Member** with a Breast and Cervical Cancer Treatment Program (BCCTP) primary **Aid Code**;

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***** Terms in **bold** are defined in the Glossary.

3. A **Health Network Eligible Member**, except as otherwise identified in this Policy, who is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole-Child Model (WCM) program, and:

    a. Is diagnosed with hemophilia;

    b. Is listed for a **Solid Organ Transplant** or approved for a Bone Marrow Transplant (BMT).

    c. Has received a **Solid Organ Transplant** or BMT within one hundred twenty (120) calendar days prior to the **Member's** effective date of enrollment in CalOptima; or

    d. Is diagnosed with **End Stage Renal Disease (ESRD)**.

D. If a **Member** is no longer required to be enrolled in **COD-A** or **CCN** as described in Sections II.B or II.C, such **Member**:

1. Is a **Health Network Eligible Member**;

2. May select **CalOptima Community Network** or any other **Health Network** in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a **Health Network Eligible Member** from the provisions of this Policy if such **Member** is enrolled in a **Health Maintenance Organization (HMO)** that, pursuant to the **Health Network's** Contract, is responsible for all **Covered Services** for the **Member**.

F. **COD-A** is responsible for a **Health Network Eligible Member** until such **Member** selects a **Health Network** or is assigned to a **Health Network**, pursuant to CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment, respectively.

G. **CalOptima Direct** is not responsible for **Covered Services** provided to a **Member** outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a **Member** with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such **Member** shall not be auto-assigned by CalOptima, and the **Member** shall remain in **COD-A**.

B. If a **Member** assigned to **COD-A** due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the **Member** select a **Health Network** or **CCN**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the **Member** fails to choose a **Health Network** or **CCN**, then CalOptima shall auto-assign the **Member**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. If a current **Member** assigned to a **Health Network** has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to

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verify a zip code within Orange County at a later date, the **Member** may remain with their assigned **Health Network** unless **Member** makes a different **Health Network** choice or meets the criteria for **COD-A** or **CCN** enrollment as stated in Section II.B or II.C.

D. If a **Health Network Eligible Member** becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The **Member's** Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the **Member** in **COD-A**.

   a. If CalOptima receives such request to enroll the **Member** in **COD-A** by the tenth (10^{th}) calendar day of the month, **CalOptima Direct** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1^{st}) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10^{th}) calendar day of the month, **COD-A** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1^{st}) calendar day of the month after the immediately following month.

2. If the **Member's** Public Guardian, or Orange County Children and Family Services does not submit a written request to enroll the **Member** in **CalOptima Direct**, the **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **Division of Financial Responsibility (DOFR)**.

3. If the **Member** returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the **Member** in a **Health Network** or **CCN**.

E. If a **Health Network Eligible Member** is diagnosed with Hemophilia:

1. The **Member's Health Network** shall notify CalOptima of the **Member's** diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the **Health Network** notifies CalOptima, in writing, by the tenth (10^{th}) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective the first (1^{st}) calendar day of the immediately following month.

   b. If the **Health Network** notifies CalOptima, in writing, after the tenth (10^{th}) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1^{st}) calendar day of the month after the immediately following month.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, to enroll the **Member** in **CalOptima Direct**, and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.E.1 of this Policy.

F. If a **Health Network Eligible Member**, is listed for a **Solid Organ Transplant** or approved for a BMT.

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1. The **Member's Health Network** shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

    a. Except as set forth in Section III.F.1.b of this Policy, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**.

    b. If the **Member** receives a **Solid Organ Transplant** or BMT after the date the **Health Network** notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month of notice.

2. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until the **Health Network** notifies CalOptima, in writing, and CalOptima transitions such **Member** to **CalOptima Direct** as set forth in Section III.F.1. of this Policy.

3. **CCN** shall be responsible for all **Covered Services** for the **Member** for three- hundred sixty-five (365) calendar days after the **Member** receives a **Solid Organ Transplant** or BMT. After three-hundred sixty-five (365) calendar days after the date the **Member** receives a **Solid Organ Transplant** or BMT, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the **CCS-**paneled Transplant Special Care Center, determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT:

    a. If it has been less than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the **Member** is ineligible for a **Solid Organ Transplant** or BMT; or

    b. If it has been more than three hundred sixty-five (365) calendar days after the **Member** transitioned to **CCN**, CalOptima shall request the **Member** select a **Health Network**, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a **Health Network Eligible Member**, except a Kaiser **Member**, is identified as a potential candidate for a **Solid Organ Transplant** or a BMT:

1. The **Member's Health Network** shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. **CCN** shall assume responsibility for all **Covered Services** for the **Member** on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the **Health Network**, for a period of not less than three hundred sixty-five (365) calendar days after the date the **Member** received such Transplant.

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3. CalOptima shall transition the **Member** to the **Member's** previous **Health Network**, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the **Member** received a **Solid Organ Transplant** or BMT.

4. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member** until the **Health Network** submits written notice and CalOptima transitions such **Member** to **CCN**, as set forth in Section III.G.1 and III.G.2 of this Policy.

H. If a **Health Network Eligible Member** is diagnosed with **ESRD** and is not already assigned to **CCN**:

1. The **Member's Health Network** shall notify CalOptima, in writing, of the **Member** by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

a. If a **Health Network** submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 15, **CCN** shall assume responsibility for the **Member** effective August 1.

b. If a **Health Network** submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, **CCN** shall assume responsibility for all **Covered Services** for the **Member** effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a **Health Network** submits Form CMS-2728-U3 on June 16, **CCN** shall assume responsibility for the **Member** effective September 1.

c. CalOptima shall provide the **Member** with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a **Member** who meets the requirements specified in Sections II.B and II.C, of this Policy, CalOptima shall transition the **Member** to **COD-A**, or **CCN**, and notify the **Member's Health Network** of such transition. CalOptima shall provide the **Member**, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The **Member's Health Network** shall be responsible for all **Covered Services** for the **Member**, in accordance with the **DOFR**, until CalOptima enrolls the **Member** in **COD-A** or **CCN**.

J. If CalOptima identifies a **Member** who meets the requirements specified in Section II.B.1. of this Policy, CalOptima shall assign the **Member** a **PCP** as follows:

1. For a **member** who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in **CalOptima Direct** pursuant to this Policy, CalOptima shall not be required to assign such **members** who are eligible for services through Medicare to a Medi-Cal **Primary Care Provider (PCP)** or require them to select a Medi-Cal **PCP** in accordance with the policy of the Department of Health Care Services (DHCS).

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2. For a **member** who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in **CalOptima Direct**, pursuant to this Policy, CalOptima shall assign such **member** to a Medi-Cal **PCP** in accordance with DHCS policy(s).

3. For an existing **Member** assigned to a **Health Network**, who gains Part A-only Dual status, CalOptima shall transition the **Member** to **COD-A** in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

    a. CalOptima shall assign the **Member** a **PCP** in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

4. For a newly enrolled **Member** who is also Medicare Part A-only Dual eligible, CalOptima shall assign the **Member** to a **PCP** in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A **Member** may request to change his or her participating **PCP** every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy FF.1001: Capitation Payment
H. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
I. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
J. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
K. California Health and Safety Code, §§ 104160 through 104163
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
N. Title 22, California Code of Regulations, §51006
O. Welfare and Institutions Code, §14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/07/15: Department of Health Care Services
B. 08/18/15: Department of Health Care Services

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C. 04/01/15: Department of Health Care Services
D. 10/01/12: Department of Health Care Services

VII. BOARD ACTION(S)

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
B. 09/06/18: Regular Meeting of the CalOptima Board of Directors
C. 08/06/15: Regular Meeting of the CalOptima Board of Directors
D. 03/06/14: Regular Meeting of the CalOptima Board of Directors
E. 03/04/10: Regular Meeting of the CalOptima Board of Directors
F. 11/05/09: Regular Meeting of the CalOptima Board of Directors
G. 06/03/08: Regular Meeting of the CalOptima Board of Directors
H. 10/19/06: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal covered 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 (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	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 member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A member who receives all covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
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), which shall be covered for members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that health network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; and 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

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P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name:_____ (Last / First) ☐ M ☐ F D.O.B._____ Age: _____

Mailing Address:_____ City:_____ ZIP:_____ Phone: _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#:_____ TIN#:_____

Medi-Cal ID#: _____

Address: Phone: _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis:_____ ICD-9: _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

☐ Inpatient ☐ Outpatient

Estimated Length of Stay: _____

Letter of Agreement (LOA) Requested

Date(s) of Service:_____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting medical records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Special Needs Screen Questionnaire for Member with Hemophilia Transitioning from Health Networks to CalOptima Direct

☐ Hemophilia A ☐ Hemophilia B ☐ Hemophilia C ☐ von Willebrands Disease

Name: CIN #: Phone No: ( ) -

Health Network: HN Contact: Phone No: ( ) -

Primary Care Physician: Phone No: ( ) -

Treating Specialists: Phone No: ( ) -

Is Member currently in Case Management?

*If member is in case management, submit a case summary.

Planned Admissions or scheduled surgeries:

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Date of Procedure: - - Type of Procedure:

Comments (include CPT and ICD-9 codes requested/authorized):

What factor is utilized?

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Comments (include CPT and ICD-9 codes requested/authorized):

Has the member been hospitalized in the past six months? ☐ Yes ☐ No

If yes:

Hospital:

Diagnosis:

RX

(Please make copies of this page if additional space needed for medications)

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of person completing this form: Date: - -

PLEASE SEND A COPY OF ALL OPEN AUTHORIZATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Claim Number

3. Social Security Number

4. Date of Birth *(mm/dd/yyyy)*

5. Patient Mailing Address *(Include City, State and Zip)*

6. Phone Number *(including area code)*

7. Sex ☐ Male ☐ Female

8. Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe
☐ Asian
☐ Native Hawaiian or Other Pacific Islander*
*complete Item 9

11. Is patient applying for ESRD Medicare coverage? ☐ Yes ☐ No

12. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ DVA ☐ Medicare Advantage ☐ Other ☐ None

13. Height INCHES ____ OR CENTIMETERS ____

14. Dry Weight POUNDS ____ OR KILOGRAMS ____

15. Primary Cause of Renal Failure *(Use ICD-10-CM Code)*

16. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

17. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 mon hs ☐ 6-12 months ☐ >12 mon hs
d. What access was used on first outpatient dialysis: ___ AVF ___ Graft ___ Catheter ☐ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No
Is maturing graft present? Yes No

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)			d. HbA1c	%	
a.2. Serum Albumin Lower Limit			e. Lipid Profile TC		
a.3. Lab Method Used (BCG or BCP)			LDL		
b. Serum Creatinine (mg/dl)			HDL		
c. Hemoglobin (g/dl)			TG		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility

21. Medicare Provider Number *(for item 20)*

22. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)*

25. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*

26. Has patient been informed of kidney transplant options? ☐ Yes ☐ No

27. If patient NOT informed of transplant options, please check all that apply:
☐ Medically unfit
☐ Patient has not been assessed
☐ Patient declines information
☐ Psychologically unfit
☐ Unsuitable due to age
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant *(mm/dd/yyyy)*	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

31. Enter Date *(mm/dd/yyyy)*	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32

34. Current Status of Transplant *(if functioning, skip items 36 and 37)*	35. Type of Donor:
☐ Functioning ☐ Non-Functioning	☐ Deceased ☐ Living Related ☐ Living Unrelated
36. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	37. Current Dialysis Treatment Site
	☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

38. Name of Training Provider	39. Medicare Provider Number of Training Provider (for Item 38)
40. Date Training Began *(mm/dd/yyyy)*	41. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
42. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	43. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

44. Printed Name and Signature of Physician personally familiar with the patient's training			45. UPIN of Physician in Item 44
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

46. Attending Physician *(Print)*	47. Physician's Phone No. *(include Area Code)*	48. UPIN of Physician in Item 46

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

49. Attending Physician's Signature of Attestation *(Same as Item 46)*	50. Date *(mm/dd/yyyy)*
51. Physician Recertification Signature	52. Date *(mm/dd/yyyy)*

53. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

54. Signature of Patient *(Signature by mark must be witnessed.)*	55. Date *(mm/dd/yyyy)*

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form SHOULD NOT be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form MUST BE completed within 45 days for ALL patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis. For patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient.

The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post- transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease.

Items 15, 17-18, 26-27, 49-50: To be completed by the attending physician.
Item 44: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 54 and 55: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Medicare claim number as it appears on his/her Medicare card.
3. Enter the patient's own social security number. This number can be verified from his/her social security card.
4. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
5. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
6. Enter the patient's home area code and telephone number.
7. Check the appropriate block to identify sex.
8. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.
9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.
10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

    White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

    Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

    American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains Tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

    Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

    Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

- Forward one copy of this form to the Social Security office servicing the claim.
- Forward one copy of this form to the ESRD Network Organization.
- Retain one copy of this form in the patient's medical records file.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0046. The time required to complete this information collection estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

11. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. Note: Even though a person may already be entitled to general Medicare coverage, he/she should reapply for ESRD Medicare coverage.

12. Check all the blocks that apply to this patient's current medical insurance status.

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees o former employees.

DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

None—Patient has no medical insurance plan.

13. Enter the patient's most recent recorded height in inches OR centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

14. Enter the patient's most recent recorded dry weight in pounds OR kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

15. To be completed by the attending physician. Enter the ICD10-CM Code to indicate the primary cause of end stage renal disease.

16. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. Check only one box for each time period. If patient is under 6 years of age, leave blank.

17. To be completed by the attending physician. Check all co-morbid conditions that apply.

*Cerebrovascular Disease includes history of stroke/cerebrovascular accident (CVA) and transient ischemic attack (TIA).

*Peripheral Vascular Disease includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

*Drug dependence means dependent on illicit drugs.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received exogenous erythropoietin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. Enter the serum creatinine value (mg/dl) and date test was taken. THIS FIELD MUST BE COMPLETED. Value must be within 45 days prior to first dialysis treatment or kidney transplant.

19c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

19d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19e. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

20. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

21. Enter the 6-digit Medicare identification code of the dialysis facility in item 20.

22. If the person is receiving a regular course of dialysis treatment, check the appropriate anticipated long-term treatment setting at the time this form is being completed.

23. If the patient is, or was, on regular dialysis, check the anticipated long-term primary type of dialysis: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. Check only one block. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

24. Enter the date (month, day, year) that a "regular course of chronic dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Chronic Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 53, that patient is restarting dialysis.

25. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 24.

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.

27. If the patient has not been informed of their options (answered "no" to Item 26), then enter all reasons why a

kidney transplant was not an option for this patient at this time.

28. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.
29. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 28.
30. Enter the 6-digit Medicare identification code of the hospital in Item 29 where the patient received a kidney transplant on the date entered in Item 28.
31. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.
32. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.
33. Enter the 6-digit Medicare identification number for hospital in Item 32.
34. Check the appropriate functioning or non-functioning block.
35. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.
36. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post-transplant, enter transplant date.
37. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting

Self-dialysis Training Patients (Medicare Applicants Only)

Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after the completion of the training program. Please complete items 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

38. Enter the name of the provider furnishing self-care dialysis training.
39. Enter the 6-digit Medicare identification number for the training provider in Item 38.
40. Enter the date self-dialysis training began.
41. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.
42. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.
43. Enter date patient completed or is expected to complete self-dialysis training.
44. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.
45. Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)
46. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.
47. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.
48. Enter the physician's UPIN assigned by CMS.

    A system of physician identifiers is mandated by Section 9202 of the Consolidated Omn bus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.
49. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.
50. Enter date physician signed this form.
51. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.
52. The date physician re-certified and signed the form.
53. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.
54. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor.
55. The date patient signed form.

Policy #: DD.2008
Title: **Health Network and CalOptima Community Network Selection Process**
Department: Customer Service
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 10/01/1995
~~Last Review Date:~~ ~~06/01/18~~
~~Last~~ Revised Date: ~~06/01/18~~04/04/2019

I. PURPOSE

This policy describes the process by which a Health Network Eligible Member shall select **CalOptima Community Network (CCN)** or a Health Network, and **CCN's** or the Health Network's responsibilities for such Member.

II. POLICY

A. CalOptima is committed to a Health Network Eligible Member's right to choose **CCN** or a Health Network. CalOptima also recognizes that it is in the best interest of a Member to establish a medical home and maintain Continuity **of** Care with a **Primary Care Provider (PCP)**.

B. CalOptima shall request a Health Network Eligible Member select **CCN** or a Health Network, in accordance with the terms and conditions of this policy.

1. Except as otherwise provided in this policy, a Health Network Eligible Member may select **CCN** or any Health Network that is accepting new Members.

2. Effective January 1, 2007, only a Member who is less than twenty-one (21) years of age may enroll in CHOC Health Alliance, as set forth in Section III.B of this policy.

3. On or after the effective date of the CalOptima Whole-Child Model program, a **member** who is known to be participating in California's Children Services (CCS) may only enroll in a **health network** that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member who does not select **CCN** or a Health Network shall be subject to the Auto-Assignment process, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

D. CalOptima recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all of the Members in the family. To facilitate this objective, CalOptima shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network or **CCN**, to that Health Network or **CCN**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

1. On and after January 1, 2007, except as otherwise provided in this policy, CalOptima shall assign a Family Linked Member to the same Health Network as his or her youngest sibling if such Family Linked Member is under the age of twenty-one (21) years~~.~~.

DRAFT

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2. If a Family Linked Member is over the age of twenty-one (21) years and his or her youngest sibling is enrolled in CHOC Health Alliance, CalOptima shall assign the Family Linked Member to the Health Network of another family **member**, if applicable.

3. On or after the effective date of the CalOptima Whole-Child Model program, if the **member** is known to be eligible with the Whole-Child Model program/**California Children Services Program (CCS)** and the **member's** youngest sibling is assigned to a **health network** that does not participate in the WCM/**CCS** program, the Family Link process will not apply.

E. A Health Network Eligible Member may change his or her Health Network or select **CCN** for any reason every thirty (30) calendar days, in accordance with this policy.

F. **CCN** or a Health Network shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima policies, and other requirements of the CalOptima program.

1. If a Health Network Eligible Member moves outside of Orange County, his or her Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima program. If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, his or her Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator /Public Guardian submits a request to enroll the Member in CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

2. If a Member becomes the responsibility of the Foster Care Program, **CCN** or his or her Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County ~~Children's~~Children & Family Services Department may request to transition the Member into **CalOptima Direct (COD) – Administrative (COD-A)**, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

G. **CCN** or a Health Network shall not be responsible for Covered Services provided to a Member outside the United States with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22 of the California Code of Regulations, Section 51006.

H. CalOptima or a Health Network shall ensure Continuity **of** Care for Members who transition into CalOptima in accordance with CalOptima Policy GG.1325: Coordination of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services.

I. In the event that a **member** is required to change **health network**s, due to **health network** termination or participation status of a **health network** in the Whole-Child Model program, CalOptima and the receiving **health network** shall collaborate to coordinate the provision of **covered services** for the affected **member**, in accordance with CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination.

III. PROCEDURE

A. **CCN** or **Health Network** Selection Process

1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima shall send an enrollment packet to a Health Network Eligible Member. The enrollment packet shall include, but not be limited to, the following information:

   a. Introductory/welcome letter;

   b. CalOptima **Health Network** Selection Form;

   c. Health Information Form;

   d. CalOptima **Member** Handbook;

   e. CalOptima **Member** Identification Card;

   f. Invitation to a **Member** orientation;

   g. **Health Network** report card;

   h. **Health Network** Listing and Provider Directory; and

   i. Postage-paid envelope to return materials to CalOptima.

2. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. CalOptima shall not accept a **Health Network** Selection Form submitted without the signature of the Member or an Authorized Representative.

   a. CalOptima shall not accept responsibility for an inappropriately signed **Health Network** Selection Form.

3. CalOptima realizes that in some instances, such as time-sensitive health care appointments or challenges with valid home addresses, it is in the best interest of the Member to allow a change of Health Network or **CCN** selection request to be made by the Member or the Member's Authorized Representative over the phone~~.~~ in accordance with CalOptima Policy DD.2006b:CalOptima Community Network Member Primary Care Provider Selection/Assignment. In those circumstances, the request will be recorded and processed by the Customer Service Representative at the time of request.

4. If CalOptima receives a Health Network Eligible Member's completed **Health Network** Selection Form by the tenth (10^{th}) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1^{st}) calendar day of the immediately following month. If CalOptima receives a Member's completed **Health Network** Selection Form after the tenth (10^{th}) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1^{st}) calendar day of the month after the immediately following month.

5. A Health Network Eligible Member who has not selected a Health Network or **CCN** within the designated timeframe shall be automatically assigned to a Health Network pursuant to CalOptima Policy AA.1207a: CalOptima Auto-Assignment. Following the assignment of a ~~Health Network Eligible~~ Member in accordance with this policy, CalOptima shall notify the Member in writing of the assignment.

6. CalOptima may apply the following criteria to Member assignments to Health Networks or **CCN**:

   a. Consistent with the provisions of this policy and CalOptima Policy AA.1207a: CalOptima Auto-Assignment Policy, CalOptima shall assign Family Linked Members to the same Health Network or **CCN**.

   b. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility less than three hundred sixty-five (365) calendar days, CalOptima shall assign the Health Network Eligible Member to **CCN** or the last Health Network to which the Member was enrolled.

   c. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility more than three hundred sixty-five (365) calendar days, CalOptima shall treat such Health Network Eligible Member as a new Member, in accordance with this policy.

7. If a Health Network contract with CalOptima is terminated, ~~a Member~~or a health network is no longer participating in the Whole-Child Model Program a **member** who is enrolled in that Health Network may choose a new Health Network or **CCN**, in accordance with this policy.

   a. If the Member does not select a new Health Network or **CCN** prior to the contract termination of the Member's current Health Network, CalOptima shall assign such Member to:

      i. A Health Network of the Member's **PCP**'s choice if the Member's **PCP**, as shown in CalOptima's system, is contracted with at least one (1) other Health Network; or

      ii. A Health Network based on Auto Assignment.

8. A Health Network Eligible Member may change his or her **PCP** every thirty (30) calendar days for any reason~~. A Health Network or CCN shall process a Health Network Eligible Member's request to change his or her PCP.~~

B. **Member**s eligible for enrollment in CHOC Health Alliance

1. ~~A Member~~Subject to other limitations set forth in this policy, a **member** who meets criteria set forth in Section II.B.2 of this policy may select CHOC Health Alliance.

2. CalOptima shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Policy AA.1207a: CalOptima Auto-Assignment.

3. Except as otherwise provided in Section ~~H~~III.B.4 of this policy, a Member who is enrolled in CHOC Health Alliance shall select another Health Network prior to his or her twenty-first (21st) birthday in accordance with the following:

    a. CalOptima shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select **CCN** or another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.

    b. If the Member does not select **CCN** or another Health Network within the designated timeframe, CalOptima shall assign the Member to **CCN** or a Health Network as follows:

        i. If the Member's **PCP** is contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network of the Member's **PCP**'s choice; or

        ii. If the Member's **PCP** is not contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network based on geographic access.

    c. The Member shall be enrolled in **CCN** or the new Health Network effective the first (1st) calendar day of the month immediately following the Member's twenty-first (21st) birthday.

4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

    a. **Member** is diagnosed with one (1) of the following **California Children's Services (CCS)**-Eligible Conditions:

        i. Cystic Fibrosis;

        ii. A rare metabolic ~~disorders~~disorder not including Phenylketonuria (PKU);

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

    b. **Member** is eligible to receive services from **CCS** for the **CCS**-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

    c. **Member** is receiving care for the **CCS**-Eligible Condition from a pediatric specialist who is contracted with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

    d. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy shall remain in CHOC Health Alliance until:

        i. The Member selects **CCN** or another Health Network; or

ii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to **CCN** or another Health Network.

~~5. CalOptima and CHOC Health Alliance shall begin developing a transition plan for a Member who is enrolled in CHOC Health Alliance and who has a CCS-Eligible Condition no later than the Member's twentieth (20th) birthday, in accordance with CalOptima Policy GG.1101: California Children's Services.~~

C. If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or **CCN** shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima program.

1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, **CCN** or a Health Network shall attempt to verify this information with the Member. **CCN** or the Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network or **CCN provider** shall notify CalOptima of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Customer Service Department.

3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

D. CalOptima recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in his or her family in accordance with Section II.D of this policy. A Family Linked Member may contact CalOptima's Customer Service Department to request enrollment in **CCN** or a different Health Network from other Members in his or her family.

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
~~D.~~E. CalOptima Policy GG.1101: California Children's Services
F. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~E.~~G. CalOptima Policy GG.1325: Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima

~~F.~~H. Contract for Health Care Services
~~G.~~I. Medi-Cal Managed Care Division (MMCD) All-Plan Letter (APL) 03-002: SB 87 Medi-Cal Contact Information Release Form
~~H.~~J. Title 22, California Code of Regulations, §§50188, 51006, and 51301 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 06/24/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 04/04/19: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 10/03/06: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 08/30/06: Special Meeting of the CalOptima Board of Directors

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VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/1995	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	07/01/2004	DD.1114	Request from Members of Same Household to Enroll in Different Health Networks	Medi-Cal
Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
Revised	04/04/2019	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
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.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~ individuals under the age of twenty-one (21) years who have CCS-~~Eligible Conditions~~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~~members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-Eligible Conditions	~~Conditions~~Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations~~, Section 41800~~ sections 41515.2 through ~~4187.6 including, but not limited to:~~ ~~1. Infectious and parasitic diseases;~~ ~~2. Neoplasms;~~ ~~3. Endocrine, nutritional, and metabolic diseases;~~ ~~4. Disease of blood and blood-forming organs;~~ ~~5. Diseases of the nervous system;~~ ~~6. Diseases of the eye;~~ ~~7. Diseases of the ear and mastoid process;~~ ~~8. Diseases of the circulatory system;~~ ~~9. Diseases of the respiratory system;~~ ~~10. Diseases of the digestive system;~~ ~~11. Diseases of the genitourinary system;~~ ~~12. Complications of pregnancy, childbirth, and puerperium;~~ ~~13. Diseases of the skin and subcutaneous tissue;~~ ~~14. Diseases of the musculoskeletal and connective tissue;~~ ~~15. Congenital anomalies;~~ ~~16. Certain causes of Perinatal morbidity and mortality; and Accidents, poisonings, violence, and immunization reactions~~41518.9..
Continuity of Care	Services provided to a ~~Member~~member rendered by an out-of-network provider with whom the ~~Member~~member has pre-existing provider relationship.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51310 of Title 22, CCR), which shall be covered for ~~Members~~members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A ~~Member~~member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another ~~Member~~member who is in his or her family and who resides in the same household.
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~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
Health Network Eligible Member	A ~~Member~~member who is eligible to choose a CalOptima ~~Health Network~~health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes ~~Covered Services.~~covered services.

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Policy #:	DD.2008
Title:	**Health Network and CalOptima Community Network Selection Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
Revised Date:	04/04/2019

I. PURPOSE

This policy describes the process by which a Health Network Eligible Member shall select **CalOptima Community Network (CCN)** or a Health Network, and **CCN's** or the Health Network's responsibilities for such Member.

II. POLICY

A. CalOptima is committed to a Health Network Eligible Member's right to choose **CCN** or a Health Network. CalOptima also recognizes that it is in the best interest of a Member to establish a medical home and maintain Continuity **of** Care with a **Primary Care Provider (PCP)**.

B. CalOptima shall request a Health Network Eligible Member select **CCN** or a Health Network, in accordance with the terms and conditions of this policy.

1. Except as otherwise provided in this policy, a Health Network Eligible Member may select **CCN** or any Health Network that is accepting new Members.

2. Effective January 1, 2007, only a Member who is less than twenty-one (21) years of age may enroll in CHOC Health Alliance, as set forth in Section III.B of this policy.

3. On or after the effective date of the CalOptima Whole-Child Model program, a **member** who is known to be participating in California's Children Services (CCS) may only enroll in a **health network** that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member who does not select **CCN** or a Health Network shall be subject to the Auto-Assignment process, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

D. CalOptima recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all of the Members in the family. To facilitate this objective, CalOptima shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network or **CCN**, to that Health Network or **CCN**, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

1. On and after January 1, 2007, except as otherwise provided in this policy, CalOptima shall assign a Family Linked Member to the same Health Network as his or her youngest sibling if such Family Linked Member is under the age of twenty-one (21) years.

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2. If a Family Linked Member is over the age of twenty-one (21) years and his or her youngest sibling is enrolled in CHOC Health Alliance, CalOptima shall assign the Family Linked Member to the Health Network of another family **member**, if applicable.

3. On or after the effective date of the CalOptima Whole-Child Model program, if the **member** is known to be eligible with the Whole-Child Model program/**California Children Services Program (CCS)** and the **member's** youngest sibling is assigned to a **health network** that does not participate in the WCM/**CCS** program, the Family Link process will not apply.

E. A Health Network Eligible Member may change his or her Health Network or select **CCN** for any reason every thirty (30) calendar days, in accordance with this policy.

F. **CCN** or a Health Network shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima policies, and other requirements of the CalOptima program.

1. If a Health Network Eligible Member moves outside of Orange County, his or her Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima program. If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, his or her Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator /Public Guardian submits a request to enroll the Member in CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

2. If a Member becomes the responsibility of the Foster Care Program, **CCN** or his or her Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County Children & Family Services Department may request to transition the Member into **CalOptima Direct (COD) – Administrative (COD-A)**, in accordance with CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.

G. **CCN** or a Health Network shall not be responsible for Covered Services provided to a Member outside the United States with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22 of the California Code of Regulations, Section 51006.

H. CalOptima or a Health Network shall ensure Continuity **of** Care for Members who transition into CalOptima in accordance with CalOptima Policy GG.1325: Coordination of Care for Members Transitioning into CalOptima Services.

I. In the event that a **member** is required to change **health network**s, due to **health network** termination or participation status of a **health network** in the Whole-Child Model program, CalOptima and the receiving **health network** shall collaborate to coordinate the provision of **covered services** for the affected **member**, in accordance with CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination.

III. PROCEDURE

A. **CCN** or **Health Network** Selection Process

1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima shall send an enrollment packet to a Health Network Eligible Member. The enrollment packet shall include, but not be limited to, the following information:

    a. Introductory/welcome letter;

    b. CalOptima **Health Network** Selection Form;

    c. Health Information Form;

    d. CalOptima **Member** Handbook;

    e. CalOptima **Member** Identification Card;

    f. Invitation to a **Member** orientation;

    g. **Health Network** report card;

    h. **Health Network** Listing and Provider Directory; and

    i. Postage-paid envelope to return materials to CalOptima.

2. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. CalOptima shall not accept a **Health Network** Selection Form submitted without the signature of the Member or an Authorized Representative.

    a. CalOptima shall not accept responsibility for an inappropriately signed **Health Network** Selection Form.

3. CalOptima realizes that in some instances, such as time-sensitive health care appointments or challenges with valid home addresses, it is in the best interest of the Member to allow a change of Health Network or **CCN** selection request to be made by the Member or the Member's Authorized Representative over the phone in accordance with CalOptima Policy DD.2006b:CalOptima Community Network Member Primary Care Provider Selection/Assignment. In those circumstances, the request will be recorded and processed by the Customer Service Representative at the time of request.

4. If CalOptima receives a Health Network Eligible Member's completed **Health Network** Selection Form by the tenth (10^{th}) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1^{st}) calendar day of the immediately following month. If CalOptima receives a Member's completed **Health Network** Selection Form after the tenth (10^{th}) calendar day of a month, the Member shall be enrolled into his or her selected Health Network no later than the first (1^{st}) calendar day of the month after the immediately following month.

5. A Health Network Eligible Member who has not selected a Health Network or **CCN** within the designated timeframe shall be automatically assigned to a Health Network pursuant to CalOptima Policy AA.1207a: CalOptima Auto-Assignment. Following the assignment of a Member in accordance with this policy, CalOptima shall notify the Member in writing of the assignment.

6. CalOptima may apply the following criteria to Member assignments to Health Networks or **CCN**:

    a. Consistent with the provisions of this policy and CalOptima Policy AA.1207a: CalOptima Auto-Assignment Policy, CalOptima shall assign Family Linked Members to the same Health Network or **CCN**.

    b. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility less than three hundred sixty-five (365) calendar days, CalOptima shall assign the Health Network Eligible Member to **CCN** or the last Health Network to which the Member was enrolled.

    c. If a Health Network Eligible Member regains eligibility after experiencing a lapse of Medi-Cal eligibility more than three hundred sixty-five (365) calendar days, CalOptima shall treat such Health Network Eligible Member as a new Member, in accordance with this policy.

7. If a Health Network contract with CalOptima is terminated, or a health network is no longer participating in the Whole-Child Model Program a **member** who is enrolled in that Health Network may choose a new Health Network or **CCN**, in accordance with this policy.

    a. If the Member does not select a new Health Network or **CCN** prior to the contract termination of the Member's current Health Network, CalOptima shall assign such Member to:

        i. A Health Network of the Member's **PCP**'s choice if the Member's **PCP**, as shown in CalOptima's system, is contracted with at least one (1) other Health Network; or

        ii. A Health Network based on Auto Assignment.

8. A Health Network Eligible Member may change his or her **PCP** every thirty (30) calendar days for any reason

B. **Member**s eligible for enrollment in CHOC Health Alliance

1. Subject to other limitations set forth in this policy, a **member** who meets criteria set forth in Section II.B.2 of this policy may select CHOC Health Alliance.

2. CalOptima shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Policy AA.1207a: CalOptima Auto-Assignment.

3. Except as otherwise provided in Section III.B.4 of this policy, a Member who is enrolled in CHOC Health Alliance shall select another Health Network prior to his or her twenty-first (21st) birthday in accordance with the following:

    a. CalOptima shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select **CCN** or another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.

    b. If the Member does not select **CCN** or another Health Network within the designated timeframe, CalOptima shall assign the Member to **CCN** or a Health Network as follows:

i. If the Member's **PCP** is contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network of the Member's **PCP**'s choice; or

ii. If the Member's **PCP** is not contracted with **CCN** or another Health Network, CalOptima shall assign the Member to a Health Network based on geographic access.

c. The Member shall be enrolled in **CCN** or the new Health Network effective the first (1st) calendar day of the month immediately following the Member's twenty-first (21st) birthday.

4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

a. **Member** is diagnosed with one (1) of the following **California Children's Services (CCS)-**Eligible Conditions:

i. Cystic Fibrosis;

ii. A rare metabolic disorder not including Phenylketonuria (PKU);

iii. Spina Bifida; or

iv. Muscular Dystrophy.

b. **Member** is eligible to receive services from **CCS** for the **CCS**-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

c. **Member** is receiving care for the **CCS**-Eligible Condition from a pediatric specialist who is contracted with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

d. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy shall remain in CHOC Health Alliance until:

i. The Member selects **CCN** or another Health Network; or

ii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to **CCN** or another Health Network.

C. If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or **CCN** shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima program.

1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, **CCN** or a Health Network shall attempt to verify this information with the Member. **CCN** or the Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network or **CCN provider** shall notify CalOptima of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Customer Service Department.

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3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

D. CalOptima recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in his or her family in accordance with Section II.D of this policy. A Family Linked Member may contact CalOptima's Customer Service Department to request enrollment in **CCN** or a different Health Network from other Members in his or her family.

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

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VIII. REVISION HISTORY

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Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
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Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
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IX. GLOSSARY

Term	Definition
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Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
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 51310 of Title 22, CCR), which shall be covered for members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another member who is in his or her family and who resides in the same household.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that health network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.

Term	Definition
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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PRI-037-105

CalOptima
A Public Agency
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HEALTH NETWORK (HN) SELECTION FORM

MEMBER NAME AND ID #			1 CHOOSE A PRIMARY CARE PROVIDER (PCP)			2 CHOOSE A HN
Last:	First:	ID #:	PCP Last Name or Clinic Name:	PCP First Name:	PCP or Clinic ID:	HN ID*

*Please see your *Health Network Selection Form Guide* for a list of Health Network IDs (HN IDs).
Consulte la *Guía para llenar el Formulario de Selección de Planes de Salud* para una lista de los números de identificación de los planes de salud (HN IDs).
Xin xem *Tài Liệu Hướng Dẫn Điền Mẫu Đơn Chọn Nhóm Y Tế* để biết danh sách Số ID của Các Nhóm Y Tế (Health Network IDs viết tắt là HN IDs).
لطفاً به راهنمای فرم انتخاب شبکه بهداشتی خود برای فهرست شماره شناسایی شبکه های بهداشتی (HN IDs) مراجعه کنید.

3 IMPORTANT! SIGN AND DATE BELOW. THIS FORM MUST BE SIGNED!

Signature of Member or Legal Representative: X _____ Date: _____

Telephone Number: ( ) – Cell Phone Number: ( ) –

E-mail Address:

Do you have insurance other than Medi-Cal / CalOptima? Yes No If Yes, Insurance Name: Policy Number:

NEED HELP? PLEASE CALL CALOPTIMA'S CUSTOMER SERVICE DEPARTMENT AT 1-714-246-8500 OR TOLL-FREE AT 1-888-587-8088

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Dear Member:

Welcome to CalOptima! CalOptima is the Medi-Cal program for Orange County. CalOptima is responsible for managing your health care benefits.

You will receive your Medi-Cal benefits through one of CalOptima's contracted health networks. Please choose a CalOptima health network and a primary care provider (PCP) who is contracted with your health network for each Medi-Cal eligible member of your family. You can choose the same health network for all your family members.

Please use the Health Network Selection Form to choose a health network and PCP for each member of your family. Fill out, sign and return the form to CalOptima as soon as possible. **If you do not choose a health network, CalOptima will choose one for you after 30 days.**

You and your eligible family members may ask to change health networks every 30 days. To do this, you need to complete a Health Network Selection Form. CalOptima has to receive your form by the 10th of the month for your health network change to be effective the 1st of the following month.

If you have questions or need help in choosing a health network, 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. TTY/TDD users can call **1-800-735-2929**. You can also visit our website at www.caloptima.org.

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[MEMBER_NAME]
Member ID: [CIN] Eff Date: [mm/dd/yyyy]

[HEALTH_NETWORK] [HN_PHONE]

Rx Services: 1-888-587-8088 DOB: [mm/dd/yyyy]
Vision Services: 1-800-438-4560* RxBIN: 600428
*for members who meet requirements RxPCN: 05720000

Providers: Eligibility must be verified at time of service.
Failure to obtain authorization may result in non-payment.

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** VOID **

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** VOID **

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** VOID **

Providers: Eligibility must be verified at time of service.
Failure to obtain authorization may result in non-payment.

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If you have a life-threatening emergency, call 911 or go to the nearest emergency room. Notify your health network within 24 hours. Emergency services for a true emergency are covered by your health network without prior authorization. Your member handbook has more information on emergency services and how to access your doctor after hours.

For Providers - Member Eligibility Verification:
1-714-246-8540
CalOptima Provider Help Desk:
1-714-246-8600
CalOptima Behavioral Health Line:
1-855-877-3885
TDD/TTY:
1-800-735-2929

If you have a life-threatening emergency, call 911 or go to the nearest emergency room. Notify your health network within 24 hours. Emergency services for a true emergency are covered by your health network without prior authorization. Your member handbook has more information on emergency services and how to access your doctor after hours.

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TDD/TTY:
1-800-735-2929

Policy #:	GG.1125
Title:	**Cancer Clinical Trials**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/02
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	~~08/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy establishes coverage guidelines for routine health care services provided in connection with a **Member's** participation in a cancer **Clinical Trial**.

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein~~, unless the routine patient care costs are the responsibility of another entity by statute (e.g. California Children's Services (CCS)).~~..

B. Routine patient care costs:

1. Routine patient care costs include health care services that would be:

   a. Provided in the absence of a **Clinical Trial**;

   b. Required for the provision of the investigational drug, item, device, or service;

   c. Required for clinically appropriate monitoring of the cancer treatment;

   d. Provided for the prevention of complications arising from the **Clinical Trial** treatment; or

   e. Needed for reasonable and necessary care arising from complications of the cancer **Clinical Trial**.

2. Routine patient care costs do not include the costs associated with the provision of any of the following:

   a. Drugs or devices that have not been approved by the Federal Drug Administration (FDA) and are associated with the **Clinical Trial**;

   b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of treatment being provided for the purposes of the **Clinical Trial**;

   c. Any item or service that is provided solely to satisfy data collection and analysis needs and is not used in the clinical management of the **Member**;

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d. Health care services that, except for the fact that they are being provided in a **Clinical Trial**, are otherwise specifically excluded from coverage under the CalOptima program;

e. Health care services customarily provided by the research sponsors free of charge for any **Member** in the **Clinical Trial**; and

f. Experimental treatment outside of an eligible cancer **Clinical Trial**.

C. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, a **Member** must meet the following requirements:

1. The **Member** must be diagnosed with cancer;

2. The **Member** must be accepted into a Phase I, II, III, or IV **Clinical Trial** for cancer; and

3. The **Member's** treating physician, who is contracted by the **Health Network** to provide health care services, or who participates with CalOptima for a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, must recommend the **Member's** participation in the cancer **Clinical Trial**.

D. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, the cancer **Clinical Trial** must meet the following requirements:

1. The cancer **Clinical Trial** endpoints must not be defined exclusively to test toxicity, or disease pathophysiology, but must have a therapeutic intent;

2. The principal purpose of the cancer **Clinical Trial** is to test whether the intervention potentially improves the **Member's** health outcomes;

3. The cancer **Clinical Trial** is well-supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

4. The cancer **Clinical Trial** does not unjustifiably duplicate existing studies;

5. The cancer **Clinical Trial** design is appropriate to answer the research question being asked in the **Clinical Trial**;

6. The cancer **Clinical Trial** is sponsored by a credible organization or individual capable of executing the proposed **Clinical Trial** successfully;

7. The cancer **Clinical Trial** is in compliance with Federal regulations relating to the protections of human subjects; and

8. All aspects of the **Clinical Trial** are conducted according to the appropriate standards of scientific integrity.

9. The treatment provided in the cancer **Clinical Trial** must either be:

   a. Approved by one (1) of the following: National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or

   b. Involve a drug that is exempt under federal regulations from a new drug application.

E. CalOptima and its **Health Networks** shall not be prohibited from restricting coverage for routine patient care costs associated with a cancer **Clinical Trial** in California, unless the protocol for the **Clinical Trial** is not provided for at a California hospital or by a California physician.

F. The provision of services as defined under this policy shall not in itself give rise to liability on the part of CalOptima, or the **Health Network**.

G. CalOptima, or a **Health Network**, shall provide care management services to a **Member** who is participating in a cancer **Clinical Trial** to assure that the **Member** is afforded continuity of care, referred to all available resources for his or her illness, and to continue to verify that all eligibility requirements as set forth herein continue to be met.

III. PROCEDURE

A. A Provider~~,~~ or Practitioner~~,~~ shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. DHCS California Children's~~'~~ Services (CCS) Numbered Letter (NL) ~~37-1992~~ 37-1292: Coverage of Experimental and/or Investigational Services
~~C.~~D. CalOptima Health Network Service Agreement
~~D.~~E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~E.~~F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~G. Health and Safety Code, §1370.6
~~G.~~H. Medicare National Coverage Determination 100-03, July 9, 2007

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~~H.~~I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
~~California Children Services (CCS)~~	~~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.~~
CalOptima Community Network (CCN)	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.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006~~.~~: Enrollment in/Eligibility with CalOptima Direct.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
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.
Member	An enrollee-beneficiary of a CalOptima program.

Policy #: GG.1125
Title: **Cancer Clinical Trials**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 11/01/02
Revised Date: TBD

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect

I. PURPOSE

This policy establishes coverage guidelines for routine health care services provided in connection with a **Member's** participation in a cancer **Clinical Trial**.

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein..

B. Routine patient care costs:

1. Routine patient care costs include health care services that would be:

   a. Provided in the absence of a **Clinical Trial**;

   b. Required for the provision of the investigational drug, item, device, or service;

   c. Required for clinically appropriate monitoring of the cancer treatment;

   d. Provided for the prevention of complications arising from the **Clinical Trial** treatment; or

   e. Needed for reasonable and necessary care arising from complications of the cancer **Clinical Trial**.

2. Routine patient care costs do not include the costs associated with the provision of any of the following:

   a. Drugs or devices that have not been approved by the Federal Drug Administration (FDA) and are associated with the **Clinical Trial**;

   b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses that a Member may require as a result of treatment being provided for the purposes of the **Clinical Trial**;

   c. Any item or service that is provided solely to satisfy data collection and analysis needs and is not used in the clinical management of the **Member**;

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d. Health care services that, except for the fact that they are being provided in a **Clinical Trial**, are otherwise specifically excluded from coverage under the CalOptima program;

e. Health care services customarily provided by the research sponsors free of charge for any **Member** in the **Clinical Trial**; and

f. Experimental treatment outside of an eligible cancer **Clinical Trial**.

C. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, a **Member** must meet the following requirements:

1. The **Member** must be diagnosed with cancer;

2. The **Member** must be accepted into a Phase I, II, III, or IV **Clinical Trial** for cancer; and

3. The **Member's** treating physician, who is contracted by the **Health Network** to provide health care services, or who participates with CalOptima for a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, must recommend the **Member's** participation in the cancer **Clinical Trial**.

D. To be eligible for coverage of routine patient care costs associated with participation in a cancer **Clinical Trial**, the cancer **Clinical Trial** must meet the following requirements:

1. The cancer **Clinical Trial** endpoints must not be defined exclusively to test toxicity, or disease pathophysiology, but must have a therapeutic intent;

2. The principal purpose of the cancer **Clinical Trial** is to test whether the intervention potentially improves the **Member's** health outcomes;

3. The cancer **Clinical Trial** is well-supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

4. The cancer **Clinical Trial** does not unjustifiably duplicate existing studies;

5. The cancer **Clinical Trial** design is appropriate to answer the research question being asked in the **Clinical Trial**;

6. The cancer **Clinical Trial** is sponsored by a credible organization or individual capable of executing the proposed **Clinical Trial** successfully;

7. The cancer **Clinical Trial** is in compliance with Federal regulations relating to the protections of human subjects; and

8. All aspects of the **Clinical Trial** are conducted according to the appropriate standards of scientific integrity.

9. The treatment provided in the cancer **Clinical Trial** must either be:

a. Approved by one (1) of the following: National Institutes of Health, the FDA, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs; or

b. Involve a drug that is exempt under federal regulations from a new drug application.

E. CalOptima and its **Health Networks** shall not be prohibited from restricting coverage for routine patient care costs associated with a cancer **Clinical Trial** in California, unless the protocol for the **Clinical Trial** is not provided for at a California hospital or by a California physician.

F. The provision of services as defined under this policy shall not in itself give rise to liability on the part of CalOptima, or the **Health Network**.

G. CalOptima, or a **Health Network**, shall provide care management services to a **Member** who is participating in a cancer **Clinical Trial** to assure that the **Member** is afforded continuity of care, referred to all available resources for his or her illness, and to continue to verify that all eligibility requirements as set forth herein continue to be met.

III. PROCEDURE

A. A Provider or Practitioner shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. DHCS California Children's Services (CCS) Numbered Letter (NL) 37-1292: Coverage of Experimental and/or Investigational Services
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health and Safety Code, §1370.6
H. Medicare National Coverage Determination 100-03, July 9, 2007
I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	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.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
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.
Member	An enrollee-beneficiary of a CalOptima program.

Policy #: GG.1515
Title: **Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 05/01/1999
~~Last Review Date:~~ ~~08/01/17~~
~~Last~~ Revised Date: ~~08/01/17~~04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima~~,~~ or a Health Network~~,~~ shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima~~,~~ or a Health Network~~,~~ shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima~~,~~ or a Health Network~~, shall not~~ will review for Medical Necessity and, if indicated, will authorize the purchase of ~~a Medically Necessary car seat~~an AOPD for children that ~~is otherwise available through the~~are not California ~~Children~~Children's Services ~~Program~~ (CCS~~) or CCS~~)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program ~~for a Member who is eligible for services through~~.

G. No sooner than the ~~CCS Program~~Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

   a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

   b. Criteria:

      i. The Member shall be over four (4) years of age;

      ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

      iii. The Member shall meet at least one (1) of the following criteria:

         a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

         b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

         c) The Member has a skeletal deformity that requires total postural support for safe transportation.

   c. Related Considerations

      i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

      ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

      iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

   a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

   b. Criteria

      i. The Member shall be over four (4) years of age;

      ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

      iii. The Member shall at least one (1) of the following criteria:

         a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

~~B. CalOptima and its Health Networks shall refer medically eligible CCS Members to the CCS program for consideration of AOPD under the EPSDT Service program.~~

~~C.~~B. A request for reimbursement of an AOPD shall be accompanied by:

~~1. A current physician prescription;~~
1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy~~,~~ or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy~~.~~ and includes:

~~D. CalOptima and its Health Networks shall monitor the outcome of CCS referrals for CCS authorization.~~
a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) /Whole -Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~98-06~~18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)~~Numbered Letters 01-0298 and 09-0598~~
H. Department of Health Services (DHCS) All Plan Letter (APL) ~~14-017~~18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal ~~Beneficiaries~~Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

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	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
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 Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.

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Policy #: GG.1515
Title: **Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 05/01/1999
Revised Date: 04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima or a Health Network shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima or a Health Network shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for children that are not California Children's Services (CCS)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program.

G. No sooner than the Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

DRAFT

A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria:

i. The Member shall be over four (4) years of age;

ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

iii. The Member shall meet at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

c) The Member has a skeletal deformity that requires total postural support for safe transportation.

c. Related Considerations

i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria

i. The Member shall be over four (4) years of age;

ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

iii. The Member shall at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

B. A request for reimbursement of an AOPD shall be accompanied by:

1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy and includes:

a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360

E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)
H. Department of Health Services (DHCS) All Plan Letter (APL) 18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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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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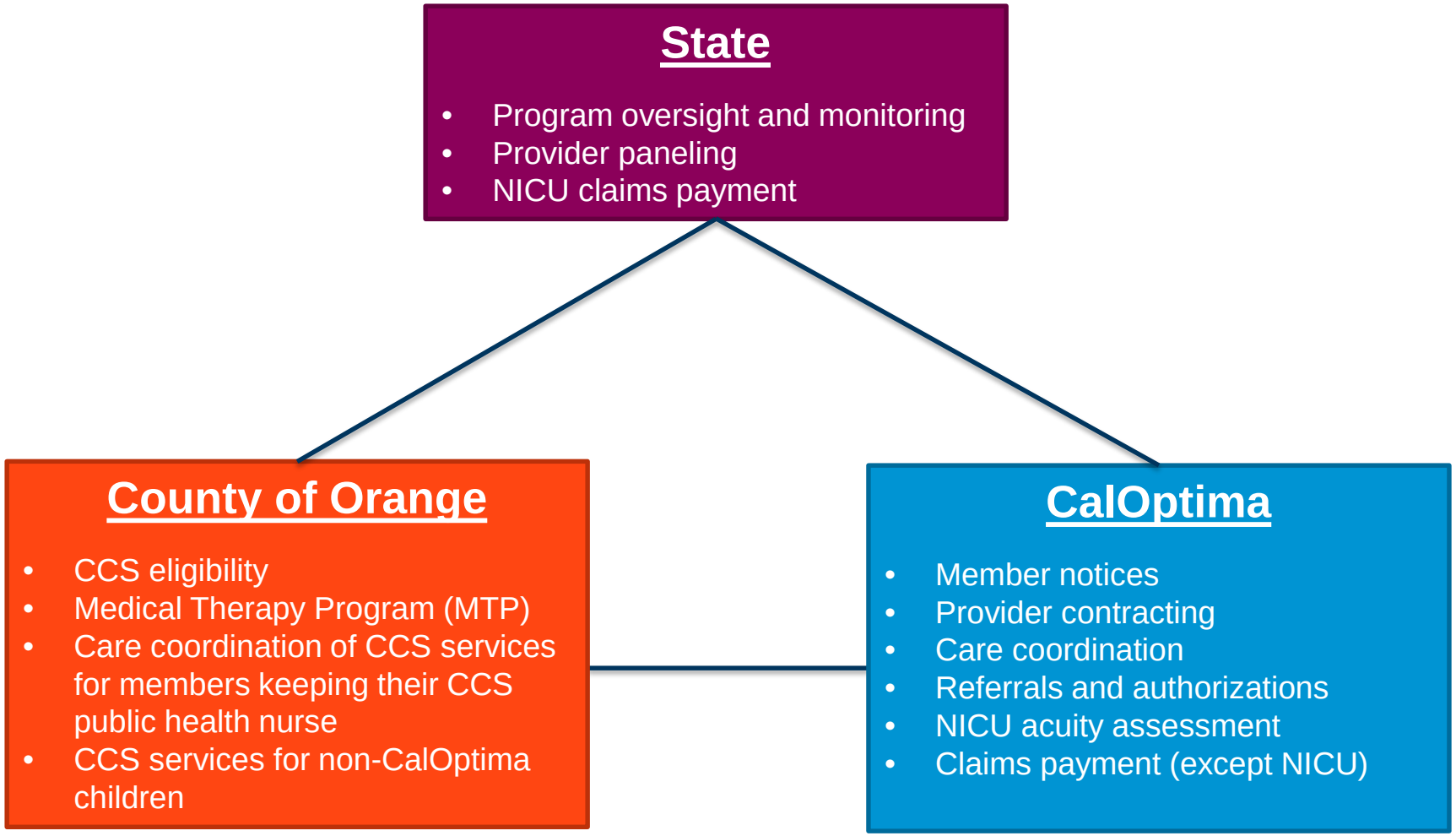
Whole-Child Model (WCM) Overview

- 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.

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.)

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. 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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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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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

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.

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]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, 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

[1] The CCS Numbered Letter index is available at: http://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), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than 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 – No sooner than 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	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume 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 will 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 determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[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

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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 (OHC), 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) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and 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, 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 will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries 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 administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries 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 CMSNet 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 COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, 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

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

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 shall communicate all resolved disputes in writing to the MCP within a timely manner. 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 CCSWCM@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 will assess each CCS child's or youth'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 shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

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 members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - 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 that 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; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   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.

   Risk Assessment
   The risk assessment process must address:

   a) 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.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and 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 assess 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 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, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- 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.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should 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 should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) 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.

d) 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 the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their 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 the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

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 the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the 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 of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[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 not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

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:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. 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 COC 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 members' 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 continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

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 child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[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 APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

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.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC 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 durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is 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. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC 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 a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or 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.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed 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.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (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 costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] 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 APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

[24] See APL 17-006, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at: http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

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.

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 centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] 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.[30]

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 fee-for-service rates, unless the provider and the MCP enter into

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting 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: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] 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.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] 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:[38]

- 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.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] 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
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] 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
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. 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 form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. 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 companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. 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 APL 17-004.[40] 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

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, except those associated with the University of California, Irvine, or St. Joseph Healthcare and its affiliates, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, DHCS changed the timing of

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Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts except those associated with the University of California, Irvine, or St. Joseph Health and its affiliates

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima clinic contracts, except for those associated with the University of California, Irvine or St. Joseph Healthcare and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
AltaMed Health Services - Anaheim Lincoln	1814 W Lincoln Ave	Anaheim	CA	92801
AltaMed Health Services - Anaheim Lincoln West	1820 W Lincoln Ave	Anaheim	CA	92801
AltaMed Health Services - East Los Angeles/Whittier	5427 Whittier Blvd	Los Angeles	CA	90022
AltaMed Health Services - Santa Ana Main	1400 N Main St	Santa Ana	CA	92701
AltaMed Medical and Dental Group-Huntington Beach	8041 Newman Ave	Huntington Beach	CA	92647
AltaMed Medical Group Santa Ana Central	1155 W Central Ave Suite 107	Santa Ana	CA	92707
AltaMed Medical Group-Garden Grove	12751 Harbor Blvd	Garden Grove	CA	92840
AltaMed Medical Group-Orange	4010 E Chapman Ave	Orange	CA	92869
AltaMed Medical Group-Santa Ana, Bristol	2720 S Bristol St Suite 110	Santa Ana	CA	92704
Benevolence Industries Inc	805 W La Veta Ave Suite 110	Orange	CA	92868
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Camino Health Center - Lake Forest	22841 Aspan St Suite A	Lake Forest	CA	92630
Center for Inherited Blood Disorders	1010 W La Veta Ave Suite 670	Orange	CA	92868
Central City Community Health Center	12116 Beach Blvd	Stanton	CA	90680
Central City Community Health Center	2237 W Ball Rd	Anaheim	CA	92804
Families Together of Orange County	661 W First St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 190	La Habra	CA	90631
Friends of Family Health - Tustin	13152 Newport Ave Suite B	Tustin	CA	92780
Hurtt Family Health Clinic	1 Hope Dr	Tustin	CA	92782
Hurtt Family Health Clinic - Anaheim	947 S Anaheim Blvd Suite 260	Anaheim	CA	92805
Hurtt Family Health Clinic - Santa Ana	1100B N Tustin Ave Suite A	Santa Ana	CA	92705
KCS Health Center	7212 Orangethorpe Ave Suite 9A	Buena Park	CA	90621

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Name	Address	City	State	Zip
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Health Clinic	12362 Beach Blvd Suite 10	Stanton	CA	90680
Mission City Community Network	1661 W Broadway Suite 11	Anaheim	CA	92802
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Reg Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
Planned Parenthood Anaheim	DBA Melody Women's Health 303 W Lincoln Ave	Anaheim	CA	92805
Planned Parenthood Costa Mesa	DBA Melody Women's Health 601 W 19th St	Costa Mesa	CA	92627
Planned Parenthood Mission Viejo	DBA Melody Women's Health 26137 La Paz Rd	Mission Viejo	CA	92691
Planned Parenthood Orange	DBA Melody Women's Health 700 S Tustin St	Orange	CA	92866
Planned Parenthood Santa Ana	DBA Melody Women's Health 1421 E 17th St	Santa Ana	CA	92705
Planned Parenthood Westminster	DBA Melody Women's Health 14372 Beach Blvd	Westminster	CA	92683
Serve the People Community Health Center	1206 E 17th St Suite 101	Santa Ana	CA	92701
Share Our Selves Community Health Center	1550 Superior Ave	Costa Mesa	CA	92627
Sierra Health Center	501 S Brookhurst Rd	Fullerton	CA	92833
Southland Health Center	9862 Chapman Ave Suite B	Garden Grove	CA	92841
VCC The Gary Center	1000 Vale Terrace	Vista	CA	92084

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Primary Care Physician (PCP) Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2020, except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and,
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

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On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, DHCS changed the timing of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts, except for those associated with the University of California, Irvine or St. Joseph Healthcare and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

3/27/2019 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated with Children's Hospital of Orange County, the University of California, Irvine and St. Joseph Health and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2020, except those associated with Children's Hospital of Orange County, the University of California-Irvine or St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County, the University of California, Irvine, and St. Joseph Health and its Affiliates, through June 30, 2020.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist contracts, except for those associated with Children's Hospital of Orange County, the University of

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California, Irvine or St. Joseph Health and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

None

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Associated with St. Joseph Health and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, associated with St. Joseph Health and its affiliates, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, 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,

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2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts associated with St. Joseph Health and its affiliates

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima clinic contracts, associated with St. Joseph Health and its affiliates for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
La Amistad De Jose Family Health Center	353 S Main St	Orange	CA	92868
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Primary Care Physician (PCP) Contracts Associated with St. Joseph Health and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2020, associated with St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and,
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, 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,

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2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts associated with St. Joseph Health and its Affiliates.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts, associated with, St. Joseph Health and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

3/27/2019 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with St. Joseph Health and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2020, associated with St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with St. Joseph Health and its Affiliates, through June 30, 2020.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist contracts, associated with St. Joseph Health and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with the University of California, Irvine

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2020, associated with the University of California-Irvine with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with the University of California, Irvine, through June 30, 2020.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist contracts, for those associated with the University of California, Irvine, for one year will be a budgeted item with no additional fiscal impact.

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts, Associated with the University of California, Irvine

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2020, associated with the University of California, Irvine with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and,
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, DHCS changed the timing of

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Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts associated with the University of California-Irvine.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts, associated with the University of California, , for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Associated with the University of California, Irvine

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, associated with the University of California, Irvine with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, DHCS changed the timing of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated

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delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts associated with the University of California, Irvine.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima clinic contracts, associated with the University of California, Irvine for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader *3/27/2019*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
UCI Family Health Center - Anaheim	300 W Carl Karcher Way	Anaheim	CA	92801
UCI Family Health Center - Santa Ana	800 N Main St	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Extensions of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with Children's Hospital of Orange County.

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2020, associated with Children's Hospital of Orange County with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County through June 30, 2020.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist contracts, associated with Children's Hospital of Orange County, for one year will be a budgeted item with no additional fiscal impact.

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Authorizing New Contracts with the Direct Contracted, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospitals to Increase Rates in Support of Hospital Discharge Obligations and to Incorporate Changes Related to the Department Health Care Services (DHCS) Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of Orange County

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1) Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into new hospital fee-for-service contracts with a July 1, 2019, effective date that are substantially similar to the current contracts, but that also address the following:
   a) Have an initial term through June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward based on rate changes implemented by the State;
   b) Modify the Medi-Cal Classic rates with Orange County acute care hospitals contracted for full scope Medi-Cal services, to support hospital discharge coordination, including the utilization by hospitals of data sharing technology to help facilitate coordination of services for homeless individuals with other providers and community partners;
   c) Provide for payments under the DHCS Hospital Directed Payments programs, including all necessary language changes to meet the program's requirements, as set forth in DHCS's All Plan Letter 19-001;
   d) Include provisions to reflect requirements associated with the WCM program and make any other required regulatory changes; and
2) Ratify the contract amendment with Children's Hospital of Orange County reflecting requirements associated with the Whole-Child Model (WCM), regulatory changes and other requirements for the period prior to the effective date of the new contract.

Background/Discussion

CalOptima currently contracts with several hospitals to provide services to Medi-Cal, OneCare, OneCare Connect and PACE members. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Hospital Discharge Process for Members Experiencing Homelessness

Subject to Board approval, CalOptima will fund hospitals to help with increased costs associated with discharge planning under new SB 1152 requirements, and to utilize data sharing technology to help facilitate coordination of services for homeless individuals with other providers and community partners. This support would be through an increase in the Medi-Cal classic rates paid to Orange County acute care hospitals contracted for full scope Medi-Cal services in Orange County.

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Contract Amendment: Whole Child Model Program and Other Regulatory Changes

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the WCM program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, DHCS changed the timing of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to include definitions and requirements associated with the WCM program in the new hospital contracts.

Staff is requesting the amendment entered into with CHOC to meet WCM network adequacy requirements be ratified. In order to support the WCM program provider network development, CalOptima completed the necessary contract changes with CHOC in January of 2019. These changes would also be included in the new CHOC hospital contract going forward.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. On January 17, 2019, DHCS issued an All Plan Letter that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. Staff requests authority to include the regulatory requirements as applicable and in accordance with state and federal guidance in the new FFS hospital contracts.

Fiscal Impact

Management will include expenses associated with the extended contracts in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima's FFS hospital contracts for one (1) year will be a budgeted item with no additional fiscal impact.

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Staff projects the recommended action to fund hospitals to support the hospital discharge coordination process for members experiencing homelessness will cost $2 million annually. Management will include funding in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
Childrens Hospital of LA	4650 W Sunset Blvd MS 87	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid Ave	Fountain Valley	CA	92708
Garden Grove Hospital and Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
Healthbridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Mission Hospital Regional Medical Center	27700 Medical Center Rd	Mission Viejo	CA	92691
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 Rose Dr	Placentia	CA	92870
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
Prime HealthCare La Palma Intercommunity Hosp	7901 Walker St	La Palma	CA	90623

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Name	Address	City	State	Zip
Promise Hospital of East Los Angeles LP DBA Suburban Medical Center	16453 S Colorado Ave	Paramount	CA	90723
Rancho Los Amigos National Rehabilitation Center	7601 E Imperial Hwy Rm 2208	Downey	CA	90242
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
UCI Medical Center	101 The City Dr South	Orange	CA	92868
West Anaheim Medical Center	3033 West Orange Ave	Anaheim	CA	92804
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2019-20

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services provider contracts through June 30, 2020, retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

Contract Extension: CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

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On November 9, 2018, DHCS changed the timing of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the ancillary contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as no disruption in care for members who are receiving treatment for a chronic or ongoing medical condition or Long-Term Support Services upon a provider's termination.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

This staff recommendation impacts FFS ancillary services provider contracts.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima ancillary contracts for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Consider Approval of Proposed Changes to CalOptima Contracting Policy EE.1135: Long Term Care Facility Contracting

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to modify existing CalOptima Contracting Policy EE.1135: Long Term Care Facility Contracting.

Background/Discussion
On October 7, 2003, the Board of Directors delegated authority to the CEO to execute new contracts with licensed Long-Term Care (LTC) facilities and approve the LTC strategy to require LTC facilities to be contracted or have a Letter of Agreement (LOA) in place in order to receive reimbursement.

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 as needed, and subject to peer review. New and modified Policies and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, programs or business practices are established.

The following table lists the existing Contract policy that has been updated, approved by CalOptima's Policy Review and Compliance Committees, and is being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	EE.1135: Long Term Care Facility Contracting	• Revises the term period of an LTC LOA from ninety (90) days to one (1) year.	• CalOptima Contracting and Long-Term Support Services (LTSS) have made a business decision to improve our business practice by adopting a one (1) year timeframe for LTC LOAs, which is the same timeframe used for LOAs with other provider types. The shorter ninety (90) day timeframe has not proven to add pressure or sense of urgency for LTCs outside of Orange County to help facilitate transfer of the

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	Policy No./Name	Summary of Changes	Reason for Change
			member's eligibility to the other county, and results in having to complete multiple LOAs for a single member during the year. CalOptima LTSS has put in place a team of dedicated staff that works with the Member's family and the LTC facility to transfer Member's eligibility to the other county.
		• Minor language and formatting changes.	• Minor updates for clarification of process, and formatting changes.

Fiscal Impact
There is no fiscal impact.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Revised CalOptima Policy EE.1135: Long Term Care Facility Contracting (redlined and clean copies)
2. Board Action October 7, 2003, V.A., Authorize the Chief Executive Officer to Execute New Contracts with Long-Term Care Facility Providers and Approve Contracting Strategy

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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Policy: EE.1135
Title: **Long Term Care Facility Contracting**
Department: Contracting
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/2004
~~Last~~ Revised Date: ~~12/01/17~~04/04/2019

Applicable to: ☒ Medi-Cal
☒ OneCare Connect

I. PURPOSE

This policy establishes CalOptima's contracting and ***Letter of Agreement (LOA)*** requirements for Long Term Care (LTC) ***f~~F~~acilities***.

II. POLICY

A. CalOptima only contracts with, and reimburses, ***f~~F~~acilities*** that are licensed and certified by the California Department of Public Health (CDPH) and approved by the ***Department of Health Care Services (DHCS)*** for participation in the Medi-Cal program.

1. CalOptima shall include all ***f~~F~~acilities*** within the ***~~S~~service a~~A~~rea*** that meet the requirements of Section II.A of this Policy in the provider network to the extent that the ***~~F~~facility*** remains licensed, certified, operating, meets CalOptima's credentialing and quality standards, and it willing to enter into a contract with CalOptima on mutually agreeable terms.

2. If CalOptima determines that a ***~~a Member's need~~Mmember's*** needs for ***~~F~~facility*** services exceeds the capacity of those currently contracted, CalOptima shall arrange access to out-of-network ***~~F~~facilities***.

3. CalOptima shall notify ***DHCS*** if it is unable to come to agreeable terms with a ***~~F~~facility*** meeting the requirements in Section II.A of this Policy, or upon termination of a ***~~F~~facility*** contract in accordance with S~~s~~ection III.D of this P~~p~~olicy, and as required by ***DHCS***.

B. CalOptima shall require c~~C~~redentialing of all contracted ***~~F~~facilities***, in accordance with CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations, prior to the execution of a contract.

C. CalOptima completes ***LOAs*** with, and reimburses, non-contracted ***~~F~~facilities*** that are licensed and certified by CDPH and approved by the ***DHCS*** for participation in the Medi-Cal program. An ***LOA*** is initiated when:

1. CalOptima places a ***~~M~~member*** in a non-contracted ***~~F~~facility***;

2. CalOptima is notified by a non-contracted ***~~F~~facility***, an acute hospital, the ***~~M~~member***, ***~~M~~member's ~~P~~personal ~~R~~representative***, or a ***~~H~~health ~~N~~network*** that;

a. A ***~~M~~member*** has been placed in a non-contracted ***facility***;

DRAFT

b. A resident in a non-contracted ~~F~~*facility* has or will become newly enrolled into CalOptima; or

c. A ~~M~~*member* that resides in the non-contracted ~~F~~*facility* under their Medicare benefit, has exhausted or will soon exhaust their Medicare benefit.

~~C.~~D. Upon identifying a need for ~~a Letter of Agreement (LOA)~~an ***LOA*** or contract with a ~~F~~*facility*, the CalOptima Director of Contracting or authorized ~~D~~*designee* shall initiate the ~~F~~*facility* contracting process in accordance with the provisions of Sections II.C, III.B, and III.C of this Policy.

~~D.~~E. ~~In accordance with this Policy, only~~Only a ~~F~~*facility* that holds a contract or ***LOA*** with CalOptima as described in this Policy is eligible to receive reimbursement for ~~C~~*covered* ~~S~~*services* furnished to a ~~M~~*member* within that ~~F~~*facility*. ~~A Facility that does not enter into a contract or LOA with CalOptima is not eligible to receive reimbursement for Covered Services furnished to a Member.~~

F. If a non-contracted ~~F~~*facility* admits a ~~M~~*member*, the non-contracted ~~F~~*facility* shall contact CalOptima Long Term Services and Support Department (LTSS) Department to initiate the ***LOA*** process in accordance with the terms and conditions set forth in Sections II.C, III.B, and III.C of this Policy.

~~E.~~G. If a ~~F~~*facility* executes a contract or ***LOA*** with CalOptima, CalOptima may retrospectively reimburse the ~~F~~*facility* up to one (1) year from the date of the execution of the contract or ***LOA***. A ~~F~~*facility* is eligible to receive such retrospective reimbursement if:

1. The ~~F~~*facility* submits an Authorization Request Form (ARF) to the LTSS Department within twenty-one (21) calendar days from the date of execution of the contract or ***LOA***, or submits time-stamped evidence to the LTSS Department that an ARF was submitted to their department;

2. The ~~M~~*member* meets the clinical criteria for ~~C~~*covered* ~~S~~*services* at the time of admission; and

3. The ARF would have been approved, but for the absence of the contract or ***LOA***.

~~F.~~H. CalOptima shall provide a ~~M~~*member* with access to the names of contracted ~~F~~*facilities* in the Provider Directory, through the CalOptima ~~website~~website's Ancillary and Facility Search Tool, and upon the ~~M~~*member's* request for such information.

~~G.~~I. If a ~~M~~*member* is admitted to a ~~F~~*facility* under the Medicare benefit, CalOptima shall reimburse a ~~F~~*facility*, regardless of contract status, for a ~~M~~*member's* Medicare coinsurance from the ~~M~~*member's* twentieth (20th) day and ~~up to~~through the one ~~hundred and first (101st~~hundredth (100th) day.

III. PROCEDURE

A. The CalOptima Contracting Department oversees and manages the ~~F~~*facility* contracting process, in collaboration with the CalOptima LTSS and Claims Department, to ensure appropriate payment for ~~C~~*covered* ~~S~~*services*.

B. For a ~~N~~*new* ~~A~~*admission* to a non-contracted ~~F~~*facility* located **within Orange County** for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Provide a contract to the non-contracted ~~***F****f**acility*~~ for review and approval via ~~certified mail with return receipt requested, and/or emailed~~e-mail as a PDF document, upon notification from CalOptima's Quality Improvement Department that the ~~***F****f**acility*~~ has been successfully credentialed; and

~~2. Notify the non-contracted Facility that a contract or LOA with CalOptima is required to be eligible to receive reimbursement for Covered Services furnished to a Member in such LTC Facility.~~

2. Complete ***LOAs*** for ~~***M****m**ember*~~ admissions while the ~~***F****f**acility's*~~ credentialing is in process.

C. For a ~~***N****n**ew A**a**dmission*~~ to a non-contracted ~~***F****f**acility*~~ located **outside of Orange County**, for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Notify the non-contracted ~~***F****f**acility*~~ that ~~a~~an ***LOA*** with CalOptima is required to be eligible to receive reimbursement for ~~***C****c**overed S**s**ervices*~~ furnished to a ~~***M****m**ember*~~ in such LTC ~~***F****f**acility***.

2. Execute ~~a~~an ***LOA*** for ~~ninety (90) calendar days~~one (1) year with the non-contracted ~~***F****f**acility***, upon written request of the LTSS Director or authorized ~~***D****d**esignee***.

   a. Except for a ~~***M****m**ember*~~ who is under conservatorship (including with the Office of the Public ~~Guardian's Office~~Guardian) or has a ~~***P****p**ersonal R**r**epresentative*~~ residing in Orange County, the ~~***F****f**acility's*~~ staff shall actively work with the ~~***M****m**ember*~~ or ~~***M****m**ember's*~~ representative to transfer the ~~***M****m**ember's*~~ Medi-Cal eligibility to the county of residence during ~~this ninety (90) calendar day timeframe~~the time frame of the ***LOA***. CalOptima's LTSS Department shall follow up with ~~***F****f**acility*~~ on a monthly basis to ensure they are actively working to transfer ~~***M****m**ember's*~~ Medi-Cal eligibility to the county of residence.

~~2.1.~~If a ~~***M****m**ember*~~ is residing in a ~~***F****f**acility*~~ outside of Orange County longer than ~~ninety (90) calendar days~~the ***LOA*** time frame, and the ~~***M****m**ember's*~~ Medi-Cal eligibility has not been transferred to the county of residence, the ~~***F****f**acility*~~ ~~may consider the following options:~~

   ~~a.~~b. ~~If the delay is due to the failure of the Member or Member's representative to arrange transfer to the county of residence within the ninety (90) calendar day timeframe, the Facility~~ shall notify the CalOptima LTSS Department prior to the ***LOA*** expiration date. The CalOptima LTSS Department shall submit a request to the CalOptima Contracting Department to initiate a ~~LTC contract. The CalOptima Contracting Department may initiate another LOA for an additional ninety (90) calendar days instead of a contract if the CalOptima LTC Department confirms that the Member or Member's representative is currently completing the process to transfer to the county of residence~~new ***LOA*** for a one (1) year term.

      ~~i. If the delay is due to the county of residence's delay in processing the transfer request, the Facility shall notify the CalOptima LTSS Department prior to the LOA expiration date. The CalOptima LTSS Department shall submit a request to the Contracting Department to initiate a new LOA for an additional ninety (90) calendar days.~~

   ~~b.~~c. The CalOptima Contracting Department may complete ~~a~~an ***LOA*** with a non-contracted ~~***F****f**acility*~~ outside of Orange County only upon the request of the LTSS Director or authorized ~~***D****d**esignee***.

c.d. The CalOptima Contracting Department may initiate a contract with a non-contracted ***Ffacility*** outside of Orange County when the Contracting Department has identified ~~that a high number of~~ ten (10) or more ***LOAs*** for unique ***Mmembers*** have been completed with the ***Ffacility*** over the past year, or at the request of the LTSS Director or authorized ***Ddesignee***.

d.e. A ***Mmember*** who is under ~~private or public~~ conservatorship (including with the Office of the Public ~~Guardian's Office)~~Guardian) or has a ***Ppersonal Rrepresentative*** residing in Orange County, may remain in a ***Ffacility*** outside of Orange County, if so requested~~, in~~. In which case, the LTSS Director or authorized ***Ddesignee*** ~~shall~~may authorize the CalOptima Contracting Department to extend a contract to the ***Ffacility***.

D. Termination of ***FFacility*** Contract

1. CalOptima shall notify ***DHCS*** upon termination of a ***Ffacility*** contract:

~~1. If The Contracting Department shall notify the CalOptima Regulatory Affairs & Compliance, Customer Service, LTSS, and Claims Department of Facility contracting actions with appropriate timeframes as follows:~~

a. ~~Within five (5) working days if~~ CalOptima ~~is unable to come to agreeable terms with a qualified~~and a ***Ffacility*** in the ***Sservice Aarea*** cannot agree on mutually agreeable terms, CalOptima shall notify the ***DHCS*** within five (5) ***working days*** of CalOptima's decision to exclude the ***Ffacility*** from its p~~P~~rovider n~~N~~etwork.

b. ~~At~~CalOptima shall provide the ***DHCS*** with notice of its termination of a contract with a ***Ffacility*** at least sixty (60) calendar days ~~from contracted Facility termination when~~ prior to the contract ~~is being terminated without cause~~termination effective date.

i. CalOptima shall not continue to assign or refer ***Mmembers*** to a ***Ffacility*** during the sixty (60) calendar days between ~~the required~~notifying the ***DHCS*** ~~notification~~ and the contract termination effective date.

c. If ~~the Facility~~ termination of a ***Ffacility*** contract is for a cause related to ~~Member~~ quality of care ~~and/~~or patient safety concerns, ~~and the contract is terminated for cause, the internal notification timeframe~~CalOptima shall expedite termination of the ***Ffacility*** contract and transfer ***members*** to an appropriate, qualified ***Ffacility*** in an expeditious manner. The ***DHCS*** shall be ~~reduced to~~ notified of the termination within seventy-two (72) hours~~.~~ of said termination.

~~i. CalOptima may expedite termination of a Facility contract and transfer Members to another qualified Facility.~~

2. CalOptima's Regulatory Affairs & Compliance Department shall notify the ***DHCS*** upon notification from the Contracting Department of any of the actions detailed in Section III.D.1 of this Policy, ~~and~~ in accordance with CalOptima Policy GG.1652: DHCS ~~requirements~~Notification of Change in the Availability or Location of Covered Services.

3. Affected ***Mmembers*** shall be notified of the actions detailed Section III.D.1 of this Policy, as applicable, in accordance with CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services.

~~III.~~IV. ATTACHMENTS

Not Applicable

~~IV.~~V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
~~A.~~B. CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services
~~B.~~C. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
D. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
E. CalOptima Long Term Care Provider Resource Manual
~~C.~~F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~D.~~G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
~~E.~~H. Title 22, California Code of Regulations (CCR), Division 3
~~F.~~I. Title 22, California Code of Regulations (CCR), Sections 51215, 51121, 51212, 51215.5, 51215.8, 51334, and 51335
~~G.~~J. Title 18, Federal Social Security Act

~~V.~~VI. REGULATORY AGENCY APPROVAL(S)

A. 10/13/15: Department of Health Care Services

~~VI.~~VII. BOARD ACTION(S)

~~Not Applicable~~04/04/2019: Regular Meeting of the CalOptima Board of Directors

~~VII.~~VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/2004	GG.1825	Long Term Care Facility Contracting	Medi-Cal
Revised	05/01/2009	GG.1825	Long Term Care Facility Contracting	Medi-Cal
Revised	01/01/2010	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	07/01/2015	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	08/01/2016	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	12/01/2017	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	04/04/2019	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect

~~VIII.~~IX. GLOSSARY

Term	Definition
Covered Services	**Medi-Cal:** Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. **OneCare Connect:** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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 (NF-B) [Skilled Nursing Facility (SNF)].
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Member	An enrollee-beneficiary of a CalOptima program.
New Admission	Shall mean a Member with no previous residence history at a Facility or one who has had a previous residence history at a Facility but was appropriately discharged as part of the Member's plan of care.
Personal 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.3009Δ: Access by Member's Personal Representative.
Service Area	County of Orange, California.
Working Days	Shall mean state of California working day(s).

Policy:	EE.1135
Title:	**Long Term Care Facility Contracting**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2004
Revised Date:	04/04/2019
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy establishes CalOptima's contracting and ***Letter of Agreement (LOA)*** requirements for Long Term Care (LTC) ***facilities***.

II. POLICY

A. CalOptima only contracts with, and reimburses, ***facilities*** that are licensed and certified by the California Department of Public Health (CDPH) and approved by the ***Department of Health Care Services (DHCS)*** for participation in the Medi-Cal program.

1. CalOptima shall include all ***facilities*** within the ***service area*** that meet the requirements of Section II.A of this Policy in the provider network to the extent that the ***facility*** remains licensed, certified, operating, meets CalOptima's credentialing and quality standards, and it willing to enter into a contract with CalOptima on mutually agreeable terms.

2. If CalOptima determines that a ***member's*** need for ***facility*** services exceeds the capacity of those currently contracted, CalOptima shall arrange access to out-of-network ***facilities***.

3. CalOptima shall notify ***DHCS*** if it is unable to come to agreeable terms with a ***facility*** meeting the requirements in Section II.A of this Policy, or upon termination of a ***facility*** contract in accordance with Section III.D of this Policy, and as required by ***DHCS***.

B. CalOptima shall require credentialing of all contracted ***facilities***, in accordance with CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations, prior to the execution of a contract.

C. CalOptima completes ***LOAs*** with, and reimburses, non-contracted ***facilities*** that are licensed and certified by CDPH and approved by the ***DHCS*** for participation in the Medi-Cal program. An ***LOA*** is initiated when:

1. CalOptima places a ***member*** in a non-contracted ***facility***;

2. CalOptima is notified by a non-contracted ***facility***, an acute hospital, the ***member***, ***member's personal representative***, or a ***health network*** that;

   a. A ***member*** has been placed in a non-contracted ***facility***;

   b. A resident in a non-contracted ***facility*** has or will become newly enrolled into CalOptima; or

c. A ***member*** that resides in the non-contracted ***facility*** under their Medicare benefit, has exhausted or will soon exhaust their Medicare benefit.

D. Upon identifying a need for an ***LOA*** or contract with a ***facility***, the CalOptima Director of Contracting or authorized ***designee*** shall initiate the ***facility*** contracting process in accordance with the provisions of Sections II.C, III.B, and III.C of this Policy.

E. Only a ***facility*** that holds a contract or ***LOA*** with CalOptima as described in this Policy is eligible to receive reimbursement for ***covered services*** furnished to a ***member*** within that ***facility***.

F. If a non-contracted ***facility*** admits a ***member***, the non-contracted ***facility*** shall contact CalOptima Long Term Services and Support Department (LTSS) Department to initiate the ***LOA*** process in accordance with the terms and conditions set forth in Sections II.C, III.B, and III.C of this Policy.

G. If a ***facility*** executes a contract or ***LOA*** with CalOptima, CalOptima may retrospectively reimburse the ***facility*** up to one (1) year from the date of the execution of the contract or ***LOA***. A ***facility*** is eligible to receive such retrospective reimbursement if:

1. The ***facility*** submits an Authorization Request Form (ARF) to the LTSS Department within twenty-one (21) calendar days from the date of execution of the contract or ***LOA***, or submits time-stamped evidence to the LTSS Department that an ARF was submitted to their department;

2. The ***member*** meets the clinical criteria for ***covered services*** at the time of admission; and

3. The ARF would have been approved, but for the absence of the contract or ***LOA***.

H. CalOptima shall provide a ***member*** with access to the names of contracted ***facilities*** in the Provider Directory, through the CalOptima website's Ancillary and Facility Search Tool, and upon the ***member's*** request for such information.

I. If a ***member*** is admitted to a ***facility*** under the Medicare benefit, CalOptima shall reimburse a ***facility***, regardless of contract status, for a ***member's*** Medicare coinsurance from the ***member's*** twentieth (20^{th}) day and through the one hundredth (100^{th}) day.

III. PROCEDURE

A. The CalOptima Contracting Department oversees and manages the ***facility*** contracting process, in collaboration with the CalOptima LTSS and Claims Department, to ensure appropriate payment for ***covered services***.

B. For a ***new admission*** to a non-contracted ***facility*** located **within Orange County** for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Provide a contract to the non-contracted ***facility*** for review and approval via e-mail as a PDF document, upon notification from CalOptima's Quality Improvement Department that the ***facility*** has been successfully credentialed; and

2. Complete ***LOAs*** for ***member*** admissions while the ***facility's*** credentialing is in process.

C. For a ***new admission*** to a non-contracted ***facility*** located **outside of Orange County**, for which CalOptima's LTSS Department has been notified, the CalOptima Contracting Department shall:

1. Notify the non-contracted ***facility*** that an ***LOA*** with CalOptima is required to be eligible to receive reimbursement for ***covered services*** furnished to a ***member*** in such LTC ***facility***.

2. Execute an ***LOA*** for one (1) year with the non-contracted ***facility***, upon written request of the LTSS Director or authorized ***designee***.

    a. Except for a ***member*** who is under conservatorship (including with the Office of the Public Guardian) or has a ***personal representative*** residing in Orange County, the ***facility's*** staff shall actively work with the ***member*** or ***member's*** representative to transfer the ***member's*** Medi-Cal eligibility to the county of residence during the time frame of the ***LOA***. CalOptima's LTSS Department shall follow up with ***facility*** on a monthly basis to ensure they are actively working to transfer ***member's*** Medi-Cal eligibility to the county of residence.

    b. If a ***member*** is residing in a ***facility*** outside of Orange County longer than the ***LOA*** time frame, and the ***member's*** Medi-Cal eligibility has not been transferred to the county of residence, the ***facility*** shall notify the CalOptima LTSS Department prior to the ***LOA*** expiration date. The CalOptima LTSS Department shall submit a request to the CalOptima Contracting Department to initiate a new ***LOA*** for a one (1) year term.

    c. The CalOptima Contracting Department may complete an ***LOA*** with a non-contracted ***facility*** outside of Orange County only upon the request of the LTSS Director or authorized ***designee***.

    d. The CalOptima Contracting Department may initiate a contract with a non-contracted ***facility*** outside of Orange County when the Contracting Department has identified ten (10) or more ***LOAs*** for unique ***members*** have been completed with the ***facility*** over the past year, or at the request of the LTSS Director or authorized ***designee***.

    e. A ***member*** who is under conservatorship (including with the Office of the Public Guardian) or has a ***personal representative*** residing in Orange County, may remain in a ***facility*** outside of Orange County, if so requested. In which case, the LTSS Director or authorized ***designee*** may authorize the CalOptima Contracting Department to extend a contract to the ***facility***.

D. Termination of ***Facility*** Contract

1. CalOptima shall notify ***DHCS*** upon termination of a ***facility*** contract:

    a. If CalOptima and a ***facility*** in the ***service area*** cannot agree on mutually agreeable terms, CalOptima shall notify the ***DHCS*** within five (5) ***working days*** of CalOptima's decision to exclude the ***facility*** from its provider network.

    b. CalOptima shall provide the ***DHCS*** with notice of its termination of a contract with a ***facility*** at least sixty (60) calendar days prior to the contract termination effective date.

        i. CalOptima shall not continue to assign or refer ***members*** to a ***facility*** during the sixty (60) calendar days between notifying the ***DHCS*** and the contract termination effective date.

    c. If termination of a ***facility*** contract is for a cause related to quality of care or patient safety concerns, CalOptima shall expedite termination of the ***facility*** contract and transfer

members to an appropriate, qualified ***facility*** in an expeditious manner. The ***DHCS*** shall be notified of the termination within seventy-two (72) hours of said termination.

2. CalOptima's Regulatory Affairs & Compliance Department shall notify the ***DHCS*** upon notification from the Contracting Department of any of the actions detailed in Section III.D.1 of this Policy, in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

3. Affected ***members*** shall be notified of the actions detailed Section III.D.1 of this Policy, as applicable, in accordance with CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Policy DD.2012 Member Notification of Change in the Availability or Location of Covered Services
C. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
D. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
E. CalOptima Long Term Care Provider Resource Manual
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medical Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
H. Title 22, California Code of Regulations (CCR), Division 3
I. Title 22, California Code of Regulations (CCR), Sections 51215, 51121, 51212, 51215.5, 51215.8, 51334, and 51335
J. Title 18, Federal Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

A. 10/13/15: Department of Health Care Services

VII. BOARD ACTION(S)

04/04/2019: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2004	GG.1825	Long Term Care Facility Contracting	Medi-Cal
Revised	05/01/2009	GG.1825	Long Term Care Facility Contracting	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2010	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	07/01/2015	EE.1135	Long Term Care Facility Contracting	Medi-Cal
Revised	08/01/2016	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	12/01/2017	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect
Revised	04/04/2019	EE.1135	Long Term Care Facility Contracting	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Covered Services	**Medi-Cal:** Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. **OneCare Connect:** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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 (NF-B) [Skilled Nursing Facility (SNF)].
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Member	An enrollee-beneficiary of a CalOptima program.
New Admission	Shall mean a Member with no previous residence history at a Facility or one who has had a previous residence history at a Facility but was appropriately discharged as part of the Member's plan of care.
Personal 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.3009Δ: Access by Member's Personal Representative.
Service Area	County of Orange, California.
Working Days	Shall mean state of California working day(s).

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 7, 2003
Regular Meeting of the CalOptima Board of Directors

Report Item

V. A. Authorize the Chief Executive Officer to Execute New Contracts with Long-Term Care Facility Providers and Approve Contracting Strategy

Contact

Richard Chambers, Chief Operating Officer
(714) 246-8400

Recommended Action

A. Authorize the Chief Executive Officer to execute new contracts with Long Term Care (LTC) facilities; and,
B. Approve the Long-Term Care contracting strategy to require LTC facilities to be contracted in order to receive reimbursement.

Background

CalOptima's responsibility to administer the Long-Term Care (LTC) room and board facility daily rate was approved by the Board as part of the FY 1998 budget. CalOptima began administering the benefit on June 1, 1998. At implementation, the local chapter of the California Association of Health Facilities (CAHF) and CalOptima agreed that contracting was sound business practice and mutually beneficial. CalOptima worked with CAHF to develop the terms of the contract and extended contracts to all skilled nursing and intermediate care facilities that provided care to CalOptima members. The response rate was high with all local facilities executing contracts with CalOptima in that initial year. In the subsequent years, many of these contracts were extended. In April 2003, nearly 230 contract amendments were sent to facilities extending their contracts from July 1, 2003 through December 31, 2003.

While our intent has always been to contract with every nursing facility that serves its members, currently some facilities are receiving payment for the room and board daily rate without a contract. Facilities without executed contracts are usually out of the local area and do not have a large census of CalOptima members. In some cases, facilities that handle special needs populations, such as foster children and conservatees of the Orange County Public Guardian, have been offered contracts but have not yet executed them. In addition, some facilities have changed ownership or failed to renew their contracts.

CalOptima staff has developed a new contracting approach that will provide the following key concepts:

- CalOptima will only contract with and reimburse a long term care (LTC) facility that is licensed by the State.

- Only facilities that have a contract will be eligible to be reimbursed the room and board daily rate for new admissions of CalOptima members who are eligible for covered services, unless the person was a resident at a facility prior to January 1, 2004. Also, a facility will be reimbursed retrospectively if they sign a contract with CalOptima and meet all other requirements.

- If a facility does not intend to contract with CalOptima, but has a CalOptima member in residence, they may be reimbursed for up to ninety (90) calendar days following admission or CalOptima eligibility on condition that the facility enters into a letter of agreement (LOA) for care of the admitted member, and one of the following occurs:

  1. The facility is engaged in transferring the member to a contracted facility or,
  2. The facility is outside of Orange County and is working with the member or their representative to transfer Medi-Cal eligibility to the county in which the member is currently residing.

- CalOptima may authorize admission, lengths of stays, and reimbursement to non-contracted LTC facilities on a case by case basis if it is determined to be in the best interests of the member.

- CalOptima will reimburse facilities, regardless of contractual status, as the coinsurance coverage for members admitted under their Medicare benefit up to the time that benefit is exhausted and CalOptima becomes the primary payer.

CalOptima may from time-to-time clarify or add concepts related to this contracting approach.

Discussion

The recommended action will create greater uniformity in the contracting process and a better ability for CalOptima to monitor expenditures and the care provided to our members. CalOptima intends to collaborate with the facilities, over the next several years, to design and implement quality studies that will benefit CalOptima's members as well as all residents of CalOptima contracted facilities. The term of the nursing facility contracts will be two years, beginning January 1, 2004 and extending through December 31, 2005. Please see the attachment, which highlights significant changes from the current contract.

CalOptima is aware that members consider their skilled nursing facilities as their home. The recommended approach outlined here allows CalOptima to reimburse long term care facilities for room and board for members admitted on or before December 31, 2003 regardless of a facility's contracting status. Beginning January 1, 2004, CalOptima will not reimburse for new admissions until a facility executes a contract with CalOptima. In anticipation that some facilities may not have a contract in place by January 1, 2004, the policy allows CalOptima to retrospectively reimburse facilities that may have admitted members without a contract back to the date of admission of that member. Therefore, there is no penalty for executing a contract after January 1, 2004. However, CalOptima will strongly encourage facilities to have contracts in place so that reimbursement for new admissions is not interrupted at the beginning of the next calendar year.

CalOptima will work, on a case-by-by case basis, with non-contracted facilities to resolve any issues arising from the admission or continued stay of a CalOptima member. This will allow an opportunity to thoughtfully attend to administrative clinical issues without having to disrupt the continuity of care being provided the member.

Fiscal Impact
There will be no additional administrative or medical costs associated with contracting and implementation of the policy in FY2003/04.

Rationale for Recommendation
The contracting process allows CalOptima to clearly and directly convey its service expectations to participating long term care providers, and it affords those providers a clear framework regarding both the process of and payment for the provision of room and board to CalOptima members.

Concurrence
Foley & Lardner

Attachment
2004 Contract for Long Term Care Facility Services - Significant Changes from the 1998 Contract

/s/ Mary K. Dewane — *10/1/2003*
Authorized Signature — **Date**

2004 Contract for Long Term Care Facility Services
Significant Changes from the 1998 Contract

- Billing provisions to reflect that CalOptima is processing electronic claims and is no longer using EDS for this service.

- Updates language to incorporate terms of prior amendments (HIPAA, Compliance Program).

- Updates language to conform to current State contract requirements related to existing LTC contract provisions (Interpreter Services, Access & Records, Discrimination).

- Requires that the facility's medical director(s) meet CalOptima's Minimum Practitioner Standards.

- Requires the facility to accept as payment in full CalOptima rates for the provision of transitional inpatient level of care when it is the financial responsibility of the health network.

- Establishes mechanism for CalOptima to implement rate changes to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHS policy, changes in Covered Services and/or by CalOptima Board actions.

- Adds provision requiring a corrective action plan to address failure to comply with contract provisions, obligations and requirements.

- Adds provision precluding assignment of contract.

- Adds provision requiring facility to give notice of transfer/discharge and accept members when the facility receives a transfer request from a non-contracted provider facility, when the facility has beds and can provide the appropriate level of care.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
21. Consider Approval of Proposed Changes to CalOptima Contracting Policy EE.1141: CalOptima Provider Contracts

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to modify existing CalOptima Contracting Policy EE.1141: CalOptima Provider Contracts.

Background/Discussion
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 as needed and subject to peer review. New and modified Policies and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, programs or business practices are established.

The following table lists the existing Contract policy that has been updated, approved by CalOptima's Policy Review and Compliance Committees, and is being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	EE.1141: CalOptima Provider Contracts	• Added statements to address conditions of participation for each line of business. • Minor language and formatting changes.	• Compliance with DHCS, CMS, and PACE guidelines. • Annual review with minor updates for clarification of process/procedure and formatting changes.

Fiscal Impact
There is no fiscal impact.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Revised CalOptima Policy EE.1141: CalOptima Provider Contracts (redlined and clean copies)

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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Policy #:	EE.1141Δ
Title:	**CalOptima Provider Contracts**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	02/01/2017
~~Last Review Date:~~	~~01/01/18~~
~~Last~~ Revised Date:	~~01/01/18~~04/04/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy details the process by which CalOptima ~~negotiates and~~ contracts with ***providers***, or establishes ~~***a contract or letter***~~***Letters*** ***of*** ~~***agreement (LOA)***~~***Agreement (LOAs),*** as appropriate, with ~~an~~ out-of-network ~~***Provider***~~***p******Providers*** to meet its State and Federal obligations regarding ***network*** adequacy and ***continuity of care***.

II. POLICY

A. CalOptima may enter into a contract for participation directly with a ***p*** ~~***P***~~***rovider*** to ensure access to ~~***C***~~***c******overed*** ~~***S***~~***s******ervices*** for ~~***M***~~***m******embers***, and to obtain cost-effective pricing for ***c*** ~~***C***~~***overed*** ~~***S***~~***s******ervices***.

B. CalOptima ~~shall~~may contract with ~~***P***~~***p******roviders*** that meet the participation requirements for applicable health care programs and are fully ***credentialed*** by CalOptima in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

C. As a condition of participation in the CalOptima Medi-Cal program, contracting ~~***P***~~***p******roviders*** shall be enrolled in the State's Medi-Cal Program in accordance with requirements set forth by the ***Department of Health Care Services (DHCS***~~***), except as provided in Section II.G of this Policy.***~~***).*** When enrollment in the State's Medi-Cal program is not available to the ***provider's*** provider type, contracting ~~***P***~~***p******roviders*** shall be subject to CalOptima's enrollment and screening process.

D. As a condition of participation in the CalOptima OneCare and OneCare Connect programs, ~~***P***~~***p******roviders*** shall not be excluded/sanctioned from participation in Medicare, shall not have opted out of Medicare, and shall not be listed on CMS' ***Preclusion List***.

E. As a condition of participation in the CalOptima Program of All-Inclusive Care for the Elderly (PACE) program, contracting health care ~~***P***~~***p******roviders*** shall be enrolled in the State's Medi-Cal Program in accordance with requirements set forth by the ***DHCS***.

~~D.~~F. CalOptima shall determine ***network*** adequacy by health care program and contract with ~~the following out of~~ those ***provider*** types needed to, at a minimum, maintain an adequate ***network*** ~~Providers~~ as ~~needed:~~described in the requirement of each program.~~.~~

~~1. Physicians, hospitals, and ancillary services;~~

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~~2. Long Term Services and Support (LTSS) services, which include but are not to limited to, contracting with Long Term Care Facilities pursuant to CalOptima Policy EE.1135: Long Term Care Facility Contracting;~~

~~3. Providers in support of the Multipurpose Senior Services Program (MSSP); and~~

~~4. Community Based Adult Services (CBAS) centers.~~

~~a. CalOptima shall extend contracts to all willing licensed and certified CBAS centers within Orange County and adjacent areas accessible to Members.~~

~~E.~~G. CalOptima shall use p~~P~~rovider c~~C~~ontract templates as approved by the CalOptima Legal Affairs Department and the ~~***the Department of Health Care Services (DHCS)***~~***DHCS*** based on ~~***P***~~***p******rovider*** type. If necessary, CalOptima may negotiate services at a rate that is not to exceed levels approved by the CalOptima Board of Directors. ~~CalOptima's Contracting Department shall obtain written approval from the CalOptima Chief Operating Officer (COO) and Chief Financial Officer (CFO) for any rate that exceeds the CalOptima Board of Directors approved level.~~

~~If there is a need~~1. CalOptima's Contracting Department shall obtain written approval from the CalOptima Chief Executive Officer (CEO) or his ***d~~D~~esignee*** for any rate that exceeds the CalOptima Board of Directors approved level.

2. Upon the recommendation of the CalOptima Chief Medical Officer (CMO), the CEO, or his ***d~~D~~esignee*** may negotiate rates and~~,~~ payment terms with ***providers*** for ***medically necessary, covered~~,~~ ~~medically necessary~~ services*** in unique situations, where contracted ***providers*** or ***providers*** that are willing to enter into standard ***LOAs*** are not qualified to provide the necessary services.

3. With Board approval, the CEO may implement new rate methodologies for Medi-Cal Fee-For-Service contracted hospitals, including but not limited to, tiered per diems, All Patient Refined Diagnosis Related Group (APR-DRG) based reimbursement, case rates, and blended per diem rates.

F. CalOptima shall execute a ***letter of agreement (LOA)*** with an out-of-network ***provider*** where ***m~~M~~edically n~~N~~ecessary, c~~C~~overed s~~S~~ervices*** to a ***~~M~~member*** are required:

a. In order to access care not available through ~~an out-of-network Provider who does not~~ contracted ***providers*** and where the ***providers*** of the necessary services do not accept CalOptima's out-of-network rates~~, CalOptima shall execute a letter of agreement (LOA) with an out-of-network Provider.~~; or

b. ~~In order to satisfy Member access and~~For ***continuity of care*** ~~requirements,~~needs where the ***provider*** will accept CalOptima's ~~Chief Medical Officer (CMO) may make an exception to the requirement that Providers furnishing services to~~ standard rates, but does not wish to be a regularly-contracted CalOptima ~~***Medi-Cal Members be enrolled in***~~ ***provider***; or

~~b.~~c. For ***continuity of care*** needs when the ~~***State's Medi-Cal Program and allow for***~~ ***provider*** will not accept CalOptima's standard rates, but transitioning the ~~contracting of a non-Medi-Cal provider on~~ care to a ~~case-by-case basis.~~contracted ***~~P~~provider***:

i. Would require the ~~***M***~~***member*** to receive services from multiple ***providers***/facilities in an uncoordinated manner which would significantly impact the ~~***M***~~***member's*** condition; or

ii. Could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment.

iii. Would require ***m~~M~~ember*** to undertake a substantial change in recommended treatment for ***~~M~~medically n~~N~~ecessary, c~~C~~overed s~~S~~ervices***.

III. PROCEDURE

A. Preliminary Evaluation

1. If CalOptima determines there is an unmet ***~~P~~provider*** coverage need which causes ***~~M~~member*** access issues and/or unmet ***continuity of care*** obligations, Contracting Department shall ~~contact~~ reach out to ~~***of network P***~~***providers*** identified through claims paid data, ~~***Letters of Agreement (LOA),***~~***LOAs***, or ***~~M~~member*** requests and invite them to enter into a contract for ~~***covered services.C***~~***covered S******ervices***. Contracted provider ***network*** adequacy will be reviewed on an ongoing basis.

2. ***Providers*** that wish to proceed with a contract for participation in CalOptima's Medi-Cal program must be actively enrolled with Medi-Cal, with the exception of ~~***P***~~***provider*** types that do not have an enrollment pathway through the State. The CalOptima Quality Improvement Department shall perform a supplemental internal screening for Provider types that do not have an enrollment pathway through the State when processing their ***credentialing*** applications.

~~2.~~3. ***Physicians*** shall be required to meet the minimum physician standards as described in CalOptima Policy GG.1643: Minimum Physician Standards, and ~~all physicians and other Providers~~ must complete a ***credentialing*** application. The CalOptima Quality Improvement Department shall review and approve or deny the ***credentialing*** application in accordance with CalOptima Policies GG.1643: Minimum Physician Standards and GG.1650Δ: Credentialing and Recredentialing of Practitioners.

4. ***Health Delivery Organizations (HDOs)*** shall be required to complete a ***credentialing*** application. The CalOptima Quality Improvement Department shall review and approve or deny the ***credentialing*** application in accordance with CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

~~3.~~5. The Quality Improvement Department shall notify the Contracting and Provider Relations Departments when a ***p~~P~~provider*** has passed or been denied ***credentialing***. If CalOptima denies ***credentialing***:

a. Contracting shall notify the ***p~~P~~provider*** that CalOptima will not be able to contract with the ~~***P***~~***provider***.

b. If ***credentialing*** has been denied for a physician who is part of a contracted physician group, the Provider Relations Department shall notify the contracted physician group that CalOptima will not be able to include the physician under the group contract.

B. Contract Completion

1. Upon receipt of an approval ~~for~~of ***credentialing*** from the Quality Improvement Department, the contract shall be completed as follows:

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a. If applicable, the Contracting Department shall negotiate rates with the ~~P~~***provider*** within limits set by the CalOptima Board of Directors, in accordance with Section II.G of this ~~p~~Policy.

b. Contract will be signed by the ~~P~~***provider***.

c. Contracting Department shall route a ~~P~~***provider***-signed c~~C~~ontract to the ~~CalOptima Chief Executive Officer (CEO), or Designee, for signature~~appropriate signer for counter-signature in accordance with the CalOptima Policy GA.3202: Signature Authority.

d. Once the contract is fully executed, the Contracting Department shall complete and forward a Contract Summary form to internal departments, as applicable.

e. Contracting shall assign the effective date as the first day of the month following the signature of both parties, unless:

i. An effective date is specified in an applicable CalOptima Board Action Agenda Referral (COBAR); or

ii. Additional time is required for information systems programming.

f. If a newly ***credentialed*** physician is part of an existing contracted physician group, the Provider Relations Department shall assign the effective date as the first day of the month following approval notification from the Quality Improvement Department. The Provider Relations Department shall notify Provider Data Management Services to enter the physician into the FACETS system.

2. The Contracting Department shall notify the ***provider*** of contract completion and forward the fully executed contract to the ***provider***.

C. ***Letter of Agreement (LOA)***

1. CalOptima shall provide ***medically necessary, covered services*** to a Member through an out-of-network ***provider*** when CalOptima is unable to provide services in the contracted ***network*** in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals~~.~~, or when it is necessary for purposes of ***continuity of care***.

~~2.~~ CalOptima shall generate ~~a~~an ***LOA*** for all Medi-Cal out-of-network long-term care~~/skilled nursing~~ facilities~~.~~

~~3. CalOptima shall generate a LOA for out-of-network~~ , Medi-Cal hospitals, physicians, ~~home health agencies~~ancillary, or other entities as ~~are~~ necessary~~.~~

~~4.~~2. ~~CalOptima shall generate a LOA for~~ , and all out-~~-~~of-~~-~~network OneCare Connect ***providers***.

~~5. The LOA template approved by the Legal Affairs Department shall specify Provider requirements, including but not limited to:~~

~~a. No costs to the Member;~~

~~b. Confidentiality of Member information;~~

~~c. Authorization requirements related to Covered Services;~~

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~~d. Billing and payment arrangements for out-of-network Providers.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicaid & Medicare Services (CMS) for OneCare
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreement
~~D.~~A. ~~CalOptima Three-way Contract with CMS and DHCS for Cal MediConnect~~
CalOptima Policy EE.1135: ~~-~~Long Term Care Facility Contracting
~~E.~~D.
~~F.~~E. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~G.~~F. CalOptima Policy GG.1643Δ: Minimum Physician Standards
~~H.~~G. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~I.~~H. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
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. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

~~None to Date~~
A. 06/05/07: Regular Meeting of the CalOptima Board of Directors
B. 06/04/09: Regular Meeting of the CalOptima Board of Directors
C. 03/06/14: Regular Meeting of the CalOptima Board of Directors
D. 11/06/14: Regular Meeting of the CalOptima Board of Directors
E. 04/04/19: 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	02/01/2017	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE

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~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Revised	04/04/2019	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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 Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.

Term	Definition
Medically Necessary	Medi-Cal: 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. OneCare: 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. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5. PACE: 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	~~For the purposes of this policy,~~ Aan enrollee-beneficiary of a CalOptima program.
Network	Primary Care Providers, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that subcontract with CalOptima for the delivery of Covered Services.
~~Network Provider~~	~~A Provider that subcontracts with CalOptima for the delivery of Covered Services.~~
Preclusion List	CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Provider	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.~~Any individual or entity that is engaged in the delivery of Covered Services, or ordering or referring for the Covered Services, and is licensed or certified to do so.

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Policy #:	EE.1141Δ
Title:	**CalOptima Provider Contracts**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	02/01/2017
Revised Date:	04/04/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy details the process by which CalOptima contracts with ***providers***, or establishes ***Letters of Agreement (LOAs),*** as appropriate, with out-of-network ***providers*** to meet its State and Federal obligations regarding ***network*** adequacy and ***continuity of care***.

II. POLICY

A. CalOptima may enter into a contract for participation directly with a ***provider*** to ensure access to ***covered services*** for ***members***, and to obtain cost-effective pricing for ***covered services***.

B. CalOptima may contract with ***providers*** that meet the participation requirements for applicable health care programs and are fully ***credentialed*** by CalOptima in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

C. As a condition of participation in the CalOptima Medi-Cal program, contracting ***providers*** shall be enrolled in the State's Medi-Cal Program in accordance with requirements set forth by the ***Department of Health Care Services (DHCS).*** When enrollment in the State's Medi-Cal program is not available to the ***provider's*** provider type, contracting ***providers*** shall be subject to CalOptima's enrollment and screening process.

D. As a condition of participation in the CalOptima OneCare and OneCare Connect programs, ***providers*** shall not be excluded/sanctioned from participation in Medicare, shall not have opted out of Medicare, and shall not be listed on CMS' ***Preclusion List***.

E. As a condition of participation in the CalOptima Program of All-Inclusive Care for the Elderly (PACE) program, contracting health care ***providers*** shall be enrolled in the State's Medi-Cal Program in accordance with requirements set forth by the ***DHCS***.

F. CalOptima shall determine ***network*** adequacy by health care program and contract with those ***provider*** types needed to, at a minimum, maintain an adequate ***network*** as described in the requirement of each program.

G. CalOptima shall use provider contract templates as approved by the CalOptima Legal Affairs Department and the ***DHCS*** based on ***provider*** type. If necessary, CalOptima may negotiate services at a rate that is not to exceed levels approved by the CalOptima Board of Directors.

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1. CalOptima's Contracting Department shall obtain written approval from the CalOptima Chief Executive Officer (CEO) or his ***designee*** for any rate that exceeds the CalOptima Board of Directors approved level.

2. Upon the recommendation of the CalOptima Chief Medical Officer (CMO), the CEO, or his ***designee*** may negotiate rates and payment terms with ***providers*** for ***medically necessary, covered services*** in unique situations, where contracted ***providers*** or ***providers*** that are willing to enter into standard ***LOAs*** are not qualified to provide the necessary services.

3. With Board approval, the CEO may implement new rate methodologies for Medi-Cal Fee-For-Service contracted hospitals, including but not limited to, tiered per diems, All Patient Refined Diagnosis Related Group (APR-DRG) based reimbursement, case rates, and blended per diem rates.

F. CalOptima shall execute a ***letter of agreement (LOA)*** with an out-of-network ***provider*** where ***medically necessary, covered services*** to a ***member*** are required:

a. In order to access care not available through contracted ***providers*** and where the ***providers*** of the necessary services do not accept CalOptima's out-of-network rates; or

b. For ***continuity of care*** needs where the ***provider*** will accept CalOptima's standard rates, but does not wish to be a regularly-contracted CalOptima ***provider***; or

c. For ***continuity of care*** needs when the ***provider*** will not accept CalOptima's standard rates, but transitioning the care to a contracted ***provider***:

i. Would require the ***member*** to receive services from multiple ***providers***/facilities in an uncoordinated manner which would significantly impact the ***member's*** condition; or

ii. Could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment.

iii. Would require ***member*** to undertake a substantial change in recommended treatment for ***medically necessary, covered services***.

III. PROCEDURE

A. Preliminary Evaluation

1. If CalOptima determines there is an unmet ***provider*** coverage need which causes ***member*** access issues and/or unmet ***continuity of care*** obligations, Contracting Department shall reach out to ***providers*** identified through claims paid data, ***LOAs***, or ***member*** requests and invite them to enter into a contract for ***covered services***. Contracted provider ***network*** adequacy will be reviewed on an ongoing basis.

2. ***Providers*** that wish to proceed with a contract for participation in CalOptima's Medi-Cal program must be actively enrolled with Medi-Cal, with the exception of ***provider*** types that do not have an enrollment pathway through the State. The CalOptima Quality Improvement Department shall perform a supplemental internal screening for Provider types that do not have an enrollment pathway through the State when processing their ***credentialing*** applications.

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3. ***Physicians*** shall be required to meet the minimum physician standards as described in CalOptima Policy GG.1643: Minimum Physician Standards, and must complete a ***credentialing*** application. The CalOptima Quality Improvement Department shall review and approve or deny the ***credentialing*** application in accordance with CalOptima Policies GG.1643: Minimum Physician Standards and GG.1650Δ: Credentialing and Recredentialing of Practitioners.

4. ***Health Delivery Organizations (HDOs)*** shall be required to complete a ***credentialing*** application. The CalOptima Quality Improvement Department shall review and approve or deny the ***credentialing*** application in accordance with CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations.

5. The Quality Improvement Department shall notify the Contracting and Provider Relations Departments when a ***provider*** has passed or been denied ***credentialing***. If CalOptima denies ***credentialing***:

    a. Contracting shall notify the ***provider*** that CalOptima will not be able to contract with the ***provider***.

    b. If ***credentialing*** has been denied for a physician who is part of a contracted physician group, the Provider Relations Department shall notify the contracted physician group that CalOptima will not be able to include the physician under the group contract.

B. Contract Completion

1. Upon receipt of an approval of ***credentialing*** from the Quality Improvement Department, the contract shall be completed as follows:

    a. If applicable, the Contracting Department shall negotiate rates with the ***provider*** within limits set by the CalOptima Board of Directors, in accordance with Section II.G of this Policy.

    b. Contract will be signed by the ***provider***.

    c. Contracting Department shall route a ***provider***-signed contract to the appropriate signer for counter-signature in accordance with the CalOptima Policy GA.3202: Signature Authority.

    d. Once the contract is fully executed, the Contracting Department shall complete and forward a Contract Summary form to internal departments, as applicable.

    e. Contracting shall assign the effective date as the first day of the month following the signature of both parties, unless:

        i. An effective date is specified in an applicable CalOptima Board Action Agenda Referral (COBAR); or

        ii. Additional time is required for information systems programming.

    f. If a newly ***credentialed*** physician is part of an existing contracted physician group, the Provider Relations Department shall assign the effective date as the first day of the month following approval notification from the Quality Improvement Department. The Provider Relations Department shall notify Provider Data Management Services to enter the physician into the FACETS system.

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2. The Contracting Department shall notify the ***provider*** of contract completion and forward the fully executed contract to the ***provider***.

C. ***Letter of Agreement (LOA)***

1. CalOptima shall provide ***medically necessary, covered services*** to a Member through an out-of-network ***provider*** when CalOptima is unable to provide services in the contracted ***network*** in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals, or when it is necessary for purposes of ***continuity of care***.

2. CalOptima shall generate an ***LOA*** for all Medi-Cal out-of-network long-term care facilities, Medi-Cal hospitals, physicians, ancillary, or other entities as necessary, and all out-of-network OneCare Connect ***providers***.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicaid & Medicare Services (CMS) for OneCare
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreement
D. CalOptima Policy EE.1135: Long Term Care Facility Contracting
E. CalOptima Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Policy GG.1643Δ: Minimum Physician Standards
G. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
H. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
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. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

A. 06/05/07: Regular Meeting of the CalOptima Board of Directors
B. 06/04/09: Regular Meeting of the CalOptima Board of Directors
C. 03/06/14: Regular Meeting of the CalOptima Board of Directors
D. 11/06/14: Regular Meeting of the CalOptima Board of Directors
E. 04/04/19: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2017	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
				PACE
Revised	01/01/2018	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	04/04/2019	EE.1141Δ	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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 Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.

Term	Definition
Medically Necessary	Medi-Cal: 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. OneCare: 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. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5. PACE: 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.
Network	Primary Care Providers, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that subcontract with CalOptima for the delivery of Covered Services.
Preclusion List	CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Provider	Any individual or entity that is engaged in the delivery of Covered Services, or ordering or referring for the Covered Services, and is licensed or certified to do so.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Approval of Proposed Revisions to CalOptima Information Services Policy IS.1306: Shared Drives Authorization and Classification

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

Recommended Action
Authorize and approve updates to CalOptima Policy IS.1306: Shared Drives Authorization and Classification, subject to regulatory approval, as necessary.

Background
In its capacity as a covered entity health plan and business associate, CalOptima is required to create and update policies and procedures implementing the requirements of the Health Insurance Portability and Accountability Act (HIPAA), including those found in regulations addressing a set of national standards for protecting electronic health information (set forth in Title 45, Code of Federal Regulations (CFR), Part 160 and Part 164, Subparts A and C, and commonly referred to as the "Security Rule").

The Security Rule requires that CalOptima implement reasonable and appropriate policies and procedures to comply with the security standards and specifications including administrative, physical, and technical safeguards related to electronic protected health information (EPHI).

- Administrative safeguards address the management, selection, development, implementation, and maintenance of security measures to protect EPHI and management of the conduct of CalOptima's workforce and business associates in relationship to its EPHI. Examples include, but are not limited to, policies and procedures addressing workforce clearance and access/termination to EPHI, security awareness and training, and security incident response.

- Physical safeguards are designed to protect CalOptima's electronic information systems and related building and equipment, from natural and environmental hazards, and unauthorized intrusion. Examples include, but are not limited to, policies and procedures addressing facility security plans, device and media controls, and disposal of EPHI and the hardware/media on which it is stored.

- Technical safeguards address the use of and access to EPHI. Examples include, but are not limited to, encryption/decryption while EPHI is at rest and during transmission, audit control, and authentication standards.

Discussion
CalOptima is required to review its policies and procedures periodically and update them as necessary in response to environmental or operational changes affecting the security of EPHI. Such policies and procedures are also required to be submitted to CalOptima's regulators. CalOptima's Information

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Services (IS) Department has reviewed the existing IS and administrative security policies and procedures to determine whether changes or enhancements for CalOptima's processes were necessary.

Proposed changes are included for CalOptima Policy IS.1306: Shared Drives Authorization and Classification to better define the roles and responsibilities of data owners and IS administrators for shared drives. The proposed changes include:

- Updating existing definitions to align with CalOptima Policy IS.1001: Glossary of Terms.
- Adding the following new terms to the Glossary:
  - Data Custodian; and
  - Electronic Protected Health Information (EPHI)
- In Section II.A.-B., clearly defining the data owners' access control responsibilities for shared drives.
- In Section II.C., outlining the IS staff access control responsibilities on shared drives, added the disclaimer that data owners should have no expectation of privacy, and included language stating that IS staff may access the contents of shared drives for quality purposes and/or as required by law.
- Adding the following policies in Section V. References, as these policies address other safeguards to data stored on shared drives:
  - CalOptima Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls
  - CalOptima Policy IS.1201: Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls
  - CalOptima Policy IS.1202: Electronic Protected Health Information (EPHI) Technical Safeguards - Data Controls
  - CalOptima Policy IS.1301: Security of Workforce Access to Electronic Protected Health Information (EPHI)
  - CalOptima Policy IS.1305: Information Classification and Handling

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Approval is recommended, subject to required regulatory approval, of updated CalOptima Policy IS.1306: Shared Drives Authorization and Classification to ensure that CalOptima is compliant with all applicable federal, state, and local laws and regulations.

Concurrence
Gary Crockett, Chief Counsel

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Attachment
CalOptima Policy IS.1306: Shared Drives Authorization and Classification (redlined and clean)

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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~~Policy #:~~ ~~IS.1306~~
~~Title:~~ ~~**Shared Drives Authorization and Classification**~~
~~Department:~~ ~~Information Services~~
~~Section:~~ ~~HIPAA Security~~

~~CEO Approval:~~ ~~Michael Schrader~~

~~Effective Date:~~ ~~12/01/14~~
~~Last Review Date:~~ ~~05/01/16~~
~~Last Revised Date:~~ ~~05/01/16~~

~~Policy #:~~ ~~IS.1306~~
Title: **Shared Drives Authorization and Classification**
Department: Information Services
Section: HIPAA Security

CEO Approval: Michael Schrader

Effective Date: 12/01/2014
Revised Date: 04/04/2019

I. PURPOSE

~~To establish~~This policy establishes the procedure and responsibilities related to assigning access and maintaining designated storage of digital folders and files on the CalOptima network shared drive, **Data Classification**, and maintaining proper controls for sensitive information.

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. CalOptima shall ensure that all workforce members have appropriate **Access** to **Electronic Protected Health Information (EPHI)**, shall prevent those who are not authorized from obtaining **Access** to **EPHI**, and each **Data Owner** shall designate a person or persons who have the authority to authorize **Access** privileges to **EPHI**, and the process for granting **Access** in accordance with CalOptima Policy IS.1301: Security of Workforce Access to EPHI and this Policy.

~~A.~~B. Each shared folder on the CalOptima network drive shall have a **Data Owner**. When a **User** requests access to a shared drive resource, the **Data Owner** shall review the request and approve, if appropriate. A **Data Owner** shall grant **Access** in the most restrictive setting, considering the **User's** role in the organization, and ensuring the minimum amount of **Access** privilege is granted in accordance with CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

C. The **Data Owner**~~/administrator~~ shall be responsible for the **Data Classification**~~,~~ and shall keep the folder list current. ~~**Access Is The Most Restrictive Setting, Ensuring The Minimum Amount Of Access Privilege Has Been Granted.**~~ **Data Classification** shall be implemented consistent with CalOptima Policy IS.1305: Information Classification and Handling.

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B.D. The Information Services (IS) teamDepartment shall retain a list of shared folder(s), ownership(s), and **Access** level(s).). While **Access** to shared folders may be restricted, **Users** and **Data Owners** should have no expectation of privacy. The IS Security group has the right, with or without cause or notice, to access the contents of shared drives at any time for quality purposes and/or as required by law in response to subpoenas, Public Records Act requests, and/or other legal requirements.;

IV.III. PROCEDURE

A. Whenever possible, shared drive **Access** shall be provisioned using groups instead of individual **Users**.

B. A new folder shall be requested to the IS teamDepartment via a **Help Desk E-Ticket**.

C. The IS teamDepartment shall create the new folder and add the requestor (or group) as the **Data Owner**/administrator unless otherwise noted.

1. The **Data Owner** of the folder shall be documented on the root of the folder in active directory (AD).

D. **Data Owners** shall maintain overall responsibility for the classification of information for which they are responsible, as well as approvers of **Access** to data (including delegation of authority).

E. The **Data Owner** or administrator shall be responsible for maintaining a current folder permission list.

F. The IS teamDepartment shall validate the **Data Owner** and obtain approval for a request to add **User Access** or have **Access** revoked to a shared folder.

1. If the request is approved, the IS Department shall confirm group membership for **Access** and complete requested action.

2. If the request is denied, the IS Department shall notify the requestor of denial and close the **Help Desk E-Ticket**.

G. If no **Data Owner** is identified for an existing folder, the folders permission level shall reflect Information Services Department as the temporary owner, until a **Data Owner** is identified.

H. For auditing and compliance, the final step shall be to update and close the **Help Desk E-Ticket**.

V.IV. ATTACHMENT(S)

Not Applicable

VI.V. REFERENCES

A. CalOptima Finance and Audit Committee Report for May 2014
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B.A. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

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D. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls
E. CalOptima Policy IS.1201: Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls
F. CalOptima Policy IS.1202: Electronic Protected Health Information (EPHI) Technical Safeguards - Data Controls
G. CalOptima Policy IS.1301: Security of Workforce Access to Electronic Protected Health Information (EPHI)
H. CalOptima Policy IS.1305: Information Classification and Handling
I. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Title 45, Code of Federal Regulations, §§ 164.308(a)(3)-(4) and 164.312(a)(1)

~~VII.~~VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~VIII.~~VII. BOARD ACTION(S)

A. 05/15/14: Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee
B. 12/04/14: Regular Meeting of the CalOptima Board of Directors
~~A. 05/15/14: Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee~~

~~IX.~~VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
~~Original~~Effective	12/01/2014	IS.1306	Shared Drives Authorization and Classification	Administrative
Revised	05/01/2016	IS.1306	Shared Drives Authorization and Classification	Administrative
Revised	04/04/2019	IS.1306	Shared Drives Authorization and Classification	Administrative

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IX. GLOSSARY

Term	Definition
Access	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations i.e., the ability or the means necessary to read, write, modify, or communicate data or information or otherwise use any CalOptima system resource.
Data Classification	The process of organizing data into categories for most effective and efficient use. Making essential data easy to locate and retrieve. Data classification is critical for Governance, Risk Management and Compliance.
Data Custodian	A member of the IS department who implements controls on behalf of the Data Owner and us responsible for the day-to-day management of data, controlling access, adding and removing privileges for Users, and ensuring that the proper controls have been implemented.
Data Owner	A member of senior management, as determined by the Data Custodian, who is accountable and responsible for determining appropriate access to data owned by the department in accordance with CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls. A Data Owner may delegate authority to granting access to department-owned data on a case-by-case basis..
Electronic Protected Health Information (EPHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information that is transmitted by Electronic Media or maintained in Electronic Media.
Help Desk E-Ticket	The electronic ticketing system used at CalOptima.
Information System	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations. An interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.
User	A person or entity with authorized access.

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Policy #:	IS.1306
Title:	**Shared Drives Authorization and Classification**
Department:	Information Services
Section:	HIPAA Security
CEO Approval:	Michael Schrader _____
Effective Date:	12/01/2014
Revised Date:	04/04/2019

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I. PURPOSE

This policy establishes the procedure and responsibilities related to assigning access and maintaining designated storage of digital folders and files on the CalOptima network shared drive, **Data Classification**, and maintaining proper controls for sensitive information.

II. POLICY

A. CalOptima shall ensure that all workforce members have appropriate **Access** to **Electronic Protected Health Information (EPHI)**, shall prevent those who are not authorized from obtaining **Access** to **EPHI**, and each **Data Owner** shall designate a person or persons who have the authority to authorize **Access** privileges to **EPHI**, and the process for granting **Access** in accordance with CalOptima Policy IS.1301: Security of Workforce Access to EPHI and this Policy.

B. Each shared folder on the CalOptima network drive shall have a **Data Owner**. When a **User** requests access to a shared drive resource, the **Data Owner** shall review the request and approve, if appropriate. A **Data Owner** shall grant **Access** in the most restrictive setting, considering the **User's** role in the organization, and ensuring the minimum amount of **Access** privilege is granted in accordance with CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

C. The **Data Owner** shall be responsible for the **Data Classification** and shall keep the folder list current. **Data Classification** shall be implemented consistent with CalOptima Policy IS.1305: Information Classification and Handling.

D. The Information Services (IS) Department shall retain a list of shared folder(s), ownership(s), and **Access** level(s). While **Access** to shared folders may be restricted, **Users** and **Data Owners** should have no expectation of privacy. The IS Security group has the right, with or without cause or notice, to access the contents of shared drives at any time for quality purposes and/or as required by law in response to subpoenas, Public Records Act requests, and/or other legal requirements.

III. PROCEDURE

A. Whenever possible, shared drive **Access** shall be provisioned using groups instead of individual **Users**.

B. A new folder shall be requested to the IS Department via a **Help Desk E-Ticket**.

C. The IS Department shall create the new folder and add the requestor (or group) as the **Data Owner**/administrator unless otherwise noted.

1. The **Data Owner** of the folder shall be documented on the root of the folder in active directory (AD).

D. **Data Owners** shall maintain overall responsibility for the classification of information for which they are responsible, as well as approvers of **Access** to data (including delegation of authority).

E. The **Data Owner** or administrator shall be responsible for maintaining a current folder permission list.

F. The IS Department shall validate the **Data Owner** and obtain approval for a request to add **User Access** or have **Access** revoked to a shared folder.

1. If the request is approved, the IS Department shall confirm group membership for **Access** and complete requested action.

2. If the request is denied, the IS Department shall notify the requestor of denial and close the **Help Desk E-Ticket**.

G. If no **Data Owner** is identified for an existing folder, the folders permission level shall reflect Information Services Department as the temporary owner, until a **Data Owner** is identified.

H. For auditing and compliance, the final step shall be to update and close the **Help Desk E-Ticket**.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Finance and Audit Committee Report for May 2014
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls
E. CalOptima Policy IS.1201: Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls
F. CalOptima Policy IS.1202: Electronic Protected Health Information (EPHI) Technical Safeguards - Data Controls
G. CalOptima Policy IS.1301: Security of Workforce Access to Electronic Protected Health Information (EPHI)
H. CalOptima Policy IS.1305: Information Classification and Handling
I. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Title 45, Code of Federal Regulations, §§ 164.308(a)(3)-(4) and 164.312(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

A. 05/15/14: Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee

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B. 12/04/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2014	IS.1306	Shared Drives Authorization and Classification	Administrative
Revised	05/01/2016	IS.1306	Shared Drives Authorization and Classification	Administrative
Revised	04/04/2019	IS.1306	Shared Drives Authorization and Classification	Administrative

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IX. GLOSSARY

Term	Definition
Access	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations i.e., the ability or the means necessary to read, write, modify, or communicate data or information or otherwise use any CalOptima system resource.
Data Classification	The process of organizing data into categories for most effective and efficient use. Making essential data easy to locate and retrieve. Data classification is critical for Governance, Risk Management and Compliance.
Data Custodian	A member of the IS department who implements controls on behalf of the Data Owner and us responsible for the day-to-day management of data, controlling access, adding and removing privileges for Users, and ensuring that the proper controls have been implemented.
Data Owner	A member of senior management, as determined by the Data Custodian, who is accountable and responsible for determining appropriate access to data owned by the department in accordance with CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls. A Data Owner may delegate authority to granting access to department-owned data on a case-by-case basis..
Electronic Protected Health Information (EPHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information that is transmitted by Electronic Media or maintained in Electronic Media.
Help Desk E-Ticket	The electronic ticketing system used at CalOptima.
Information System	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations. An interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.
User	A person or entity with authorized access.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendment A07 to the PACE Agreement between DHCS and CalOptima ("DHCS PACE Agreement") regarding Calendar Year (CY) 2018 capitation rates and other language updates.

Background

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

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide health care services. The current Agreement expires on December 31, 2019, while the capitation rates are meant to be renewed on a calendar year basis.

Discussion

On February 25, 2019, DHCS provided CalOptima with Amendment A07 for the DHCS PACE Agreement to include updates for:

- Implementing the CY 2018 capitation rates retroactive to January 1, 2018;
- Updating language in Exhibits A, B and E;
- Increasing the maximum amount payable to accommodate for the continuation of services; and
- All other terms and conditions in the CalOptima DHCS PACE Agreement remain the same.

Rate Revisions – Calendar Year 2018 Rate Amendment (Exhibit B)

On August 8, 2018, DHCS provided CalOptima the draft proposed rates for CY 2018, for the period of January 1, 2018 through December 31, 2018. The methodology used to develop them was based on the new experience-based rates methodology that is informed by the Rate Development Template (RDT) process. This is the first year DHCS applies experience-based rates/RDT to PACE, which is consistent with the way DHCS develops rates for Managed Care Plans for the Medi-Cal program. DHCS finalized the CY 2018 rates and worked with CMS between the September 2018 and February 2019 for approval.

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DHCS' final CY 2018 rate amendment is consistent with the draft version provided to CalOptima and will be retroactive to the beginning of 2018.

Rate changes for the period January 1, 2018 through December 31, 2018 reflect the following:

- Revised capitation rates, retroactive to January 1, 2018.
- The Managed Care Organization (MCO) tax will apply to capitation for both the *Full-Dual* population and *Non-Dual eligible* population.
- The revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population have built-in adjustments for Medi-Cal program changes.
- Language updates to incorporate the application of "R Letters" in the event there is delay in a determination to increase or decrease capitation rates, so that an amendment or change order may not be processed in time to permit payment of new rates commencing January 1st. The R Letter shall serve as notification from DHCS to CalOptima of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract.
- Language updates to specify Federal regulation (42 CFR 460.182) requires that the state makes monthly capitation payments to PACE organization for Medi-Cal participants which are less than the amount that would otherwise have been paid (AWOP) under the State plan if those participants were not enrolled in the PACE program.
- Language updates to specify effective January 1, 2018, the capitation rates shall be compliant with State Plan Amendment 18-005.

Language Updates (Exhibits A and E)

This amendment also incorporates additional language updates for the following provisions:

1. Exhibit A
   - Additional language to specify that if a PACE organization does not operate a primary care clinic licensed to operate by the California Department of Public Health pursuant to California Health and Safety Code section 1204, et seq., then that PACE organization must operate its primary care clinic in accordance with all requirements applicable to the operation of licensed primary care clinics, subject to oversight and approval of DHCS. CalOptima PACE currently complies with requirements applicable to the operation of licensed primary care clinics, subject to the oversight and approval of DHCS, such that this clarifying provision does not result in a change to current CalOptima PACE operations.
   - Additional language to specify restrictions on delegation. Existing and applicant PACE Organizations are not allowed to delegate to a separate entity the operation of an existing or additional (expansion) PACE Center and Interdisciplinary Team (IDT). DHCS reserves the right to determine whether a PACE organization's delegation arrangement involves a separate entity. If DHCS determines that the delegation arrangement involves a separate entity, DHCS may terminate the contract or take other appropriate action, including but not limited to requiring the PACE Organization to comply with a Corrective Action Plan. The prohibition on delegation does not prohibit a PO from utilizing alternative care settings (ACS).
   - Revised language for emergency preparedness, for an annual requirement consistent with federal regulations to update the emergency preparedness plan, communication plan, training, and policies and procedures.

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- A clarifying provision that PACE will be required to ensure the federal government, State, and Members are held harmless if PACE does not pay for emergency services.

2. Exhibit E
   - Clarifying language for Duties of the State, Provision 1, *Payment for Services* was amended to specify that capitation payments to PACE organizations are reasonable.

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

Fiscal Impact
The recommended action to execute Amendment A07 to the DHCS PACE Agreement will allow for the implementation of final CY 2018 Medi-Cal PACE rates. Upon analysis, staff estimates the retroactive application of the revised capitation rates and actual PACE enrollment for the period of January 1, 2018, through December 31, 2018, results in a net increase of approximately $1.4 million, as compared to CY 2017 Medi-Cal PACE rates. This represents a 14.3% rate increase for the dual eligible population and a 4.8% increase for the Medi-Cal only population from previously accrued amounts.

Rationale for Recommendation
CalOptima's execution of Amendment A07 to the DHCS PACE Agreement is necessary for the continued operation of CalOptima PACE.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to PACE Primary Agreements

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 23

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

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

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Amendments to Primary Agreement with DHCS	Board Approval
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	**Pending**
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima.
2. If requests for letters of support are approved, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to submit CalOptima letter(s) of support to the Department of Health Care Services.

Background

The Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process on October 27, 2017, and on August 17, 2018, that outline the process for an independent PACE facility to operate in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. California Welfare & Institutions Code section 14087.5 *et seq*. provides that when a COHS plan is established in a county, that COHS plan holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exemption to the existing law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to the state and federal regulators to make all subsequent decisions on the application.

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In response to the DHCS policy letters, on September 6, 2018 the Board approved a process to consider requests for letters of support from organizations seeking to establish PACE operations in Orange County independent of CalOptima. Elements of the process include, but are not limited to:

- Geographic ZIP code designation, consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific zip codes;
- Threshold Criteria (50% weighting), including PACE operating experience, financial soundness quality performance/metrics and demographic competence; and,
- Primary Criteria (50% weighting), including the potential impact on CalOptima PACE program/operations and independent POs operating in Orange County, if any.

Requests for letters of support were accepted from November 1, 2018 through January 31, 2019.

Discussion

CalOptima received requests for letters of support from two organizations, AltaMed Health Services (AltaMed) and Innovative Integrated Health, Inc. dba Fresno PACE (Fresno PACE). Both organizations submitted documentation for the requested elements.

Geographic ZIP code designation

AltaMed Health Services	Innovative Integrated Health, Inc. dba Fresno PACE
• PO seeks to operate in zip codes in Anaheim and Santa Ana • 48.7% of current CalOptima PACE participants reside in these cities • All requested zip codes overlap CalOptima service areas	• PO seeks to operate in one or more zip codes in 16 of the 34 cities in Orange County including: Anaheim, Brea, Buena Park, Cypress, Fullerton, Irvine, La Palma, Lake Forest, Los Alamitos, Midway City, Orange, Placentia, Stanton, Villa Park, Westminster, Yorba Linda • 47.1% of current CalOptima PACE participants reside in these cities. • All requested zip codes overlap CalOptima service areas

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Threshold Criteria

Criteria	Response	
	AltaMed Health Services	Innovative Integrated Health, Inc. dba Fresno PACE
PACE operating experience	Information submitted; no areas of concern identified in the information submitted	Information submitted. PO will have five (5) years experience in November 2019
Financial Soundness	Information submitted; no areas of concern identified in the information submitted	Information submitted; no areas of concern identified in the information submitted.
Quality Performance/Metrics	PO outperformed CalPACE average performance for all criteria requested with the exception of readmission rate; note readmission rates are highly variable due to the small baseline population	PO outperformed CalPACE average performance for all criteria requested.
Demographic competence	Information submitted; no areas of concern identified in the information submitted	Information submitted; no areas of concern identified in the information submitted

Primary Criteria

In addition to the above, independent POs were required to provide information related to the potential impact on CalOptima PACE program/operations and independent POs operating in Orange County, if any.

AltaMed

AltaMed's request indicates an intention to focus on Anaheim and Santa Ana. These cities border Garden Grove, the primary service location for CalOptima PACE. Nearly 49% of CalOptima PACE enrollees are from the two proposed cities. AltaMed also indicated it would establish a particular focus on low-income Hispanic population. More than 50% of CalOptima PACE participants list Spanish as their primary language and approximately 80% of CalOptima PACE staff are bilingual, primarily Spanish speaking. Further, AltaMed's request notes that many of the participants in its existing PACE programs originate from referrals from primary care providers; it further specifically notes that AltaMed's Federally Qualified Health Clinics (FQHCs) in Anaheim and Santa Ana would serve as an "excellent built-in" referral system for an AltaMed PACE. Additionally, CalOptima PACE received regulatory approval to use community-based physicians to increase access and support continuity of care for PACE participants

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Fresno PACE

Fresno PACE's request states that it has not chosen zip codes, especially in Garden Grove and Santa Ana, which represent a high percentage of CalOptima PACE. Approximately 47% of CalOptima PACE participants reside in the cities identified by Fresno PACE. Additionally, CalOptima PACE recently partnered with Sultan Adult Day Care in Anaheim, a contracted Community-Based Adult Services (CBAS) provider, as an Alternate Care Setting (ACS). Sultan Adult Day Care is a registered dba of Pacific GIS, Inc. Per Pacific GIS's licensing documentation at the California Department of Aging, several of its officers and directors are also officers and/or directors of Fresno PACE.

Potential Impact on CalOptima PACE

CalOptima staff has identified the following impact of adding independent POs in Orange County.

- Modification to COHS model: COHS plans hold the exclusive right to contract for Medi-Cal services in the county. If approved, CalOptima will need to specifically request that DHCS submit to the federal government a request to amend California's section 1115 Waiver to allow the independent operation of a specified PO in Orange County.

- No control over sites or service areas: There is no indication that DHCS would require a new letter of support if an approved independent PO later seeks to expand its service area. Thus, it is possible that these POs could request expansion beyond the current request without input from CalOptima.

- Increased administrative costs for CalOptima PACE: Both POs have expressed interest in central Orange County where a significant number of CalOptima PACE participants reside, which may require that CalOptima PACE make a greater investment into marketing. CalOptima PACE maintains a very low marketing budget. In the most recent National PACE Association National Benchmarking Report, CalOptima expended only $14.00 per member per month for marketing expenses compared to the national median of $43.50 per member per month.

Overall Summary

As proposed, independent POs would overlap with CalOptima PACE and raise the potential of adverse selection of membership served. While there currently is no "wait list" for qualifying individuals interested in participating in PACE in Orange County, independent POs in Orange County may bring greater awareness of the PACE program, and add choice and preference for mostly low-income seniors in Orange County.

Staff recommends that the Board consider whether to submit to DHCS a letter of support in response to the request of each organization seeking to offer PACE services in Orange County independent of CalOptima in accordance with regulatory guidance.

Fiscal Impact

In the event the Board approves the request(s) for letters of support from one or both POs and authorizes the CEO to submit such letter(s) to DHCS, the fiscal impact is unknown at this time. The addition of one or two PACE facilities operating in overlapping service areas with CalOptima's current PACE

program will likely have an adverse effect on current levels of enrollment, revenue, and income. Lower enrollment or decelerating enrollment growth would decrease revenues and increase unit cost, directly affecting administrative expenses as many PACE services rely on maximizing economies of scale. In addition, a reduction in net income will elongate the payback period for CalOptima's capital investments in the PACE program.

Rationale for Recommendation

Consistent with the October 27, 2017 and August 17, 2018 PACE Policy Letters, to determine whether or not the CalOptima Board will authorize CalOptima to submit to DHCS a Letter of Support in response to each organization's request in connection with such organization's interest in becoming an independent PACE Organization in Orange County.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 1, 2018, Consider Authorizing Contracts with Alternate Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)
2. Board Action dated September 6, 2018, Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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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

PACE

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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

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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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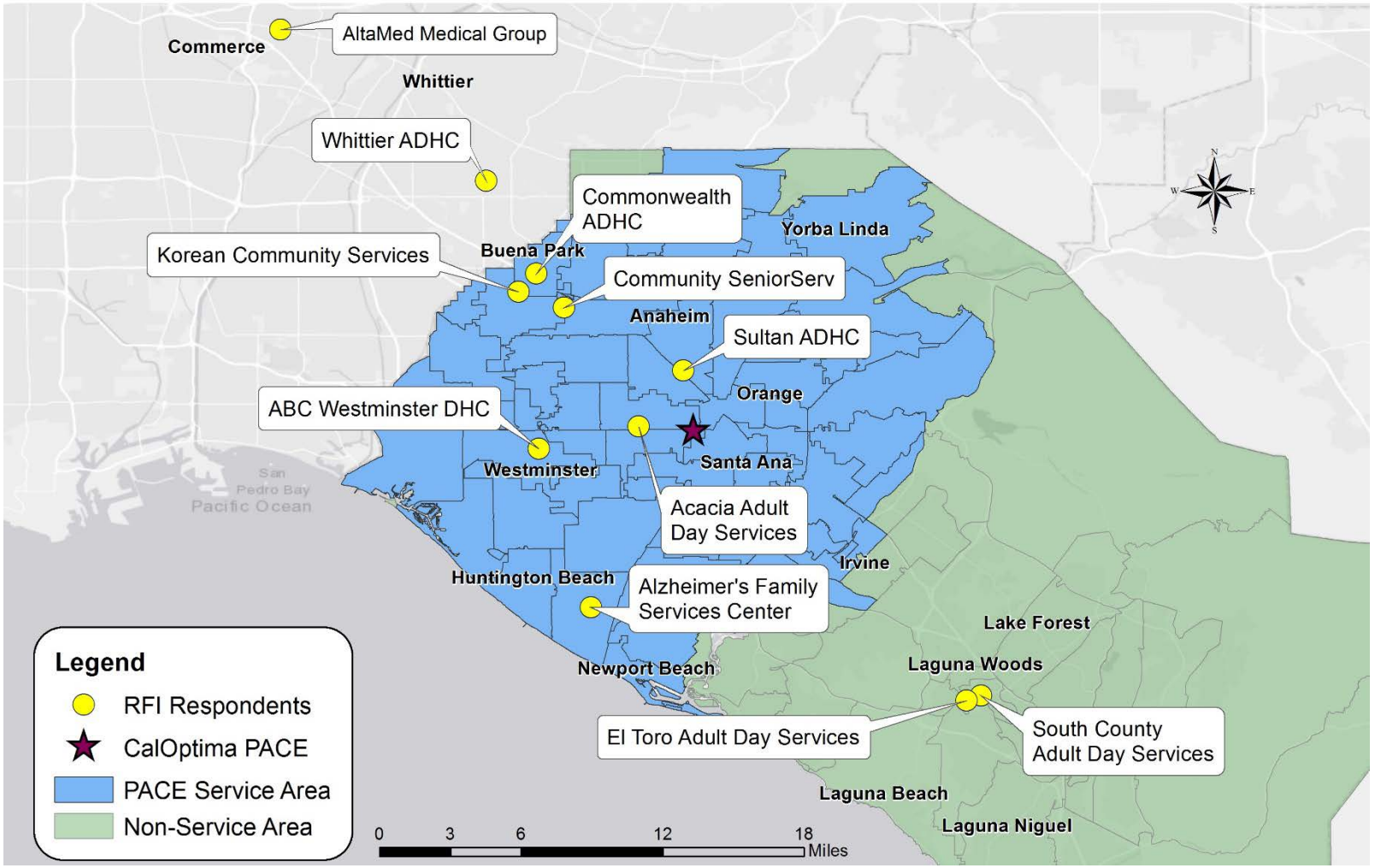
RFI Respondents/PACE Service Area



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PACE CalOptima A Public Agency Better. Together.

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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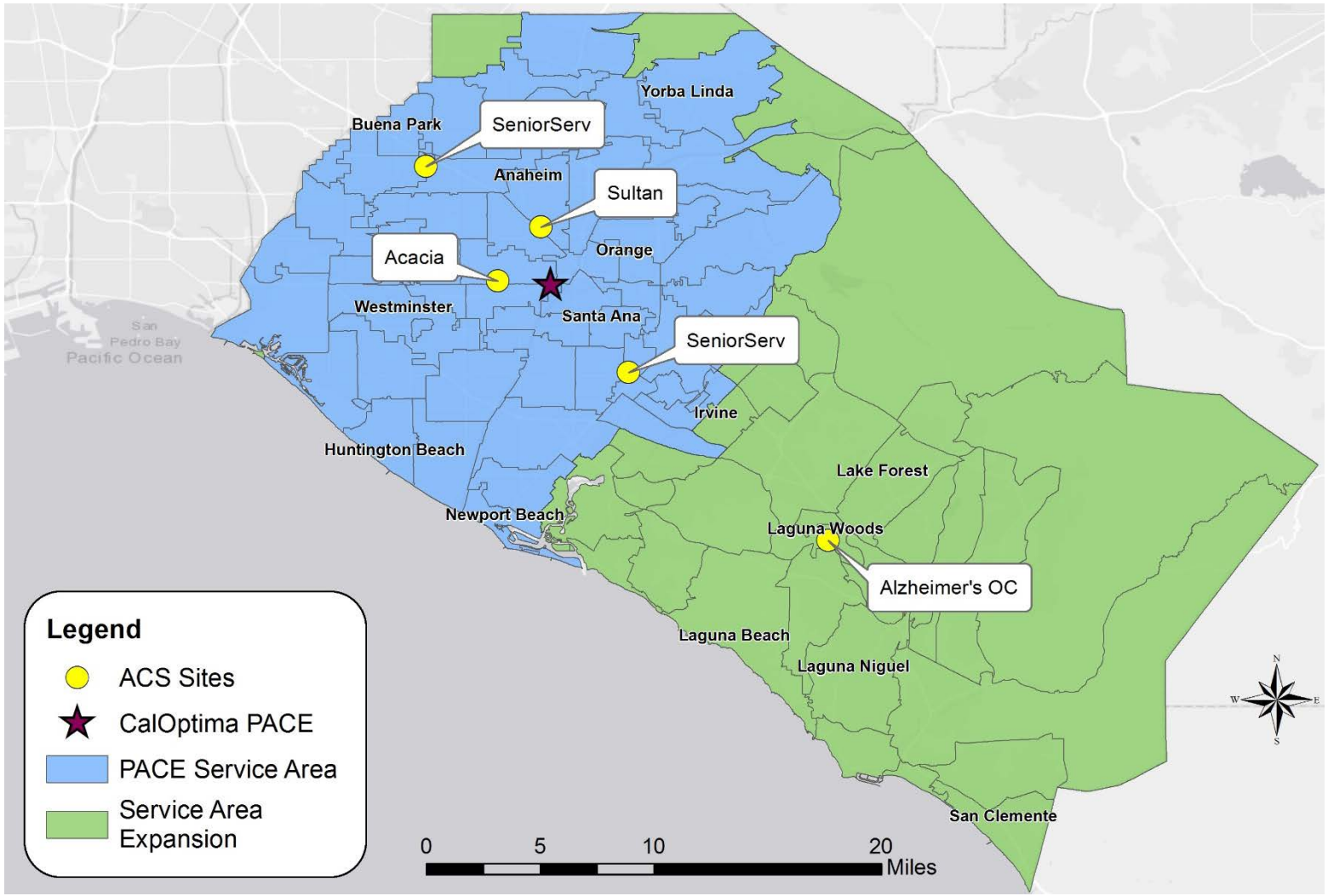
Proposed ACS Sites



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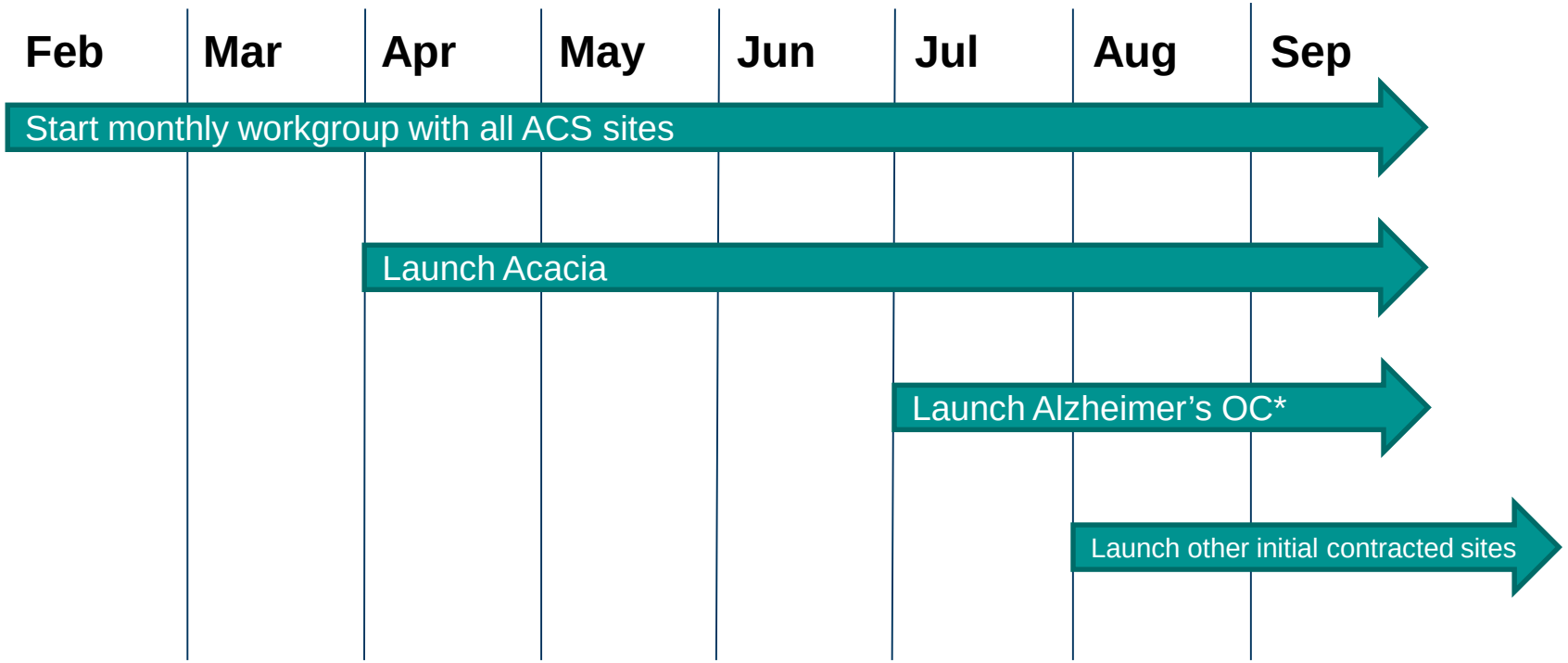
Phased Implementation

- 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

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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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

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

Recommended Action

Authorize the CEO to implement a process to consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima, with all final decisions subject to Board approval.

Background

PACE is a comprehensive health care program that CalOptima provides for frail seniors in Orange County. The PACE model is a person-centered, community-based alternative to nursing home care. PACE supports elders and their families by providing preventive and primary care, and coordinating behavioral health and acute care, as well as long-term services and supports. The intensive care coordination helps individuals with complex chronic care needs to continue living in the community as long as possible. CalOptima opened Orange County's first PACE center in October 2013, and the program has grown to nearly 300 participants. CalOptima recently launched several new initiatives designed to expand access to PACE, including partnerships with Community-Based Adult Services (CBAS) centers, a greater role for community-based physicians in caring for PACE participants, and a larger PACE service area to reach all eligible seniors in Orange County.

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process, including guidance on operation of an independent PACE facility in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions code section 14087.5 *et seq*. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exception to the existing

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law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS plans' only role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to state and federal regulators to make all subsequent decisions on the application.

Since the release of the DHCS policy letters, staff has received informal inquiries from groups interested in applying to become independent POs in Orange County on how and whether CalOptima intends to respond to any requests for letters of support requesting that DHCS seek formal modification of California law governing the COHS framework.

Should CalOptima decide to provide one or more letters of support to independent POs, the decision would then be out of CalOptima's hands, and the independent POs would follow an application process first involving DHCS, and if DHCS submits the request, CMS would consider whether to approve the requested waiver amendment. If CMS approves the waiver amendment, DHCS would then evaluate the independent PO application, and if approved, the application would go to CMS for final approval.

Separate from considering requests from independent POs, CalOptima staff is continuing Board-approved expansion efforts through collaboration with community partners. These include expanding CBAS center use through Alternative Care Setting sites, continuing to cultivate referrals from contracted community-based physicians, enrollment efforts in South Orange County, increasing current sales and marketing efforts, adding a Veteran's Choice option to encourage enrollment by veterans, and adding a Medicare-only members option.

Discussion

In response to the DHCS policy letters and independent PO inquiries, staff is recommending that the Board approve an internal review process for the evaluation of requests for letters of support from organizations seeking to establish independent PACE operations in Orange County and making recommendations to the Board.

Elements of the process to consider letter of support requests include, but are not limited to:

1. **Application timeline window:** Subject to Board approval, staff anticipates accepting letters of support requests beginning November 1, 2018, to January 31, 2019.
2. **Geographic ZIP code designation:** Consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific ZIP codes the independent PO is interested in serving.
3. **Threshold Criteria (~~20~~50% weighting):** All letter of support requests from independent POs shall include and will be evaluated based on the following criteria: Rev. 9/6/18
    a. PACE operating experience
        i. Show a minimum of five (5) years of operating experience
        ii. Provide proof of regulatory audits with no sanctions

iii. Submit operational policies and procedures
iv. Obtain reference letters from member advocates, providers and community stakeholders

b. Financial soundness
   i. Submit financial statements (income statements and balance sheets) for the three most recent consecutive years
   ii. Report financial metrics (i.e. liquidity, debt ratio, short-term viability, delinquency)
   iii. Obtain third-party risk report via Dunn and Bradstreet (where available)

c. Quality performance/metrics
   i. Report performance against current CalPACE averages in areas of participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and participant satisfaction rating

d. Demographic competence
   i. Provide a general PACE demographic profile data of the ZIP code area of interest
   ii. Demonstrate staff experience and/or understanding in serving PACE participants similar to those in the potential geographic area
      1. Training in cultural competency
      2. Language capability
      3. Accommodations for low literacy
      4. Response to socioeconomic factors

4. **Primary Criteria (~~80~~ 50% weighting):** Potential impact on CalOptima PACE program/operations and other POs operating in Orange County, if any. Rev. 9/6/18
   a. For POs with strong demonstrated performance on the Threshold Criteria, the focus would be on, for example, evaluation overlap with existing PACE facilities in the County (e.g., also considering likelihood of adverse member selection, geographic separation, etc.); how the PO's application demonstrates that they are proposing to offer complementary PACE services (e.g., for unique member populations, serving remote/underserved geographic areas of the County, bringing new providers, or in some other meaningful ways, enhancing existing PACE facilities).

5. **Return to the Board with Recommendations**. After analyzing PO proposals and requests for letters of support, staff will return to the Board with recommendations.

Fiscal Impact

The recommended action is projected to be budget neutral. CalOptima's Fiscal Year 2018–19 Operating Budget, approved by the Board on June 7, 2018, included projected revenues and expenses related to the continuation of PACE expansion.

Staff anticipates that the administrative expenses included in the Board-approved operating budget are sufficient to cover the anticipated costs related to the recommended action.

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Rationale for Recommendation

Staff recommends that the Board adopt a process for considering requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima. As a public agency, CalOptima should be prepared to respond to such potential requests.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS PACE Policy Letter 17-03, issued on October 27, 2017.
2. DHCS PACE Policy Letter 18-01, issued on August 17, 2018.
3. Presentation: PACE Response to Regulatory Guidance

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

8/29/2018 — **Date**

Back to Agenda

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: October 27, 2017

Policy Letter 17-03
Replacing PACE Policy Letter 16-01

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the revised Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) released the 2017 PACE Application Guidance on January 17, 2017, to address its electronic PACE application submission timelines and review process. Effective immediately, all new and expansion PACE applications are required to be submitted to CMS through the web-based Health Plan Management System (HPMS). Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of

the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter State/CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Key Dates for CMS Application Submission

The downloadable PDF of the application and additional information such as application submission deadlines can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Application_Training_Feb_2017.pdf.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

Based on the CMS application submission deadlines, LOI to DHCS would follow the below timeframes:

Letter of Intent to DHCS no later than…	**Initial Application Submission to DHCS no later than…**	**CMS Application Submission Deadlines *last business day of Quarter**
October 1, 2017	November 1, 2017	January 1, 2018
January 1, 2018	February 1, 2018	April 1, 2018
April 1, 2018	May 1, 2018	July 1, 2018
July 1, 2018	August 1, 2018	October 1, 2018

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership

- Identify all competitive factors impacting the market, such as:
  - Existing POs
  - Managed care plans (MCPs)
  - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
  - Medi-Cal Waiver Programs
  - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
  - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a

third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan,

notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

Jacey Cooper, Acting Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X		X	
Governing Body	3.3	X		X	
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X		X	
Grievance	3.7	X		X	
Appeals	3.8	X		X	
Enrollment	3.9	X		X	
Disenrollment	3.10	X		X	
Personnel Compliance	3.11	X			
Program Integrity	3.12	X			
Contracted Services	3.13	X	X		
Required Services	3.14	X			
Service Delivery	3.15	X			
Infection Control	3.16	X			
Interdisciplinary Team	3.17	X			
Participant Assessment	3.18	X			
Plan of Care	3.19	X			
Restraints	3.20	X			
Physical Environment	3.21	X			
Emergency and Disaster Preparedness	3.22	X			
Transportation Services	3.23	X	X		
Dietary Services	3.24	X			
Termination	3.25	X		X	
Maintenance of Records & Reporting	3.26	X			
Medical Records	3.27	X			
Quality Assessment Performance Improvement	3.28	X		X	
State Attestations	3.29	X		X	X
Waivers	3.30	X		X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: August 17, 2018

Policy Letter 18-01
Supersedes PACE Policy Letter 17-03

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the updated Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

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- Zip code only expansions subject to shorter CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

CMS application submission deadlines can be found under the application training guide here: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date and the initial application must be submitted at least 60 days prior to the proposed CMS submission date.

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-

Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

ORIGINAL SIGNED BY

Sarah Eberhardt-Rios, Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X	X	X	X
Governing Body	3.3	X	X	X	X
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X	X	X	X
Grievance	3.7	X	X	X	X
Appeals	3.8	X	X	X	X
Enrollment	3.9	X	X	X	X
Disenrollment	3.10	X	X	X	X
Personnel Compliance	3.11	X	X		
Program Integrity	3.12	X	X		
Contracted Services	3.13	X	X		
Required Services	3.14	X	X		
Service Delivery	3.15	X	X		
Infection Control	3.16	X	X		
Interdisciplinary Team	3.17	X	X		
Participant Assessment	3.18	X	X		
Plan of Care	3.19	X	X		
Restraints	3.20	X	X		
Physical Environment	3.21	X	X		
Emergency and Disaster	3.22	X	X		
Transportation Services	3.23	X	X		
Dietary Services	3.24	X	X		
Termination	3.25	X	X	X	X
Maintenance of Records &	3.26	X	X		
Medical Records	3.27	X	X		
Quality Assessment Performance Improvement	3.28	X	X	X	X
State Attestations	3.29	X	X	X	X
Waivers	3.30	X	X	X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

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Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

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PACE

CalOptima

A Public Agency

Better. Together.

PACE Response to Regulatory Guidance

Board of Directors Meeting

September 6, 2018

Phil Tsunoda, Executive Director, Public Policy and Public Affairs

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Current PACE Landscape

- Alternative and new methods of expansion are in line with the national PACE growth initiative, known as PACE 2.0

- CalOptima PACE has a variety of expansion strategies in place
  - Alternative Care Settings
  - Community-based physicians
  - Service area expansion to south Orange County

- DHCS Policy Letters create an opportunity for independent PACE centers to operate in County Organized Health System (COHS) counties

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DHCS Policy Letters

- October 2017 and August 2018 letters outline the policies affecting the application review process and timelines, as well as restrictions on delegation

- Of note to CalOptima, the policy letters require a letter of support from the COHS health plan as part of an independent PACE Organization (PO) application

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DHCS Policy Letters (Cont.)

"DHCS will only consider the operation of an independent PO in a COHS county if the applicant includes a letter of support from the COHS stating:

- The COHS' support for the establishment of the independent PO in the county
- The COHS' request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county"

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Regulatory Approval

- CalOptima's *only role* with regard to an independent PO applying to operate in a COHS county is *at the beginning*, in considering whether to issue a letter of support and associated 1115 Waiver amendment request
- Lengthy application process follows this sequence:
  1) Independent PO requests from COHS a letter of support, which includes the 1115 Waiver amendment request
  2) If letter of support is provided, independent PO submits to DHCS a letter stating its intent to apply to operate a PACE center
  3) DHCS considers whether to submit to CMS the waiver amendment request
  4) If DHCS submits, CMS considers whether to approve the waiver amendment request
  5) If CMS approves the waiver amendment, DHCS evaluates the independent PO application
  6) If DHCS approves the application, CMS evaluates the independent PO application

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Process for Consideration of Letter of Support

- CalOptima proposes a fair and objective evaluation process that includes, but is not limited to, certain elements:

- Application timeline window
  - Independent POs may submit letter of support requests during the period of November 1, 2018, to January 31, 2019

- Geographic ZIP code designation
  - Independent POs must include the specific ZIP codes the PO is interested in serving within Orange County

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Process for Consideration of Letter of Support (Cont.)

- Threshold Criteria (20%)
  1. Operating experience
  2. Financial soundness
  3. Quality performance
  4. Demographic competence

- Primary Criteria (80%)
  5. Potential impact to CalOptima PACE program

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Criterion 1: Operating Experience

- Show a minimum of five years of experience operating a PACE center
- Provide evidence of regulatory audits with no sanctions
- Submit operational policies and procedures
- Obtain reference letters from member advocates, providers and community stakeholders

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Criterion 2: Financial Soundness

- Submit financial statements for the three most recent consecutive years
  - Income statements
  - Balance sheets
- Report important financial metrics
  - Liquidity
  - Debt ratio
  - Short-term viability
  - Delinquency
- Obtain third-party risk report via Dunn and Bradstreet where available

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Criterion 3: Quality Performance

- Report performance against current CalPACE averages
  - Participants residing in nursing homes
  - Hospital admissions per 1,000
  - Hospital days per 1,000
  - Hospital readmission rate
  - Emergency room visits per 1,000
  - Participant satisfaction rating

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Criterion 4: Demographic Competence

- Provide a general PACE demographic profile of the ZIP code area of interest

- Demonstrate staff experience/understanding in serving PACE participants similar to the potential participants in the geographic area of interest
  - Training in cultural competency
  - Language diversity and capability
  - Accommodations for low literacy
  - Response to socioeconomic factors

Criterion 5: Impact to CalOptima PACE

- State potential impacts of an independent PO on CalOptima's existing PACE program

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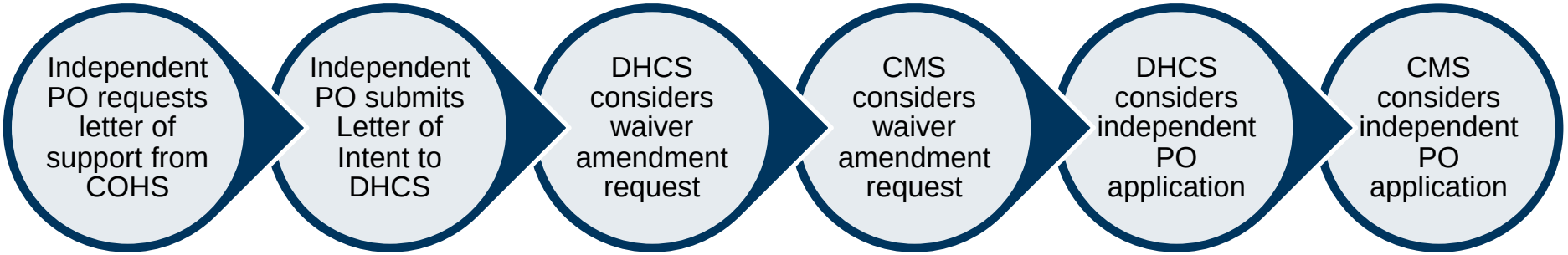
PACE Application Process



If the application is approved, the independent PO would contract directly with DHCS and CMS

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PACE CalOptima A Public Agency Better. Together.

Recommended Actions

- Approve CalOptima PACE expansion strategy in response to state regulatory guidance.

- Authorize the CEO to implement a process to consider letters of support for qualified organizations seeing to establish an independent PACE facility in Orange County.
  - Staff to bring back for Board approval any recommendation regarding a letter of support for an independent PO letter.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Contract with Vendor for Consulting Services Related to CalOptima's Strategic Plan 2020-2022

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

1. Approve recommended consultant Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities;
2. Authorize the Chief Executive Officer (CEO) with the assistance of Legal Counsel to enter into an agreement with the recommended consulting organization; and
3. In the event CalOptima and Chapman Consulting are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Pacific Health Consulting Group for consulting services for the CalOptima Strategic Plan 2020-2022 activities.

Background

At the February 7, 2019, CalOptima Board of Directors meeting, staff presented an Informational Item on the Year 2 Progress Report of CalOptima's 2017-2019 Strategic Plan and a Planning Process for CalOptima's 2020-2022 Strategic Plan.

The 2017-2019 Strategic Plan will expire at the end of the 2019 calendar year. Following CalOptima's competitive bidding process in accordance with CalOptima Policy GA.5002: Purchasing, staff initiated a Request for Proposal (RFP) on January 9, 2019, for consulting services for the CalOptima 2020-2022 Strategic Plan activities.

Discussion

On February 20, 2019, CalOptima received seven (7) RFP responses for strategic planning consulting services from the following organizations:

- Chapman Consulting
- Curt Pringle & Associates
- Medecision, Inc.
- Milliman, Inc.
- Optum
- Pacific Health Consulting Group
- Spring Street Exchange

The submitted proposals were reviewed by an evaluation team consisting of representatives from Strategic Development, Government Affairs, Program Implementation, Health Network Management, Vendor Management and Customer Service. Additionally, the top two vendors (Chapman Consulting and Pacific Health Consulting Group) were invited for an interview.

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The recommended consultant will help facilitate several activities, including, but not limited to: review of CalOptima's previous Strategic Plan and specified data; interviews and planning sessions with members of CalOptima's Board of Directors executive level staff, and CalOptima Advisory Committees; engagement with key stakeholders; develop a draft of the Strategic Plan; and present a final plan to the Board of Directors.

Vendor	Final Weighted Score
Chapman Consulting	19.15
Pacific Health Consulting Group	11.25

Based on the final weighted scores, staff recommends contracting with Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities in an amount not to exceed $81,950.

Chapman Consulting, LLC was established in January of 2018 as an independent consulting firm. Prior to establishing an independent consulting firm, the principal of Chapman Consulting, Ms. Athena Chapman, previously worked with the California Association of Health Plans (CAHP) as the Vice President of State programs. Ms. Chapman also worked with the Center for Medicare & Medicaid Services (CMS) as well as at the Department of Health Care Services (DHCS). Chapman Consulting has expertise in health care policy, delivery, administration, and financing and specific expertise in the Medi-Cal program. The proposed consultant has worked with health plans that provide coverage in the commercial market, the Covered California healthcare exchange and Medicaid and has a strong track record of building relationships between the government, providers, purchasers, vendors, and other stakeholders. Chapman Consulting can take complex health policy issues and provide succinct and relevant policy analysis and program recommendations. The proposed consultant also has extensive experience with meeting facilitation and has successfully developed several strategic and project-based plans for health care organizations. Chapman Consulting provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis, to a variety of health care related organizations. Chapman Consulting recently worked with the Coalition of Orange County Community Health Centers.

In the event CalOptima cannot reach agreeable contract terms with Chapman Consulting within thirty (30) days of CalOptima providing a response to any proposed contract change, staff recommends the Board of Directors authorize a similar process with Pacific Health Consulting Group and attempt to reach agreement on contract terms within a thirty (30) day timeframe.

Upon completion of the contracted work, the consulting organization will provide CalOptima and the Board of Directors with an updated organizational Strategic Plan for 2020-2022.

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Fiscal Impact

The recommended action to authorize an agreement for consulting services for the CalOptima Strategic Plan 2020-2022 activities has no additional fiscal impact for the current fiscal year. The CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018 included $50,000 for this purpose. Management will include the remaining $31,950 in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

Development of the proposed Strategic Plan is consistent with direction provided by the Board of Directors at the February 7, 2019, meeting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Strategic Plan Scope of Work
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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Scope of Work
CalOptima
Strategic Planning Development

Anticipated Consultant Outcomes
To develop and approve the 2020-2022 Strategic Plan in collaboration with CalOptima Board of Directors, Executive Leadership and Community stakeholders.

The CONTRACTOR shall provide the following tasks and activities. Please note the dates provided are estimated dates and are for planning purposes only.

1. **Project Initiation** — April 2019
   - Define key deliverables
   - Identify key contacts
   - Establish detailed work plan and milestones

2. **Discovery** — May-June 2019
   - Review previous strategic plans
   - Interview CalOptima Board of Directors
   - Interview CalOptima Executive team and other key staff
   - Identify strategic priority areas
   - Identify over-arching themes and outcomes
   - Identify key stakeholders

3. **Planning and Design** — June-July 2019
   - Consolidate feedback received during interview sessions
   - Facilitate planning session with CalOptima Board of Directors
   - Establish stakeholder engagement plan

4. **Stakeholder Engagement** — July-August 2019
   - Engage CalOptima advisory committees
     - Member Advisory Committee
     - Provider Advisory Committee
     - OneCare Connect Member Advisory Committee
     - Whole Child Model Family Advisory Committee
   - Engage and interview other key stakeholders/key informants
   - Consolidate feedback

5. **Strategic Plan Development** — August -September 2019
   - Analyze feedback
   - Develop draft strategic plan

6. **Finalize Strategic Plan** — September-December 2019
   - Finalize draft
   - Review draft with Board of Directors
   - Incorporate feedback
   - Review Final with Board of Directors

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman Consulting	1133 Los Robles St.	Davis	CA	95618
Pacific Health Consulting Group	72 Oak Knoll Ave.	San Anselmo	CA	94960
Curt Pringle & Associates	1801 E. Katella Ave., Suite 1002	Anaheim	CA	92805
Medecision, Inc.	550 E. Swedesford Road, Suite 220	Wayne	PA	19087
Milliman, Inc.	1301 Fifth Ave., Suite 3800	Seattle	WA	98101
Optum	11000 Optum Circle	Eden Prairie	MN	55344
Spring Street Exchange	26 Grant St.	Lexington	MA	02420

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
26. Consider Appointment to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

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

Recommended Action
The Whole-Child Model Family Advisory Committee (WCM FAC) recommends the appointment of Cathleen Collins as a Family Member Representative for the remainder of a two-year term ending June 30, 2020.

Background
Senate Bill 586 (SB 586) was signed into law on September 25, 2016 and authorized the establishment of the Whole-Child Model incorporating California Children's Services (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, the CalOptima Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017 to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program.

The WCM FAC is comprised of eleven voting members, seven to nine of whom will be designated as family representatives, and two to four will be designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's eleven seats are designated as community seats, WCM FAC candidates representing the community 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. The initial appointments of WCM FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five seats will be appointed for a one-year term and six seats will be appointed for a two-year term.

For the first nomination process to fill the seats, CalOptima's Member Advisory Committee (MAC) was asked to participate in the WCM Family Advisory Committee nominating ad hoc committee. The candidates were considered by the MAC before being submitted to the Board for consideration. 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. For this nomination process, WCM FAC Ad Hoc members evaluated the candidate on February 11, 2019 and requested a recommendation at the February 26, 2019 WCM FAC meeting.

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Discussion
CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included notification methods, such as sending notification flyers to Orange County agencies and community-based organizations (CBOs) representing California Children Services (CCS) children, posting recruitment announcements on the CalOptima.org as well as networking with the current WCM FAC committee members for qualified candidates. Upon receipt of an application from an interested candidate the application is submitted to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on February 11, 2019, Subcommittee members received and evaluated the single application received for the Family Representative seat. The subcommittee, including WCM FAC Chair Maura Byron, Vice Chair Pamela Patterson and Grace Leroy Loge, recommended the candidate for the open seat and forwarded the proposed candidate to the WCM FAC for consideration at the February 26, 2019 meeting.

We have two additional Family Representative seats under active recruitment; interested candidates will be directed to the CalOptima website for completing the application process.

Candidate for this open position is as follows:

Family Member Representative
Cathleen Collins*

Ms. Collins is an active consumer advocate whose child is currently a CalOptima and CCS member. Ms. Collins has held leadership posts with Children's Hospital of Orange County (CHOC), Mission Hospital, United Cerebral Palsy of Orange County, as well as serving as a board member for the Extraordinary Lives Foundation. Ms. Collins has extensive knowledge of CCS services and is passionate about the special needs population, having devoted her life to their benefit and welfare. Currently, Ms. Collins is an independent consultant and strategic partner for local non-profit organizations in healthcare and Catholic institutions. Her clients include Extraordinary Lives Foundation, Serving Kids Hope, and the Orthopedic Institute for Children in Los Angeles, etc.

Fiscal Impact
Each family representative appointed to the WCM-FAC is authorized to receive a stipend of up to $50 per committee meeting attended. Funding for stipends provided to WCM-FAC family representatives is a budgeted item under the CalOptima Fiscal Year 2018-19 Operating Budget. There is no additional fiscal impact related to the recommended action.

Rationale for Recommendation
As stated in policy, the WCM FAC established a Nominations Ad Hoc to review the potential candidate for a vacancy on the Committee. The WCM FAC met to discuss the recommended candidate and concurred with the Subcommittee's recommendations. The WCM FAC forwards the recommended candidate to the Board of Directors for consideration.

*Indicates WCM FAC recommendation

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Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

*Indicates WCM FAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize expenditure for CalOptima's participation in the following community event:
    a. Up to $10,000 and staff participation at Age Well Senior Services' 12th Annual South County Senior Summit in Aliso Viejo on May 17, 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 event will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

12th Annual South County Senior Summit

Staff recommends the authorization of expenditures for participation in Age Well Senior Services' 12th Annual South County Senior Summit. This is an educational event featuring a panel of experts who will provide information on new approaches for risk reduction, care taking, and treatment of dementia. The theme for the summit is "Back to the Future of Aging and Dementia" where over twelve hundred (1,200) seniors are anticipated to attend. This event provides an opportunity to share

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information about CalOptima's programs and services with our members, who are seniors residing in South County. A $10,000 financial commitment for the South County Senior Summit includes: A five (5) minute speaking opportunity at the event, one (1) premier exhibit booth location, CalOptima logo on event advertising, half-page advertisement in event program, large event banner at event, CalOptima information in each attendee's event bag and verbal recognition at the event. CalOptima staff time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share programs and services designed to support our seniors, including OneCare, OneCare Connect, PACE and long-term services and supports. CalOptima staff will share information regarding these programs in accordance with the CMS marketing and communication guidelines.

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 activity and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $10,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2018-19 Operating Budget approved by the CalOptima Board of Directors on June 7, 2018.

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

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Attachments
Event Information Package

/s/ Michael Schrader *3/27/2019*
Authorized Signature **Date**

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Case Management
In-Home Care Support
Meals on Wheels

Tel: (949) 855-8033

Age Well®
Senior Services
A NONPROFIT SERVING ORANGE COUNTY'S OLDER ADULTS

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Fax: (949) 855-8025

February 4, 2019

As the lead sponsoring nonprofit agency, Age Well Senior Services, Inc. cordially invites you to support the 2019 South County Senior Summit!

This popular 12th annual event is being presented by Orange County Supervisor Lisa Bartlett, Chairwoman of the Board of Supervisors, in partnership with the Orange County Office on Aging, Soka University of America, and Age Well Senior Services, Inc. The 2019 Senior Summit will take place Friday, May 17 in the city of Aliso Viejo at the beautiful Soka University Recreation Complex.

The program will feature a panel of experts providing timely presentations related to our theme, ***"Back to the Future of Aging and Dementia."*** As such, the 2019 South County Senior Summit will offer valuable information on new, cutting-edge approaches for Risk Reduction, Care Taking, and Treatment of Dementia as well as other debilitating aging-related conditions.

Over 1,200 older adults are expected to attend the 2019 Senior Summit, which will begin at 8 AM with an interactive vendor fair and complimentary breakfast, followed by an informative and engaging program commencing at 9 AM with a welcome address by OC Supervisor Lisa Bartlett. At the conclusion of the program, a complimentary lunch will be provided for all attendees, and Soka University will also conduct special private tours of its stunning Performing Arts Center.

By becoming a sponsor of the 12th annual South County Senior Summit, your organization will be officially recognized in the event program attendees will receive upon arrival. Your ***tax-deductible*** donation will also provide your organization with the options and incentives listed in the attached Sponsor Pledge Form

As an organizational sponsor, not only will you be supporting the South County Senior Summit, but you will also benefit immensely from this excellent opportunity to directly connect with hundreds of older adults in one convenient location while clearly demonstrating your care and concern for them.

To become a sponsor of the 12th annual South County Senior Summit, please complete and return the attached Pledge Form by Friday, May 3. Thank you so much for your consideration. We look forward to seeing you at the 2019 South County Senior Summit!

Sincerely,

Steve Moyer
Chief Executive Officer
Age Well Senior Services, Inc.

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SPONSOR PLEDGE FORM

Organization: _____

Contact Person: _____ **Phone:** ( ) _____

Address: _____

Fax: ( ) _____ **Email:** _____

Sponsorship Levels:

☐ **Title Sponsor $15,000** – As a Title Sponsor, your Organization will be offered a 10-Minute Speaking Role at the Event. Your Logo will be prominently featured on Event Advertising as "Title Sponsor". You will also receive Verbal Recognition and be presented a Special Award from Supervisor Bartlett at the Summit; Full-Page advertising space in the Event Program; Premier Booth Location; Two Large Banners prominently displayed at the Summit; Product/Service Information in the Event Bag; Recognition about Title Sponsorship in the Supervisor's Newsletter; and a Certificate of Recognition from Supervisor Bartlett.

☐ **Diamond Sponsor $10,000** – As a Diamond Sponsor, your Organization will be offered a 5-Minute Speaking Role at the Event. Your Logo will be featured on Event Advertising as a "Diamond Sponsor". You will receive Verbal Recognition and be presented a Special Award from Supervisor Bartlett at the Summit; Half-Page advertising in Event Program; One Large Banner displayed at Summit; Premium Booth Location; Product/Service Information in the Event Bag, Recognition about Diamond Sponsorship in the Supervisor's Newsletter; and a Certificate of Recognition from Supervisor Bartlett.

☐ **Platinum Sponsor $5,000** – As a Platinum Sponsor, your Organization will receive Verbal Recognition and a Special Award from Supervisor Bartlett at the Summit; Quarter-Page advertising in the Event Program; Preferred Booth Location; Product/Service Information in the Event Bag; Recognition about your Platinum Sponsorship in the Supervisor's Newsletter; and a Certificate of Recognition from Supervisor Bartlett.

☐ **Gold Sponsor $2,500** – As a Gold Sponsor, you will receive Verbal Recognition and a Special Award from Supervisor Bartlett at the Summit; Individual Booth Location; Special Recognition in the Event Program; and a Certificate of Recognition from Supervisor Bartlett.

☐ **Silver Sponsor $1,000** – Silver Sponsors will receive Verbal Recognition from Supervisor Bartlett at the Summit; Special Recognition in the Event Program; Individual Booth Space; and a Certificate of Recognition from Supervisor Bartlett.

☐ **Bronze Sponsor $500** – Recognition in the Event Program; Booth Space; Certificate of Recognition from Supervisor Bartlett.

☐ **Non-Profit Sponsor $250** – Recognition in the Event Program; Booth Space; Certificate of Recognition from Supervisor Bartlett.

To ensure your Sponsorship Level is properly recognized on Event Advertising, return this form by May 3 with your **tax-deductible** check (Tax ID # 93-1163563) made payable to **Age Well Senior Services** and note **"Senior Summit"** in the memo line. You may also email your completed Sponsor Pledge Form and high resolution logo file to Beth Apodaca at **bapodaca@myagewell.org**. Please mail your sponsor check to:

Age Well Senior Services, Inc.
c/o Beth Apodaca
24461 Ridge Route Drive, Suite 220
Laguna Hills, CA 92653

Phone: (949) 855-8033
Fax: (949) 855-8025

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Board of Directors Meeting
April 4, 2019

Provider Advisory Committee (PAC) Update

March 14, 2019 PAC Meeting

PAC Nominations Ad Hoc committee reviewed, and recommended Harold "Pat" Patton be moved forward to the Board as the Hospital Representative. PAC requested an Ad Hoc be formed to review the PAC recruitment, application and nominations process prior to the 2020 annual recruitment.

Chief Operating Officer Ladan Khamseh, provided an update on open positions for the PAC and the MAC and encourage the committee members to assist with recruitment for both committees. Ms. Khamseh also provided updates on CalOptima's implementation of Health Homes Program (HHP) and Qualified Medicare Beneficiary (QMB) program annual outreach.

Nancy Huang, Interim Chief Financial Officer provided an update on the 2017/18 rates for Proposition 56 - Supplemental Payments and noted that rates would be increasing for 2018/19. Ms. Huang advised the committee that the Centers for Medicare and Medicaid Services (CMS) would be auditing all plans on Medical Loss Ratio (MLR) for the last 30 months.

Arif Shaikh, Director, Government Affairs discussed the Department of Managed Health Care (DMHC) and the possibility of new Knox Keene licensing requirements that may impact some of CalOptima's health networks.

Kelly Rex-Kimmett, Director, Quality Analytics presented CalOptima's proposed health network quality performance rating methodology

Michael Schrader, Chief Executive Officer provided the PAC with a verbal Homeless Health update that elicited much discussion among the PAC members.

PAC also received updates from David Ramirez, M.D., Chief Medical Officer and Michelle Laughlin, Executive Director, Network Operations.

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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Board of Directors Meeting
April 4, 2019

Member Advisory Committee (MAC) Update

March 14, 2019 MAC Meeting

MAC Nominations Ad Hoc committee reviewed and recommended applicants for the Children and Long-Term Services and Supports Representatives. MAC recommended Pamela Pimentel for the Children's, seat which will be forwarded to the CalOptima Board for their approval at a future meeting. It was recommended that recruitment will continue for the Long-Term Services and Supports Representative. MAC requested an Ad Hoc be formed to review the MAC recruitment, applications, and nominations process prior to the 2020 annual recruitment.

Ladan Khamseh, Chief Operating Officer provided an update on the Qualified Medicare Beneficiary outreach Program (QMB). Ms. Khamseh also provided an update on open positions for the PAC and MAC and encouraged the committee members to assist with recruitment for both committees.

MAC Members, at the request of Member Sweeney received an excellent presentation from Healthy Smile's. Harvey Lee, DDS, Chief Dental Officer, and Ligia Hallstrom, VP of Field Operations from Healthy Smiles for Kids of Orange County spoke about the need for early dental intervention for children.

Michael Schrader, Chief Executive Officer provided the MAC with a verbal report on the status of Homeless Health. There was much discussion among members and staff with regard to the topic.

MAC also received an Opioid Epidemic update from David Ramirez, M.D., Chief Medical Officer, and a Behavioral Health Update from Donald Sharps, M.D., Behavioral Health Medical Director. Arif Shaikh, Director, Government Affairs presented a State Budget update and presented information on Dental Initiatives.

MAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the MAC's current activities.

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Board of Directors Meeting
April 4, 2019

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

At the February 28, 2019 OneCare Connect Member Advisory Committee (OCC MAC) meeting, members were notified that Family Member Representative Kristen Trom had passed away in December 2018. Members were also notified that Christine Chow the Member Advocate Representative and Richard Santana, the In-Home Support and Services – Union Provider Representative had resigned their positions on the OCC MAC. Both accepted other positions at other companies.

Michael Schrader, Chief Executive Officer provided an update on Homeless Health that was approved at the special Board meeting on February 22, 2019. Mr. Schrader also spoke about the eight-person care coordination team that will work on this program.

OCC MAC members heard an informational presentation by Dr. Michelle Eslami of Rockport Health Care on Understanding Skilled Nursing in Today's Changing Health Care Environment that generated questions and discussion among the members.

OCC MAC members also received presentations and updates on the opioid crisis, dental initiatives and an update on the FY 2019/20 State Budget.

OCC MAC also formed two ad hoc committees, one for the special recruitment that was held in February for the Member Advocate position. Vice Chair Patty Mouton, Member Ted Chigaros and Member Sandra Finestone agreed to review applicants for the special recruitment that ended on February 15, 2019. The second ad hoc formed reviewed applications received from the recruitment for expiring seats that are currently available, and consists of Vice Chair Patty Mouton, Member Ted Chigaros and Member Keiko Gamez.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the Committees activities.

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Introduction to the FY 2019-20 CalOptima Budget: Part 1

Board of Directors Meeting
April 4, 2019

Nancy Huang
Interim Chief Financial Officer

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Overview

- Lines of Business
- Enrollment and Revenue
- Medical and Administrative Expenses
- Overview
  - Medical Expenses
    - Provider Risk Arrangements
  - Administrative Expenses
  - Capital Budget
- FY 2019-20 Program Updates
- Budget Timeline
- Board Approval Timeline

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Lines of Business

	Start Date	Program Type	Contractor/ Regulator
Medi-Cal CalOptima Better. Together.	October 1995	California's Medicaid program	California Department of Health Care Services (DHCS)
OneCare (HMO SNP) CalOptima Better. Together.	October 2005	Medicare Advantage Special Needs Plan (SNP)	Centers for Medicare & Medicaid Services (CMS)
PACE CalOptima Better. Together.	October 2013	Medicare and Medicaid Program	Three-way contract: CMS, DHCS and CalOptima
OneCare Connect CalOptima Better. Together.	July 2015	Medicare and Medicaid Duals Demonstration	Three-way contract: CMS, DHCS and CalOptima

- Medi-Cal program includes: (1) Classic and (2) Medi-Cal Expansion

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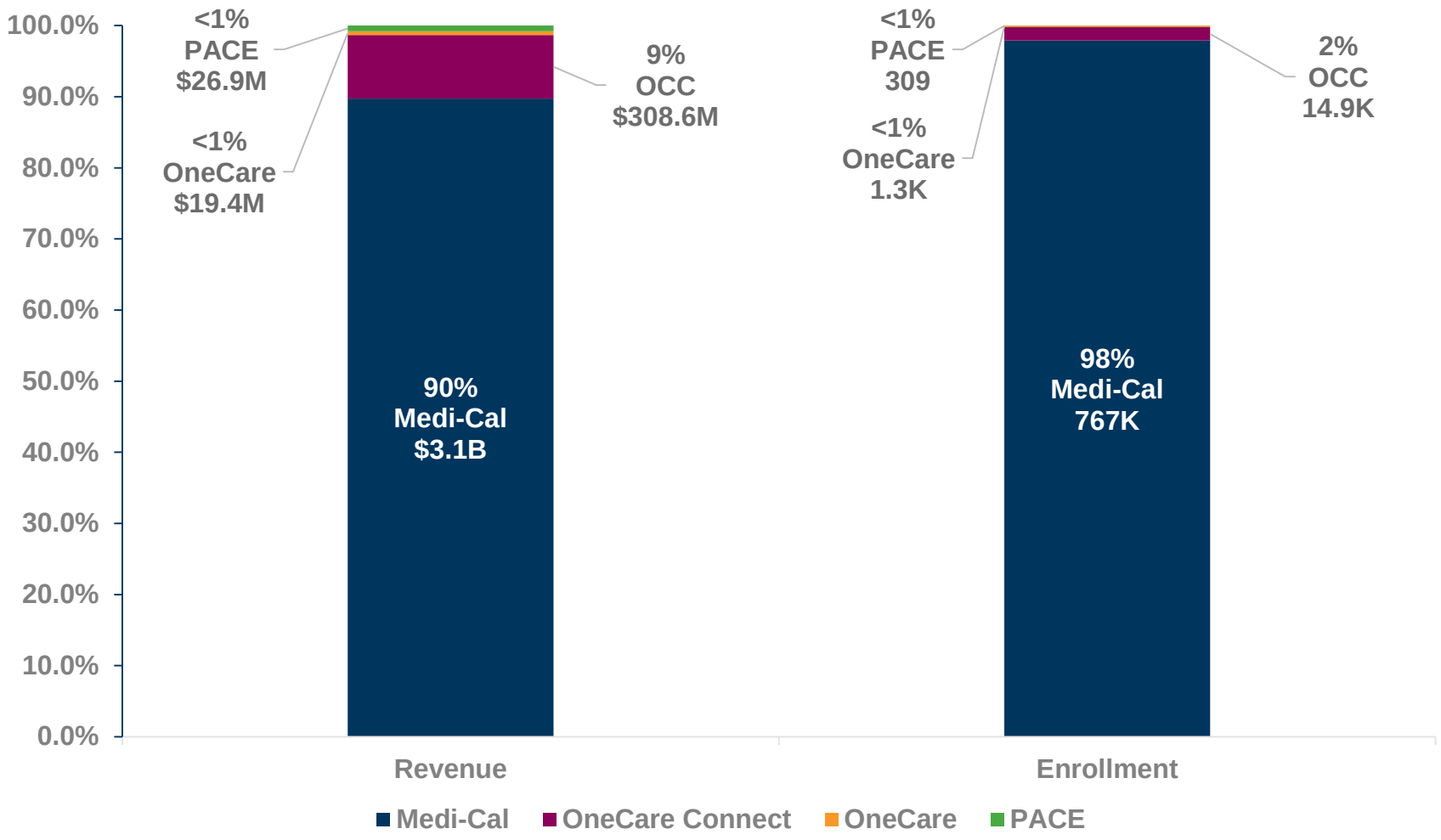
Enrollment and Revenue



Source: FY 2018-19 Operating Budget

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Enrollment

- Medi-Cal enrollment defined by eligibility for aid
  - Adult, Children, Medi-Cal Expansion, Seniors and Persons with Disabilities (SPD), Long Term Care, Breast and Cervical Cancer Treatment Program (BCCTP), Dual eligibles
  - Additional program specific enrollment
    - Whole Child Model, Health Homes Program
- OneCare Connect and OneCare enrollment defined by medical condition
  - Medicare: Aged, End-stage Renal Disease (ESRD), Hospice
  - Medi-Cal: Institutional, Home & Community Based Services (HCBS), Community Well
- PACE enrollment defined by program eligibility
  - Dual eligibles (Medicare and Medi-Cal) and Medi-Cal only

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Medi-Cal Revenue

- Enrollment drives revenue
  - Different revenue rates for each aid category
- State provides funding for new programs and benefits
  - Examples: Medi-Cal Expansion, California Children's Services (CCS), Coordinated Care Initiative (CCI), Proposition 56
  - Uncertainties/risks associated with new revenue
    - Correct pricing and adequate funding to deliver services
    - Timeliness of funding is unpredictable; will impact cash flow and reserves
- Timing of rate releases
  - Medi-Cal contract rates begin July 1
    - Draft rates typically provided in May
  - CCI rates based on calendar year
  - Rates do not become final until they are certified by CMS

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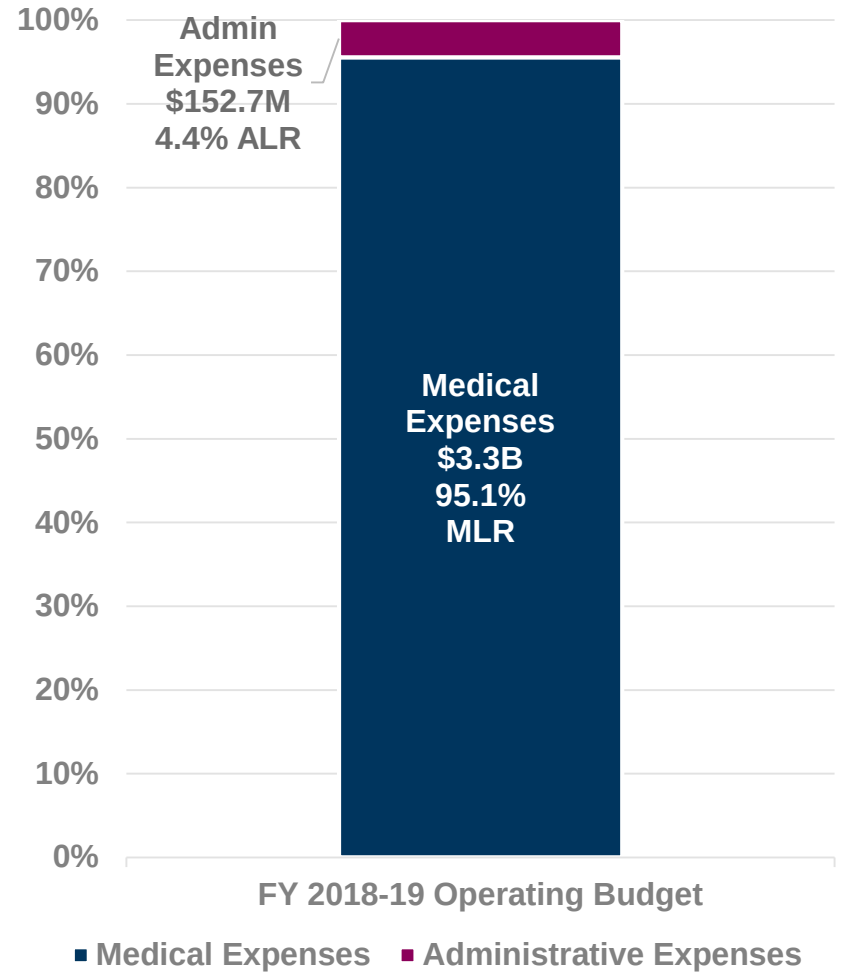
Medicare Revenue

- Medicare provides funding for two components
  - Part A/B: funding for hospital and physician services
  - Part D: funding for prescription drugs
- Revenue is determined by two primary factors
  - Base rate which is determined via bid or set to FFS benchmark
  - Risk Adjustment Factor (RAF) applied to the base rate
- Risk Adjustment Factor
  - Based on member's medical condition
  - Adjusts funding to match the expected expense of the condition
  - Heavily dependent on Plan's ability to collect and submit data
- Applies to OneCare Connect, OneCare and PACE

Medical and Administrative Expenses



Source: FY 2018-19 Operating Budget (6/7/18 COBAR)

- Medical Expenses
  - Provider capitation payments
  - Claims payments to hospitals & providers
  - Prescription drugs
  - Care management & care coordination activities
- Administrative Expenses
  - Salaries & benefits
  - Purchased services
  - Professional fees
  - Printing & postage

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Medical and Administrative Expenses (cont.)

- Medical Expenses make up 95.1% of the Operating Budget
  - Driven primarily by program, utilization, unit cost, and service mix
  - Provider payments are continually evaluated for reasonability and sufficiency
  - Goal is to maximize quality and access to care for members

- Administrative Expenses make up 4.4% of the Operating Budget
  - Majority of expenses are related to personnel
    - Personnel depends on membership, utilization level and regulatory requirements
  - More details on non-salary expenses will be provided as part of the budget package

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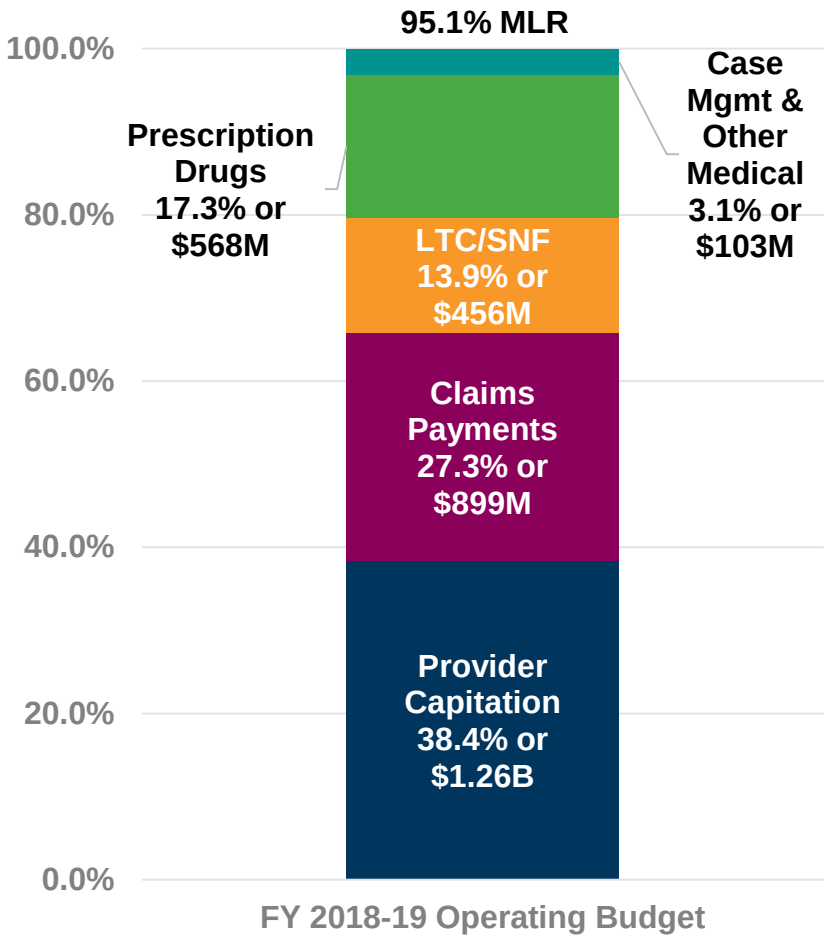
Overview of Medical Expenses

- 5 categories
  - Provider Capitation
  - Claims Payments
  - LTC/Skilled Nursing Facilities
  - Prescription Drugs
  - Case Management & Other Medical



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Overview of Provider Risk Arrangements

- Capitation
  - Provider paid a per member per month payment for each enrolled member
  - Receives payment regardless of whether or not a member seeks care
  - At-risk arrangement
- Fee-for-Service
  - Provider paid a fee for each particular service rendered
  - Receives payment for each visit
  - No risk arrangement
- Shared Risk
  - Capitation and Fee-for Service arrangement
  - Risk pool shared between CalOptima and health network

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CalOptima Provider Risk Arrangements

Model	Professional	Hospital	Pharmacy	Other Medical	Membership Distribution*
Kaiser	Capitation	Capitation	Capitation	Capitation	6%
HMO	Capitation	Capitation	Fee-For-Service	Fee-For-Service	17%
PHC	Capitation	Capitation	Fee-For-Service	Fee-For-Service	28%
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service	26%
CCN	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service	24%

*Membership Distribution based on Feb 2019 actuals

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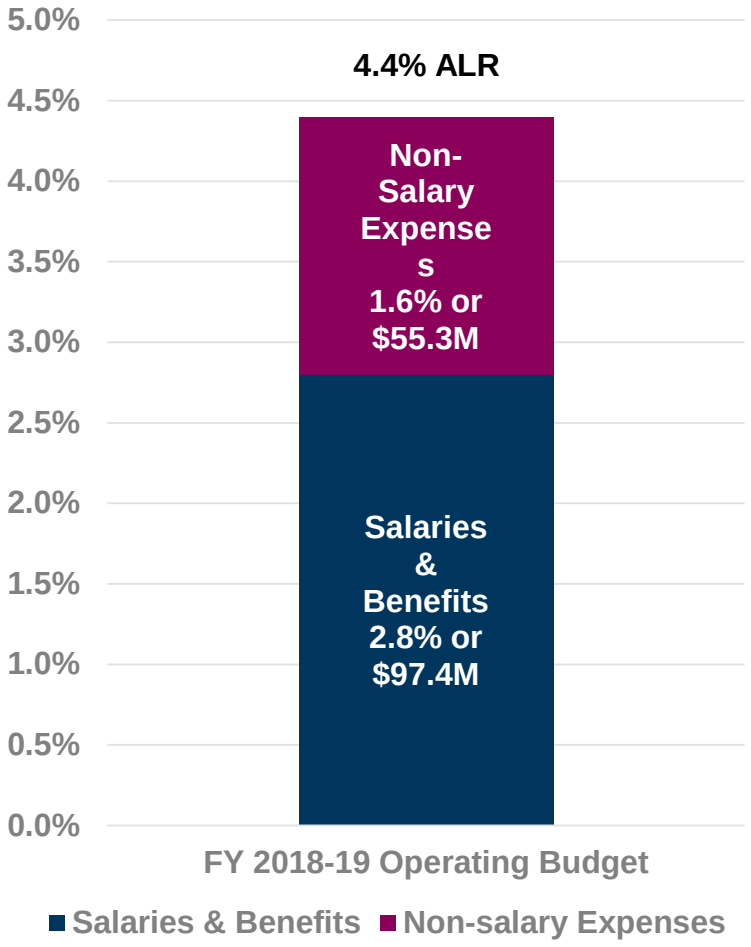
Overview of Administrative Expenses

- 2 categories
  - Salaries & benefits
  - Non-salary expenses
- Process
  - Purchasing Department reviews all contract obligations
  - Departments identify resource requirements based on service levels, enrollment, regulatory requirements and program needs
  - Sr. Management reviews and approves their departments' budgets



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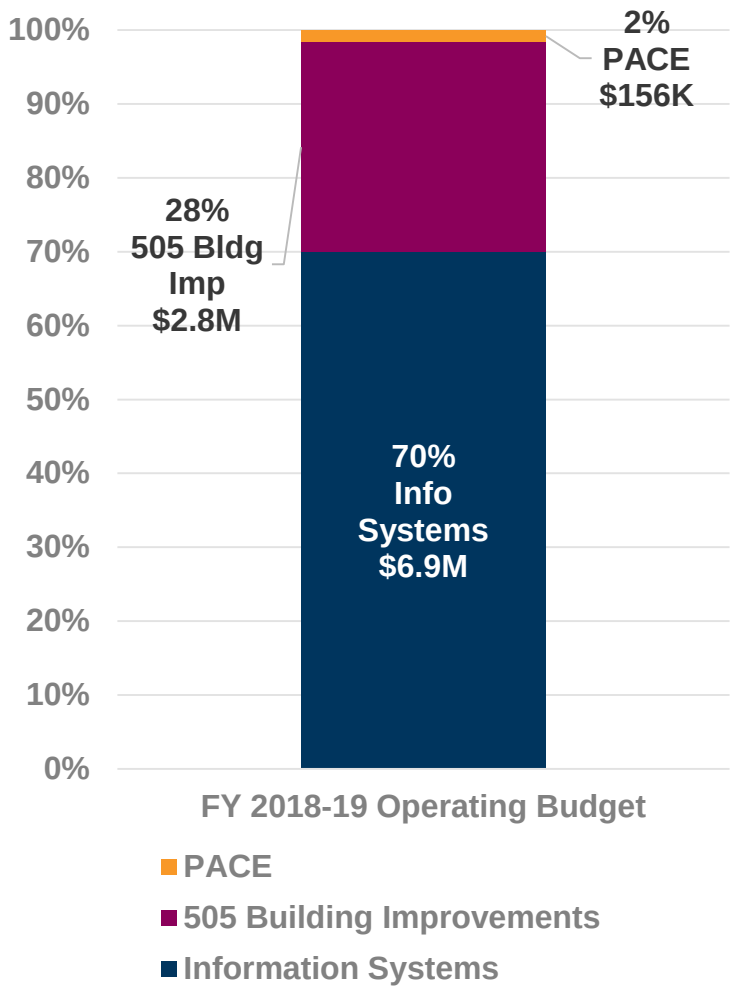
Overview of Capital Budget



- 3 Categories
  - Information Systems: Information technology infrastructure needs
  - 505 Building Improvements
  - PACE center
- Process
  - Departments submit requests for capital projects based on strategic and operational needs
  - Information Services Department reviews technology requests

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FY 2019-20 Program Updates

- Benefit Changes
- Rate Adjustment
  - Projected rate decrease to Medi-Cal Expansion
  - New Whole Child Model Capitation Rate
- Program Updates
  - Jul 2019: Whole-Child Model (CCS Redesign)
  - Tentative Jan 2020: Health Homes Program
- Operational Updates
  - OneCare Connect and OneCare Mental Health Benefit

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Budget Timeline

Budget Preparation

- Late Feb – Early Mar: Departments prepare budgets
- Mid-Mar – End Mar: Finance meets with Departments on budget proposals
- Early Apr: CFO reviews proposed budget
- 4/4: Board Information Item on Budget: Part 1

Budget Review

- Early Apr – Mid-Apr: Executives review proposed budget; Hold additional department meetings, if needed
- 4/23: Finalize budget and sign-off from Executives

Budget Approval

- End Apr – Mid-May: Prepare May FAC and June BOD materials
- 5/2: Board Information Item on Budget: Part 2
- 5/16: FAC meeting
- 6/6: Board meeting

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Board Approval Timeline

Date	Meeting
April 4, 2019	Present information item to Board of Directors: Introduction to the FY 2019-20 Budget: Part 1
May 2, 2019	Present information item to Board of Directors: Introduction to the FY 2019-20 Budget: Part 2
May 16, 2019	Present FY 2019-20 budgets to Finance and Audit Committee
June 6, 2019	Present FY 2019-20 budgets to Board of Directors
July 1, 2019	Beginning of Fiscal Year 2019-20

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Financial Summary

February 2019

Board of Directors Meeting

April 4, 2019

Nancy Huang

Interim Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

- February 2019 MTD:
  - Overall enrollment was 761,202 member months
    - Actual lower than budget 22,259 or 2.8%
      - Medi-Cal: unfavorable variance of 21,752 members
        - Whole Child Model (WCM) unfavorable variance of 12,502 members
          - Actual members reside in their original aid codes until program starts
        - Medi-Cal Expansion (MCE) unfavorable variance of 6,562 members
        - Temporary Assistance for Needy Families (TANF) unfavorable variance of 4,586 members
        - Long-Term Care (LTC) unfavorable variance of 146 members
        - Seniors and Persons with Disabilities (SPD) favorable variance of 2,043 members
      - OneCare Connect: unfavorable variance of 644 members
    - 2,704 decrease from January
      - Medi-Cal: decrease of 2,649
      - OneCare Connect: decrease of 78
      - OneCare: increase of 19
      - PACE: increase of 4

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FY 2018-19: Consolidated Enrollment (cont.)

- February 2019 YTD:
  - Overall enrollment was 6,162,179 member months
    - Actual lower than budget 112,244 members or 1.8%
      - Medi-Cal: unfavorable variance of 110,227 members or 1.8%
        - TANF unfavorable variance of 44,925 members
        - MCE unfavorable variance of 41,031 members
        - WCM unfavorable variance of 25,004 members
        - LTC unfavorable variance of 650 members
        - SPD favorable variance of 1,383 members
      - OneCare Connect: unfavorable variance of 2,749 members or 2.3%
      - OneCare: favorable variance of 744 members or 7.0%
      - PACE: unfavorable variance of 12 member or 0.5%

FY 2018-19: Consolidated Revenues

- February 2019 MTD:
  - Actual lower than budget $11.0 million or 3.7%
    - Medi-Cal: unfavorable to budget $10.1 million or 3.8%
      - Unfavorable volume variance of $7.6 million
      - Unfavorable price variance of $2.5 million
        - $22.9 million of WCM revenue due to delayed start of program, offset by
        - $13.8 million of Coordinated Care Initiative (CCI) revenue due to calendar year (CY) 2018 rate increase
        - $9.8 million prior year (PY) CCI revenue due to CY 2018 true-up rate increase
        - $1.4 million due to favorable MCE rates
    - OneCare Connect: unfavorable to budget $1.4 million or 5.3%
      - Unfavorable volume variance of $1.2 million
      - Unfavorable price variance of $0.3 million
        - Medicare Part C rates, offset by
        - $1.7 million revenue true-up due to CY 2018 rate increase

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FY 2018-19: Consolidated Revenues (cont.)

- February 2019 MTD
  - OneCare: favorable to budget $0.5 million or 28.8%
    - Favorable volume variance of $0.2 million
    - Favorable price variance of $0.3 million
  - PACE: favorable to budget $0.1 million or 4.3%
    - Unfavorable volume variance of $0.1 million
    - Favorable price variance of $0.2 million

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FY 2018-19: Consolidated Revenues (cont.)

- February 2019 YTD:
  - Actual lower than budget $52.3 million or 2.3%
    - Medi-Cal: unfavorable to budget $49.0 million or 2.4%
      - Unfavorable volume variance of $36.4 million
      - Unfavorable price variance of $12.6 million due to:
        - $45.8 million of WCM revenue
        - $10.6 million of FY19 non-LTC revenue from non-LTC aid codes
        - $5.6 million of Proposition 56 revenue
        - $2.0 million of FY19 Behavioral Health Treatment (BHT) revenue
        - Offset by favorable variance due to:
          - $18.3 million of CCI revenue
          - $11.2 million due to favorable MCE rates
          - $3.1 million of Hepatitis C revenue
          - $4.5 million of PY non-LTC revenue from non-LTC aid codes
          - $11.3 million of PY CCI revenue

FY 2018-19: Consolidated Revenues (cont.)

- February 2019 YTD:
  - OneCare Connect: unfavorable to budget $3.5 million or 1.7%
    - Unfavorable volume variance of $4.7 million
    - Favorable price variance of $1.2 million
  - OneCare: favorable to budget $34.1 thousand or 0.3%
    - Favorable volume variance of $900.9 thousand
    - Unfavorable price variance of $866.9 thousand due to:
  - PACE: favorable to budget $137.6 thousand or 0.8%
    - Unfavorable volume variance of $87.1 thousand
    - Favorable price variance of $224.7 thousand

FY 2018-19: Consolidated Medical Expenses

- February 2019 MTD:
  - ➢ Actual lower than budget $19.2 million or 7.0%
    - ▪ Medi-Cal: favorable variance of $17.5 million
      - Favorable volume variance of $7.0 million
      - Favorable price variance of $10.5 million
        - ➢ Provider Capitation expenses favorable variance of $6.3 million due to delay of WCM program, offset by Proposition 56 and Child Health and Disability Prevention Program (CHDP) expenses that were budgeted in Professional Claims
        - ➢ Prescription Drug expenses favorable variance of $5.2 million mainly due to delay of WCM program
        - ➢ Facilities expenses unfavorable variance of $4.5 million
        - ➢ Professional Claim expenses favorable variance of $3.9 million due to:
          - CHDP expenses of $2.0 million
          - BHT expenses of $1.9 million
          - Proposition 56 expenses of $2.6 million offset by: Non-Medical Transportation (NMT) expenses of $0.3 million and Incurred But Not Reported (IBNR) expenses of $1.7 million

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FY 2018-19: Consolidated Medical Expenses (cont.)

- February 2019 MTD:
  - OneCare Connect: favorable variance of $1.6 million or 6.6%
    - Favorable volume variance of $1.1 million
    - Favorable price variance of $0.5 million
  - OneCare: unfavorable variance of $194.2 thousand or 13.2%
    - Unfavorable volume variance of $164.6 thousand
    - Unfavorable price variance of $29.6 thousand
  - PACE: favorable variance of $0.3 million or 14.4%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $0.2 million

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FY 2018-19: Consolidated Medical Expenses (cont.)

- February 2019 YTD:
  - Actual lower than budget $85.2 million or 4.0%
    - Medi-Cal: favorable variance of $81.4 million
      - Favorable volume variance of $34.5 million
      - Favorable price variance of $46.9 million
        - Professional Claim expenses favorable variance of $46.4 million
        - Prescription Drug expenses favorable variance of $22.2 million
        - Facilities expenses unfavorable variance of $18.3 million
        - Provider Capitation expenses unfavorable variance of $11.6 million
        - Managed Long Term Services and Supports (MLTSS) expenses favorable variance of $7.0 million
    - OneCare Connect: favorable variance of $2.3 million
      - Favorable volume variance of $4.5 million
      - Unfavorable price variance of $2.2 million
- Medical Loss Ratio (MLR):
  - February 2019 MTD: Actual: 88.7% Budget: 91.8%
  - February 2019 YTD: Actual: 93.3% Budget: 94.9%

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FY 2018-19: Consolidated Administrative Expenses

- February 2019 MTD:
  - Actual lower than budget $1.7 million or 13.4%
    - Salaries, wages and benefits: favorable variance of $1.1 million
    - Other categories: favorable variance of $0.5 million

- February 2019 YTD:
  - Actual lower than budget $17.2 million or 17.0%
    - Salaries, wages & benefits: favorable variance of $8.9 million
    - Other categories: favorable variance of $8.3 million

- Administrative Loss Ratio (ALR):
  - February 2019 MTD: Actual: 3.7% Budget: 4.1%
  - February 2019 YTD: Actual: 3.8% Budget: 4.5%

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FY 2018-19: Change in Net Assets

- February 2019 MTD:
  - $25.4 million surplus
  - $12.8 million favorable to budget
    - Lower than budgeted revenue of $11.0 million
    - Lower than budgeted medical expenses of $19.2 million
    - Lower than budgeted administrative expenses of $1.7 million
    - Higher than budgeted investment and other income of $2.9 million

- February 2019 YTD:
  - $88.3 million surplus
  - $71.0 million favorable to budget
    - Lower than budgeted revenue of $52.3 million
    - Lower than budgeted medical expenses of $85.2 million
    - Lower than budgeted administrative expenses of $17.2 million
    - Higher than budgeted investment and other income of $21.0 million

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Enrollment Summary: February 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
64,541	65,338	(797)	(1.2%)	Aged	513,000	516,428	(3,428)	(0.7%)
590	620	(30)	(4.8%)	BCCTP	4,833	4,960	(127)	(2.6%)
46,995	44,125	2,870	6.5%	Disabled	375,926	370,988	4,938	1.3%
302,286	304,344	(2,058)	(0.7%)	TANF Child	2,469,524	2,501,682	(32,158)	(1.3%)
90,742	93,270	(2,528)	(2.7%)	TANF Adult	743,884	756,651	(12,767)	(1.7%)
3,379	3,525	(146)	(4.1%)	LTC	27,242	27,892	(650)	(2.3%)
236,680	243,242	(6,562)	(2.7%)	MCE	1,897,805	1,938,836	(41,031)	(2.1%)
-	12,502	(12,502)	(100.0%)	WCM*	-	25,004	(25,004)	(100.0%)
745,213	**766,965**	**(21,752)**	**(2.8%)**	**Medi-Cal Total**	**6,032,214**	**6,142,441**	**(110,227)**	**(1.8%)**
14,209	**14,853**	**(644)**	**(4.3%)**	**OneCare Connect**	**116,289**	**119,038**	**(2,749)**	**(2.3%)**
1,472	**1,324**	**148**	**11.2%**	**OneCare**	**11,336**	**10,592**	**744**	**7.0%**
308	**319**	**(11)**	**(3.4%)**	**PACE**	**2,340**	**2,352**	**(12)**	**(0.5%)**
761,202	**783,461**	**(22,259)**	**(2.8%)**	**CalOptima Total**	**6,162,179**	**6,274,423**	**(112,244)**	**(1.8%)**

*Note: Actual members residing in their original aid codes (TANF & SPD) until start of program

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Financial Highlights: February 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
761,202	783,461	(22,259)	-2.8%	Member Months	6,162,179	6,274,422	(112,243)	-1.8%
288,736,739	299,721,674	(10,984,935)	-3.7%	Revenues	2,207,848,429	2,260,160,814	(52,312,385)	-2.3%
255,989,750	275,182,841	19,193,091	7.0%	Medical Expenses	2,060,064,758	2,145,273,675	85,208,917	4.0%
10,727,900	12,392,581	1,664,681	13.4%	Administrative Expenses	83,782,059	100,965,840	17,183,781	17.0%
22,019,089	**12,146,252**	**9,872,837**	**81.3%**	**Operating Margin**	**64,001,611**	**13,921,299**	**50,080,312**	**359.7%**
3,335,666	416,667	2,919,000	700.6%	Non Operating Income (Loss)	24,295,412	3,333,333	20,962,078	628.9%
25,354,755	**12,562,919**	**12,791,836**	**101.8%**	**Change in Net Assets**	**88,297,023**	**17,254,633**	**71,042,391**	**411.7%**
88.7%	91.8%	3.2%		Medical Loss Ratio	93.3%	94.9%	1.6%	
3.7%	4.1%	0.4%		Administrative Loss Ratio	3.8%	4.5%	0.7%	
7.6%	4.1%	3.6%		Operating Margin Ratio	2.9%	0.6%	2.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: February 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
20.3	11.6	8.7	Medi-Cal	68.3	20.8	47.5
0.9	0.5	0.4	OCC	(6.1)	(6.5)	0.4
0.3	0.0	0.3	OneCare	(0.1)	(0.5)	0.4
0.5	0.0	0.5	PACE	1.9	0.1	1.9
22.0	**12.1**	**9.9**	**Operating**	**64.0**	**13.9**	**50.1**
3.3	0.4	2.9	Inv./Rental Inc, MCO tax	24.3	3.3	21.0
3.3	**0.4**	**2.9**	**Non-Operating**	**24.3**	**3.3**	**21.0**
25.4	**12.6**	**12.8**	**TOTAL**	**88.3**	**17.3**	**71.0**

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Consolidated Revenue & Expense: February 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,533	236,680	745,213	14,209	1,472	308	761,202
REVENUES							
Capitation Revenue	$ 150,927,793	$ 108,033,206	$ 258,960,999	$ 25,277,728	$ 2,078,009	$ 2,420,003	$ 288,736,739
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	150,927,793	108,033,206	258,960,999	25,277,728	2,078,009	2,420,003	288,736,739
MEDICAL EXPENSES							
Provider Capitation	35,630,917	49,622,849	85,253,766	10,243,078	682,194		96,179,038
Facilities	22,448,258	24,635,305	47,083,563	4,252,795	385,769	382,580	52,104,707
Ancillary	-	-	-	653,997	110,907	-	764,904
Professional Claims	17,082,441	6,369,118	23,451,559	-	-	438,212	23,889,771
Prescription Drugs	16,802,850	18,791,105	35,593,955	4,983,116	459,729	190,281	41,227,081
MLTSS	30,767,161	2,964,492	33,731,654	1,087,172	(32,425)	6,964	34,793,364
Medical Management	2,015,733	817,953	2,833,686	1,055,535	54,063	634,475	4,577,759
Quality Incentives	755,379	409,408	1,164,787	276,180		3,080	1,444,047
Reinsurance & Other	494,271	146,536	640,808	200,000	6,202	162,069	1,009,079
Total Medical Expenses	125,997,011	103,756,767	229,753,778	22,751,872	1,666,439	1,817,660	255,989,750
Medical Loss Ratio	83.5%	96.0%	88.7%	90.0%	80.2%	75.1%	88.7%
GROSS MARGIN	**24,930,782**	**4,276,439**	**29,207,221**	**2,525,856**	**411,570**	**602,342**	**32,746,989**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,781,343	745,198	28,618	101,852	6,657,011
Professional fees			143,847	3,524	14,667	77	162,114
Purchased services			1,047,637	188,620	16,850	15,633	1,268,740
Printing & Postage			249,380	33,006	5,961		288,347
Depreciation & Amortization			693,950			2,081	696,031
Other expenses			1,293,511	44,721		2,984	1,341,216
Indirect cost allocation & Occupancy			(322,325)	589,123	44,020	3,624	314,442
Total Administrative Expenses			8,887,343	1,604,191	110,116	126,250	10,727,900
Admin Loss Ratio			3.4%	6.3%	5.3%	5.2%	3.7%
INCOME (LOSS) FROM OPERATIONS			20,319,878	921,665	301,454	476,092	22,019,089
INVESTMENT INCOME							3,335,609
OTHER INCOME			58				58
CHANGE IN NET ASSETS			**$ 20,319,936**	**$ 921,665**	**$ 301,454**	**$ 476,092**	**$ 25,354,755**
BUDGETED CHANGE IN NET ASSETS			11,624,280	485,915	11,127	24,930	12,562,919
VARIANCE TO BUDGET - FAV (UNFAV)			$ 8,695,655	$ 435,750	$ 290,328	$ 451,162	$ 12,791,836

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Consolidated Revenue & Expense: February 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,134,409	1,897,805	6,032,214	116,289	11,336	2,340	6,162,179
REVENUES							
Capitation Revenue	$ 1,098,172,599	$ 880,674,076	$ 1,978,846,675	$ 198,939,324	$ 12,859,857	$ 17,202,573	$ 2,207,848,429
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,098,172,599	880,674,076	1,978,846,675	198,939,324	12,859,857	17,202,573	2,207,848,429
MEDICAL EXPENSES							
Provider Capitation	286,247,938	402,079,608	688,327,546	90,843,708	3,611,186		782,782,441
Facilities	178,369,114	186,220,944	364,590,058	28,565,640	3,455,183	3,105,220	399,716,100
Ancillary	-	-	-	5,142,566	319,719	-	5,462,286
Professional Claims	127,594,299	50,083,749	177,678,047	-	-	3,469,062	181,147,109
Prescription Drugs	137,237,174	155,557,468	292,794,643	42,911,809	3,724,138	1,352,983	340,783,573
MLTSS	254,716,818	22,518,046	277,234,865	11,083,006	411,497	33,911	288,763,279
Medical Management	16,784,336	8,061,829	24,846,164	8,898,358	494,732	5,011,385	39,250,639
Quality Incentives	6,140,080	3,272,838	9,412,918	2,378,380		23,400	11,814,698
Reinsurance & Other	4,596,740	2,619,483	7,216,223	1,780,245	49,298	1,298,869	10,344,635
Total Medical Expenses	1,011,686,498	830,413,964	1,842,100,463	191,603,711	12,065,753	14,294,831	2,060,064,758
Medical Loss Ratio	92.1%	94.3%	93.1%	96.3%	93.8%	83.1%	93.3%
GROSS MARGIN	**86,486,100**	**50,260,112**	**136,746,212**	**7,335,613**	**794,104**	**2,907,741**	**147,783,671**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			48,111,151	6,061,067	264,647	784,496	55,221,362
Professional fees			1,242,556	218,321	117,334	6,491	1,584,701
Purchased services			5,960,842	1,443,894	120,942	72,845	7,598,523
Printing & Postage			2,505,782	552,917	70,035	47,523	3,176,256
Depreciation & Amortization			3,498,033			16,642	3,514,675
Other expenses			9,599,136	348,497	377	20,510	9,968,521
Indirect cost allocation & Occupancy			(2,423,246)	4,798,423	307,617	35,228	2,718,021
Total Administrative Expenses			68,494,253	13,423,120	880,951	983,735	83,782,059
Admin Loss Ratio			3.5%	6.7%	6.9%	5.7%	3.8%
INCOME (LOSS) FROM OPERATIONS			68,251,959	(6,087,507)	(86,847)	1,924,006	64,001,611
INVESTMENT INCOME							24,294,611
OTHER INCOME			801				801
CHANGE IN NET ASSETS			**$ 68,252,760**	**$ (6,087,507)**	**$ (86,847)**	**$ 1,924,006**	**$ 88,297,023**
BUDGETED CHANGE IN NET ASSETS			20,791,412	(6,476,569)	(456,360)	62,816	17,254,633
VARIANCE TO BUDGET - FAV (UNFAV)			$ 47,461,349	$ 389,062	$ 369,513	$ 1,861,190	$ 71,042,391

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Balance Sheet:
As of February 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$254,989,251	Accounts Payable	$28,207,047
Investments	489,775,756	Medical Claims liability	751,085,844
Capitation receivable	445,247,613	Accrued Payroll Liabilities	11,946,403
Receivables - Other	23,017,885	Deferred Revenue	53,194,800
Prepaid expenses	6,802,558	Deferred Lease Obligations	69,947
		Capitation and Withholds	80,436,376
Total Current Assets	**1,219,833,063**	**Total Current Liabilities**	**924,940,416**
Capital Assets			
Furniture & Equipment	38,297,211		
Building/Leasehold Improvements	5,721,219		
505 City Parkway West	50,260,097		
	94,278,527		
Less: accumulated depreciation	(46,108,158)		
Capital assets, net	48,170,369	Other (than pensions) post employment benefits liability	25,547,203
Other Assets		Net Pension Liabilities	25,305,373
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	27,874,816	**TOTAL LIABILITIES**	**975,792,993**
Long-term Investments	521,739,666		
Total Board-designated Assets	549,614,481	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	549,914,481		
TOTAL ASSETS	**1,817,917,913**	TNE	81,928,057
		Funds in Excess of TNE	768,000,533
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	849,928,590
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,829,050,963**	**TOTAL LIABILITIES & FUND BALANCES**	**1,829,050,963**

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Board Designated Reserve and TNE Analysis
As of February 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	150,338,977				
	Tier 1 - Logan Circle	150,182,421				
	Tier 1 - Wells Capital	149,707,190				
Board-designated Reserve		450,228,589	314,171,327	483,928,207	136,057,261	(33,699,618)
TNE Requirement	Tier 2 - Logan Circle	99,385,893	81,928,057	81,928,057	17,457,836	17,457,836
	Consolidated:	**549,614,481**	**396,099,385**	**565,856,264**	**153,515,097**	**(16,241,782)**
	Current reserve level	*1.94*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

February 2019

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CalOptima - Consolidated
Financial Highlights
For the Eight Months Ended February 28, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
761,202	783,461	(22,259)	(2.8%)	Member Months	6,162,179	6,274,423	(112,244)	(1.8%)
288,736,739	299,721,674	(10,984,935)	(3.7%)	Revenues	2,207,848,429	2,260,160,814	(52,312,385)	(2.3%)
255,989,750	275,182,841	19,193,091	7.0%	Medical Expenses	2,060,064,758	2,145,273,675	85,208,917	4.0%
10,727,900	12,392,581	1,664,681	13.4%	Administrative Expenses	83,782,059	100,965,840	17,183,781	17.0%
22,019,089	**12,146,252**	**9,872,837**	**81.3%**	**Operating Margin**	**64,001,611**	**13,921,299**	**50,080,312**	**359.7%**
3,335,667	416,667	2,919,000	700.6%	Non Operating Income (Loss)	24,295,412	3,333,333	20,962,078	628.9%
25,354,757	**12,562,919**	**12,791,836**	**101.8%**	**Change in Net Assets**	**88,297,023**	**17,254,633**	**71,042,391**	**411.7%**
88.7%	91.8%	3.2%		Medical Loss Ratio	93.3%	94.9%	1.6%	
3.7%	4.1%	0.4%		Administrative Loss Ratio	3.8%	4.5%	0.7%	
7.6%	4.1%	3.6%		Operating Margin Ratio	2.9%	0.6%	2.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Eight Months Ended February 28, 2019

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	745,213	766,965	(21,752)	(2 8%)
OneCare Connect	14,209	14,853	(644)	(4 3%)
OneCare	1,472	1,324	148	11 2%
PACE	308	319	(11)	(3 4%)
Total	761,202	783,461	(22,259)	(2 8%)

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 20,320	$ 11,624	$ 8,696	74 8%
OneCare Connect	922	486	436	89 7%
OneCare	301	11	290	2636 4%
PACE	476	25	451	1804 0%
505 Bldg	-	-	-	0 0%
Investment Income & Other	3,336	417	2,919	700 0%
Total	$ 25,355	$ 12,563	$ 12,792	101 8%

MLR	Actual	Budget	% Point Var
Medi-Cal	88 7%	91 9%	3 2
OneCare Connect	90 0%	91 2%	1 2
OneCare	80 2%	91 2%	11 0

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,887	$ 10,231	$ 1,343	13 1%
OneCare Connect	1,604	1,857	253	13 6%
OneCare	110	131	20	15 7%
PACE	126	174	47	27 3%
Total	$ 10,728	$ 12,393	$ 1,665	13 4%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	993	1,089	97
OneCare Connect	223	234	11
OneCare	5	6	1
PACE	70	88	18
Total	1,291	1,417	126

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	751	704	47
OneCare Connect	64	63	0
OneCare	294	221	73
PACE	4	4	1
Total	1,112	992	120

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	6,032,214	6,142,441	(110,227)	(1 8%)
OneCare Connect	116,289	119,038	(2,749)	(2 3%)
OneCare	11,336	10,592	744	7 0%
PACE	2,340	2,352	(12)	(0 5%)
Total	6,162,179	6,274,423	(112,244)	(1 8%)

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 68,253	$ 20,791	$ 47,461	228 3%
OneCare Connect	(6,088)	(6,477)	389	6 0%
OneCare	(87)	(456)	370	80 9%
PACE	1,924	63	1,861	2954 0%
505 Bldg	-	-	-	0 0%
Investment Income & Other	24,295	3,333	20,962	628 9%
Total	$ 88,297	$ 17,255	$ 71,042	411 7%

MLR	Actual	Budget	% Point Var
Medi-Cal	93 1%	94 9%	1 8
OneCare Connect	96 3%	95 8%	(0 6)
OneCare	93 8%	95 3%	1 5

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 68,494	$ 83,474	$ 14,980	17 9%
OneCare Connect	13,423	15,069	1,646	10 9%
OneCare	881	1,054	173	16 4%
PACE	984	1,369	385	28 1%
Total	$ 83,782	$ 100,966	$ 17,184	17 0%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	7,622	8,533	911
OneCare Connect	1,764	1,872	108
OneCare	39	48	9
PACE	511	641	130
Total	9,936	11,094	1,158

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	791	720	72
OneCare Connect	66	64	2
OneCare	289	221	69
PACE	5	4	1
Total	1,151	1,008	143

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended February 28, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	761,202		783,461		(22,259)	
REVENUE						
Medi-Cal	$ 258,960,999	$ 347.50	$ 269,094,816	$ 350.86	$ (10,133,817)	$ (3.36)
OneCare Connect	25,277,728	1,778.99	26,691,998	1,797.08	(1,414,270)	(18.09)
OneCare	2,078,009	1,411.69	1,613,980	1,219.02	464,030	192.67
PACE	2,420,003	7,857.15	2,320,881	7,275.49	99,122	581.66
Total Operating Revenue	288,736,739	379.32	299,721,674	382.56	(10,984,935)	(3.24)
MEDICAL EXPENSES						
Medi-Cal	229,753,778	308.31	247,239,722	322.36	17,485,943	14.05
OneCare Connect	22,751,872	1,601.23	24,348,656	1,639.31	1,596,784	38.08
OneCare	1,666,439	1,132.09	1,472,259	1,111.98	(194,180)	(20.11)
PACE	1,817,660	5,901.49	2,122,204	6,652.68	304,544	751.19
Total Medical Expenses	255,989,750	336.30	275,182,841	351.24	19,193,091	14.94
GROSS MARGIN	32,746,989	43.02	24,538,834	31.32	8,208,156	11.70
ADMINISTRATIVE EXPENSES						
Salaries and benefits	6,657,011	8.75	7,784,998	9.94	1,127,987	1.19
Professional fees	162,114	0.21	412,958	0.53	250,844	0.32
Purchased services	1,268,740	1.67	1,238,936	1.58	(29,804)	(0.09)
Printing & Postage	288,347	0.38	533,146	0.68	244,798	0.30
Depreciation & Amortization	696,031	0.91	464,166	0.59	(231,866)	(0.32)
Other expenses	1,341,216	1.76	1,586,145	2.02	244,929	0.26
Indirect cost allocation & Occupancy expense	314,442	0.41	372,234	0.48	57,792	0.07
Total Administrative Expenses	10,727,900	14.09	12,392,581	15.82	1,664,681	1.73
INCOME (LOSS) FROM OPERATIONS	22,019,089	28.93	12,146,252	15.50	9,872,837	13.43
INVESTMENT INCOME						
Interest income	3,280,787	4.31	416,667	0.53	2,864,120	3.78
Realized gain/(loss) on investments	23,794	0.03	-	-	23,794	0.03
Unrealized gain/(loss) on investments	31,028	0.04	-	-	31,028	0.04
Total Investment Income	3,335,609	4.38	416,667	0.53	2,918,942	3.85
OTHER INCOME	58	-	-	-	58	-
CHANGE IN NET ASSETS	**25,354,755**	**33.31**	**12,562,919**	**16.04**	**12,791,836**	**17.27**
MEDICAL LOSS RATIO	**88.7%**		**91.8%**		**3.2%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.1%**		**0.4%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,162,179		6,274,422		(112,243)	
REVENUE						
Medi-Cal	$ 1,978,846,675	$ 328.05	$ 2,027,811,519	$ 330.13	$ (48,964,844)	$ (2.08)
OneCare Connect	198,939,324	1,710.73	202,458,549	1,700.80	(3,519,225)	9.93
OneCare	12,859,857	1,134.43	12,825,802	1,210.90	34,055	(76.47)
PACE	17,202,573	7,351.53	17,064,944	7,255.50	137,629	96.03
Total Operating Revenue	2,207,848,429	358.29	2,260,160,814	360.22	(52,312,385)	(1.93)
MEDICAL EXPENSES						
Medi-Cal	1,842,100,463	305.38	1,923,545,872	313.16	81,445,409	7.78
OneCare Connect	191,603,711	1,647.65	193,866,372	1,628.62	2,262,661	(19.03)
OneCare	12,065,753	1,064.37	12,228,399	1,154.49	162,646	90.12
PACE	14,294,831	6,108.90	15,633,032	6,646.70	1,338,201	537.80
Total Medical Expenses	2,060,064,758	334.31	2,145,273,675	341.91	85,208,917	7.60
GROSS MARGIN	147,783,671	23.98	114,887,139	18.31	32,896,532	5.67
ADMINISTRATIVE EXPENSES						
Salaries and benefits	55,221,362	8.96	64,154,528	10.22	8,933,167	1.26
Professional fees	1,584,701	0.26	3,301,166	0.53	1,716,465	0.27
Purchased services	7,598,523	1.23	9,894,373	1.58	2,295,851	0.35
Printing & Postage	3,176,256	0.52	4,265,164	0.68	1,088,907	0.16
Depreciation & Amortization	3,514,675	0.57	3,713,329	0.59	198,654	0.02
Other expenses	9,968,521	1.62	12,659,412	2.02	2,690,891	0.40
Indirect cost allocation & Occupancy expense	2,718,021	0.44	2,977,867	0.47	259,846	0.03
Total Administrative Expenses	83,782,059	13.60	100,965,840	16.09	17,183,781	2.49
INCOME (LOSS) FROM OPERATIONS	64,001,611	10.39	13,921,299	2.22	50,080,312	8.17
INVESTMENT INCOME						
Interest income	21,471,183	3.48	3,333,333	0.53	18,137,850	2.95
Realized gain/(loss) on investments	(1,815,343)	(0.29)	-	-	(1,815,343)	(0.29)
Unrealized gain/(loss) on investments	4,638,770	0.75	-	-	4,638,770	0.75
Total Investment Income	24,294,611	3.94	3,333,333	0.53	20,961,277	3.41
OTHER INCOME	801	-	-	-	801	-
CHANGE IN NET ASSETS	**88,297,023**	**14.33**	**17,254,633**	**2.75**	**71,042,391**	**11.58**
MEDICAL LOSS RATIO	**93.3%**		**94.9%**		**1.6%**	
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 February 28, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,533	236,680	745,213	14,209	1,472	308	761,202
REVENUES							
Capitation Revenue	$ 150,927,793	$ 108,033,206	$ 258,960,999	$ 25,277,728	$ 2,078,009	$ 2,420,003	$ 288,736,739
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	150,927,793	108,033,206	258,960,999	25,277,728	2,078,009	2,420,003	288,736,739
MEDICAL EXPENSES							
Provider Capitation	35,630,917	49,622,849	85,253,766	10,243,078	682,194		96,179,038
Facilities	22,448,258	24,635,305	47,083,563	4,252,795	385,769	382,580	52,104,707
Ancillary	-	-	-	653,997	110,907	-	764,904
Professional Claims	17,082,441	6,369,118	23,451,559	-	-	438,212	23,889,771
Prescription Drugs	16,802,850	18,791,105	35,593,955	4,983,116	459,729	190,281	41,227,081
MLTSS	30,767,161	2,964,492	33,731,654	1,087,172	(32,425)	6,964	34,793,364
Medical Management	2,015,733	817,953	2,833,686	1,055,535	54,063	634,475	4,577,759
Quality Incentives	755,379	409,408	1,164,787	276,180		3,080	1,444,047
Reinsurance & Other	494,271	146,536	640,808	200,000	6,202	162,069	1,009,079
Total Medical Expenses	125,997,011	103,756,767	229,753,778	22,751,872	1,666,439	1,817,660	255,989,750
Medical Loss Ratio	83 5%	96 0%	88 7%	90 0%	80 2%	75 1%	88 7%
GROSS MARGIN	**24,930,782**	**4,276,439**	**29,207,221**	**2,525,856**	**411,570**	**602,342**	**32,746,989**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,781,343	745,198	28,618	101,852	6,657,011
Professional fees			143,847	3,524	14,667	77	162,114
Purchased services			1,047,637	188,620	16,850	15,633	1,268,740
Printing & Postage			249,380	33,006	5,961		288,347
Depreciation & Amortization			693,950			2,081	696,031
Other expenses			1,293,511	44,721		2,984	1,341,216
Indirect cost allocation & Occupancy			(322,325)	589,123	44,020	3,624	314,442
Total Administrative Expenses			8,887,343	1,604,191	110,116	126,250	10,727,900
Admin Loss Ratio			3 4%	6 3%	5 3%	5 2%	3 7%
INCOME (LOSS) FROM OPERATIONS			20,319,878	921,665	301,454	476,092	22,019,089
INVESTMENT INCOME							3,335,609
OTHER INCOME			58				58
CHANGE IN NET ASSETS			**$ 20,319,936**	**$ 921,665**	**$ 301,454**	**$ 476,092**	**$ 25,354,755**
BUDGETED CHANGE IN NET ASSETS			11,624,280	485,915	11,127	24,930	12,562,919
VARIANCE TO BUDGET - FAV (UNFAV)			$ 8,695,655	$ 435,750	$ 290,328	$ 451,162	$ 12,791,836

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eight Months Ended February 28, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,134,409	1,897,805	6,032,214	116,289	11,336	2,340	6,162,179
REVENUES							
Capitation Revenue	$ 1,098,172,599	$ 880,674,076	$ 1,978,846,675	$ 198,939,324	$ 12,859,857	$ 17,202,573	$ 2,207,848,429
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,098,172,599	880,674,076	1,978,846,675	198,939,324	12,859,857	17,202,573	2,207,848,429
MEDICAL EXPENSES							
Provider Capitation	286,247,938	402,079,608	688,327,546	90,843,708	3,611,186		782,782,441
Facilities	178,369,114	186,220,944	364,590,058	28,565,640	3,455,183	3,105,220	399,716,100
Ancillary	-	-	-	5,142,566	319,719	-	5,462,286
Professional Claims	127,594,299	50,083,749	177,678,047	-	-	3,469,062	181,147,109
Prescription Drugs	137,237,174	155,557,468	292,794,643	42,911,809	3,724,138	1,352,983	340,783,573
MLTSS	254,716,818	22,518,046	277,234,865	11,083,006	411,497	33,911	288,763,279
Medical Management	16,784,336	8,061,829	24,846,164	8,898,358	494,732	5,011,385	39,250,639
Quality Incentives	6,140,080	3,272,838	9,412,918	2,378,380		23,400	11,814,698
Reinsurance & Other	4,596,740	2,619,483	7,216,223	1,780,245	49,298	1,298,869	10,344,635
Total Medical Expenses	1,011,686,498	830,413,964	1,842,100,463	191,603,711	12,065,753	14,294,831	2,060,064,758
Medical Loss Ratio	92 1%	94 3%	93 1%	96 3%	93 8%	83 1%	93 3%
GROSS MARGIN	**86,486,100**	**50,260,112**	**136,746,212**	**7,335,613**	**794,104**	**2,907,741**	**147,783,671**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			48,111,151	6,061,067	264,647	784,496	55,221,362
Professional fees			1,242,556	218,321	117,334	6,491	1,584,701
Purchased services			5,960,842	1,443,894	120,942	72,845	7,598,523
Printing & Postage			2,505,782	552,917	70,035	47,523	3,176,256
Depreciation & Amortization			3,498,033			16,642	3,514,675
Other expenses			9,599,136	348,497	377	20,510	9,968,521
Indirect cost allocation & Occupancy			(2,423,246)	4,798,423	307,617	35,228	2,718,021
Total Administrative Expenses			68,494,253	13,423,120	880,951	983,735	83,782,059
Admin Loss Ratio			3 5%	6 7%	6 9%	5 7%	3 8%
INCOME (LOSS) FROM OPERATIONS			68,251,959	(6,087,507)	(86,847)	1,924,006	64,001,611
INVESTMENT INCOME							24,294,611
OTHER INCOME			801				801
CHANGE IN NET ASSETS			**$ 68,252,760**	**$ (6,087,507)**	**$ (86,847)**	**$ 1,924,006**	**$ 88,297,023**
BUDGETED CHANGE IN NET ASSETS			20,791,412	(6,476,569)	(456,360)	62,816	17,254,633
VARIANCE TO BUDGET - FAV (UNFAV)			$ 47,461,349	$ 389,062	$ 369,513	$ 1,861,190	$ 71,042,391

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February 28, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $25.4 million, $12.8 million favorable to budget
- Operating surplus is $22.0 million, with a surplus in non-operating income of $3.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $88.3 million, $71.0 million favorable to budget
- Operating surplus is $64.0 million, with a surplus in non-operating of $24.3 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
20.3	11.6	8.7	Medi-Cal	68.3	20.8	47.5
0.9	0.5	0.4	OCC	(6.1)	(6.5)	0.4
0.3	0.0	0.3	OneCare	(0.1)	(0.5)	0.4
0.5	0.0	0.5	PACE	1.9	0.1	1.9
22.0	**12.1**	**9.9**	**Operating**	**64.0**	**13.9**	**50.1**
3.3	0.4	2.9	Inv./Rental Inc, MCO tax	24.3	3.3	21.0
3.3	**0.4**	**2.9**	**Non-Operating**	**24.3**	**3.3**	**21.0**
25.4	**12.6**	**12.8**	**TOTAL**	**88.3**	**17.3**	**71.0**

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CalOptima - Consolidated
Enrollment Summary
For the Eight Months Ended February 28, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
64,541	65,338	(797)	(1.2%)	Aged	513,000	516,428	(3,428)	(0.7%)
590	620	(30)	(4.8%)	BCCTP	4,833	4,960	(127)	(2.6%)
46,995	44,125	2,870	6.5%	Disabled	375,926	370,988	4,938	1.3%
302,286	304,344	(2,058)	(0.7%)	TANF Child	2,469,524	2,501,682	(32,158)	(1.3%)
90,742	93,270	(2,528)	(2.7%)	TANF Adult	743,884	756,651	(12,767)	(1.7%)
3,379	3,525	(146)	(4.1%)	LTC	27,242	27,892	(650)	(2.3%)
236,680	243,242	(6,562)	(2.7%)	MCE	1,897,805	1,938,836	(41,031)	(2.1%)
-	12,502	(12,502)	(100.0%)	WCM*	-	25,004	(25,004)	(100.0%)
745,213	**766,965**	**(21,752)**	**(2.8%)**	**Medi-Cal Total**	**6,032,214**	**6,142,441**	**(110,227)**	**(1.8%)**
14,209	**14,853**	**(644)**	**(4.3%)**	**OneCare Connect**	**116,289**	**119,038**	**(2,749)**	**(2.3%)**
1,472	**1,324**	**148**	**11.2%**	**OneCare**	**11,336**	**10,592**	**744**	**7.0%**
308	**319**	**(11)**	**(3.4%)**	**PACE**	**2,340**	**2,352**	**(12)**	**(0.5%)**
761,202	**783,461**	**(22,259)**	**(2.8%)**	**CalOptima Total**	**6,162,179**	**6,274,423**	**(112,244)**	**(1.8%)**
				Enrollment (by Network)				
164,898	167,252	(2,354)	(1.4%)	HMO	1,332,510	1,343,080	(10,570)	(0.8%)
213,269	221,920	(8,651)	(3.9%)	PHC	1,735,536	1,777,166	(41,630)	(2.3%)
191,144	188,503	2,641	1.4%	Shared Risk Group	1,541,669	1,530,612	11,057	0.7%
175,902	189,290	(13,388)	(7.1%)	Fee for Service	1,422,499	1,491,583	(69,084)	(4.6%)
745,213	**766,965**	**(21,752)**	**(2.8%)**	**Medi-Cal Total**	**6,032,214**	**6,142,441**	**(110,227)**	**(1.8%)**
14,209	**14,853**	**(644)**	**(4.3%)**	**OneCare Connect**	**116,289**	**119,038**	**(2,749)**	**(2.3%)**
1,472	**1,324**	**148**	**11.2%**	**OneCare**	**11,336**	**10,592**	**744**	**7.0%**
308	**319**	**(11)**	**(3.4%)**	**PACE**	**2,340**	**2,352**	**(12)**	**(0.5%)**
761,202	**783,461**	**(22,259)**	**(2.8%)**	**CalOptima Total**	**6,162,179**	**6,274,423**	**(112,244)**	**(1.8%)**

*Note: Actual members reside in their original aid codes (TANF & SPD) prior to start of program

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CalOptima
Enrollment Trend by Network
Fiscal Year 2019

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	YTD Actual	YTD Budget	Variance
HMOs											
Aged	3,844	3,866	3,841	3,841	3,854	3,842	3,837	3,821	30,746	31,388	(642)
BCCTP	1	1	1	1	1	1	1	1	8	8	0
Disabled	6,744	6,789	6,789	6,811	6,838	6,813	6,807	6,824	54,415	53,800	615
TANF Child	58,435	58,267	58,162	58,110	57,723	56,929	56,504	56,327	460,457	462,000	(1,543)
TANF Adult	29,473	29,373	29,404	29,529	29,392	29,131	28,926	28,716	233,944	233,520	424
LTC	2	2	3	4	1	1	2	2	17	32	(15)
MCE	68,597	68,602	68,919	69,646	69,547	69,385	69,020	69,207	552,923	558,236	(5,313)
WCM									-	4 096	(4 096)
Total	**167,096**	**166,900**	**167,119**	**167,942**	**167,356**	**166,102**	**165,097**	**164,898**	**1,332,510**	**1,343,080**	**(10,570)**
PHCs											
Aged	1,600	1,621	1,620	1,673	1,673	1,645	1,593	1,565	12,990	14,056	(1,066)
BCCTP									-		0
Disabled	7,243	7,239	7,230	7,212	7,226	7,231	7,190	7,187	57,758	54,010	3,748
TANF Child	157,157	156,755	157,444	158,169	157,483	156,497	155,299	154,625	1,253,429	1,269,722	(16,293)
TANF Adult	12,731	12,684	12,787	12,785	12,596	12,476	12,049	11,890	99,998	99,952	46
LTC		1				1	1		3		3
MCE	39,060	38,992	39,234	39,568	39,402	39,204	37,896	38,002	311,358	324,512	(13,154)
WCM									-	14 914	(14 914)
Total	**217,791**	**217,292**	**218,315**	**219,407**	**218,380**	**217,054**	**214,028**	**213,269**	**1,735,536**	**1,777,166**	**(41,630)**
Shared Risk Groups											
Aged	3,593	3,605	3,621	3,642	3,610	3,589	3,635	3,614	28,909	29,084	(175)
BCCTP									-		0
Disabled	7,626	7,554	7,486	7,473	7,493	7,463	7,409	7,419	59,923	58,496	1,427
TANF Child	67,471	67,226	67,159	67,251	66,739	66,119	65,717	65,144	532,826	526,714	6,112
TANF Adult	30,936	30,567	30,622	30,670	30,417	30,217	29,947	29,702	243,078	239,098	3,980
LTC	2		1	1		2			6	24	(18)
MCE	83,554	83,443	84,008	85,253	85,270	84,916	85,218	85,265	676,927	673,212	3,715
WCM									-	3 984	(3 984)
Total	**193,182**	**192,395**	**192,897**	**194,290**	**193,529**	**192,306**	**191,926**	**191,144**	**1,541,669**	**1,530,612**	**11,057**
Fee for Service (Dual)											
Aged	49,903	50,943	50,657	50,741	51,018	51,265	51,130	51,194	406,851	406,048	803
BCCTP	16	15	18	14	13	11	11	10	108	200	(92)
Disabled	20,706	20,863	20,741	20,761	20,812	20,921	20,739	20,879	166,422	168,294	(1,872)
TANF Child	2	3	2	2	1	2	2	2	16	12	4
TANF Adult	1,081	1,083	1,064	1,055	1,038	1,029	1,028	992	8,370	8,302	68
LTC	3,025	3,019	3,007	3,077	3,079	3,096	3,062	3,027	24,392	24,960	(568)
MCE	2,327	2,367	2,416	2,388	2,237	2,141	2,086	2,141	18,103	11,944	6,159
WCM									-	40	(40)
Total	**77,060**	**78,293**	**77,905**	**78,038**	**78,198**	**78,465**	**78,058**	**78,245**	**624,262**	**619,800**	**4,462**
Fee for Service (Non-Dual)											
Aged	4,702	3,727	4,153	4,118	4,018	4,128	4,311	4,347	33,504	35,852	(2,348)
BCCTP	613	596	601	581	589	574	584	579	4,717	4,752	(35)
Disabled	4,802	4,672	4,617	4,678	5,209	4,676	4,068	4,686	37,408	36,388	1,020
TANF Child	30,166	31,801	28,765	26,649	25,545	26,010	27,672	26,188	222,796	243,234	(20,438)
TANF Adult	20,308	20,588	20,198	19,628	19,315	19,401	19,614	19,442	158,494	175,779	(17,285)
LTC	353	360	367	347	356	340	351	350	2,824	2,876	(52)
MCE	44,399	44,410	43,161	40,810	40,393	41,103	42,153	42,065	338,494	370,932	(32,438)
WCM									-	1 970	(1 970)
Total	**105,343**	**106,154**	**101,862**	**96,811**	**95,425**	**96,232**	**98,753**	**97,657**	**798,237**	**871,783**	**(73,546)**
Grand Totals											
Aged	63,642	63,762	63,892	64,015	64,173	64,469	64,506	64,541	513,000	516,428	(3,428)
BCCTP	630	612	620	596	603	586	596	590	4,833	4,960	(127)
Disabled	47,121	47,117	46,863	46,935	47,578	47,104	46,213	46,995	375,926	370,988	4,938
TANF Child	313,231	314,052	311,532	310,181	307,491	305,557	305,194	302,286	2,469,524	2,501,682	(32,158)
TANF Adult	94,529	94,295	94,075	93,667	92,758	92,254	91,564	90,742	743,884	756,651	(12,767)
LTC	3,382	3,382	3,378	3,429	3,436	3,440	3,416	3,379	27,242	27,892	(650)
MCE	237,937	237,814	237,738	237,665	236,849	236,749	236,373	236,680	1,897,805	1,938,836	(41,031)
WCM*									-	25 004	(25 004)
Total MediCal MM	**760,472**	**761,034**	**758,098**	**756,488**	**752,888**	**750,159**	**747,862**	**745,213**	**6,032,214**	**6,142,441**	**(110,227)**
OneCare Connect	**16,399**	**13,137**	**14,681**	**14,665**	**14,610**	**14,301**	**14,287**	**14,209**	**116,289**	**119,038**	**(2,748)**
OneCare	**1,390**	**1,384**	**1,375**	**1,404**	**1,423**	**1,435**	**1,453**	**1,472**	**11,336**	**10,592**	**744**
PACE	**273**	**286**	**286**	**289**	**295**	**299**	**304**	**308**	**2,340**	**2,352**	**(12)**
Grand Total	**778,534**	**775,841**	**774,440**	**772,846**	**769,216**	**766,194**	**763,906**	**761,202**	**6,162,179**	**6,274,422**	**(112,243)**

*Note Actual members reside in their original aid codes (TANF & SPD) prior to start of program

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ENROLLMENT:

Overall February enrollment was 761,202

- Unfavorable to budget 22,259 or 2.8%
- Decreased 2,704 or 0.4% from prior month (January 2019)
- Decreased 33,376 or 4.2% from prior year (February 2018)

Medi-Cal enrollment was 745,213

- Unfavorable to budget 21,752 or 2.8%
    - Whole Child Model (WCM) unfavorable 12,502
        - Actual members reside in their original aid codes (TANF & SPD) prior to start of program
    - Medi-Cal Expansion (MCE) unfavorable 6,562
    - Temporary Assistance for Needy Families (TANF) unfavorable 4,586
    - Long-Term Care (LTC) unfavorable 146
    - Seniors and Persons with Disabilities (SPD) favorable 2,043
- Decreased 2,649 from prior month

OneCare Connect enrollment was 14,209

- Unfavorable to budget 644 or 4.3%
- Decreased 78 from prior month

OneCare enrollment was 1,472

- Favorable to budget 148 or 11.2%
- Increased 19 from prior month

PACE enrollment was 308

- Unfavorable to budget 11 or 3.4%
- Increased 4 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
745,213	**766,965**	**(21,752)**	**(2.8%)**	**Member Months**	**6,032,214**	**6,142,441**	**(110,227)**	**(1.8%)**
				Revenues				
258,960,999	269,094,816	(10,133,817)	(3 8%)	Capitation revenue	1,978,846,675	2,027,811,519	(48,964,844)	(2 4%)
-	-	-	0 0%	Other income	-	-	-	0 0%
258,960,999	**269,094,816**	**(10,133,817)**	**(3.8%)**	**Total Operating Revenue**	**1,978,846,675**	**2,027,811,519**	**(48,964,844)**	**(2.4%)**
				Medical Expenses				
86,418,553	95,441,879	9,023,326	9 5%	Provider capitation	697,740,464	698,695,769	955,306	0 1%
47,083,563	43,846,312	(3,237,251)	(7 4%)	Facilities	364,590,058	352,654,363	(11,935,694)	(3 4%)
23,451,559	28,117,719	4,666,160	16 6%	Professional Claims	177,678,047	228,156,630	50,478,583	22 1%
35,593,955	42,015,813	6,421,857	15 3%	Prescription drugs	292,794,643	320,751,551	27,956,909	8 7%
33,731,654	33,563,986	(167,667)	(0 5%)	MLTSS	277,234,865	289,388,446	12,153,582	4 2%
2,833,686	3,723,379	889,693	23 9%	Medical management	24,846,164	29,654,040	4,807,876	16 2%
640,808	530,634	(110,174)	(20 8%)	Reinsurance & other	7,216,223	4,245,072	(2,971,151)	(70 0%)
229,753,778	**247,239,722**	**17,485,943**	**7.1%**	**Total Medical Expenses**	**1,842,100,463**	**1,923,545,872**	**81,445,409**	**4.2%**
29,207,221	**21,855,094**	**7,352,127**	**33.6%**	**Gross Margin**	**136,746,212**	**104,265,647**	**32,480,565**	**31.2%**
				Administrative Expenses				
5,781,343	6,771,309	989,966	14 6%	Salaries, wages & employee benefits	48,111,151	55,847,562	7,736,411	13 9%
143,847	350,275	206,428	58 9%	Professional fees	1,242,556	2,799,699	1,557,144	55 6%
1,047,637	949,069	(98,568)	(10 4%)	Purchased services	5,960,842	7,575,439	1,614,598	21 3%
249,380	423,310	173,930	41 1%	Printing and postage	2,505,782	3,386,476	880,695	26 0%
693,950	462,075	(231,875)	(50 2%)	Depreciation and amortization	3,498,033	3,696,604	198,571	5 4%
1,293,511	1,498,367	204,856	13 7%	Other operating expenses	9,599,136	11,957,184	2,358,048	19 7%
(322,325)	(223,591)	98,734	44 2%	Indirect cost allocation, Occupancy Expense	(2,423,246)	(1,788,730)	634,516	35 5%
8,887,343	**10,230,814**	**1,343,471**	**13.1%**	**Total Administrative Expenses**	**68,494,253**	**83,474,235**	**14,979,982**	**17.9%**
				Operating Tax				
11,289,532	10,935,923	353,609	3 2%	Tax Revenue	91,378,058	86,529,269	4,848,789	5 6%
11,289,532	10,935,923	(353,609)	(3 2%)	Premium tax expense	91,378,058	75,745,131	(15,632,927)	(20 6%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
44,518	249,874	(205,356)	(82 2%)	Grant Revenue	355,735	1,998,992	(1,643,257)	(82 2%)
30,388	223,107	192,720	86 4%	Grant expense - Service Partner	235,025	1,784,856	1,549,831	86 8%
14,130	26,767	12,637	47 2%	Grant expense - Administrative	120,710	214,136	93,426	43 6%
-	-	-	**0.0%**	**Total Grant Income**	-	-	-	**0.0%**
58	**-**	**58**	**0.0%**	**Other income**	**801**	**-**	**801**	**0.0%**
58	-	58	0 0%	MC Other income	801	-	801	0 0%
20,319,936	**11,624,280**	**8,695,655**	**74.8%**	**Change in Net Assets**	**68,252,760**	**20,791,412**	**47,461,349**	**228.3%**
88.7%	***91.9%***	***3.2%***	***3.4%***	***Medical Loss Ratio***	***93.1%***	***94.9%***	***1.8%***	***1.9%***
3.4%	***3.8%***	***0.4%***	***9.7%***	***Admin Loss Ratio***	***3.5%***	***4.1%***	***0.7%***	***15.9%***

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MEDI-CAL INCOME STATEMENT FEBRUARY MONTH:

REVENUES of $259.0 million are unfavorable to budget $10.1 million, driven by:

- Unfavorable volume related variance of $7.6 million
- Unfavorable price related variance of $2.5 million due to:
  - $22.9 million of WCM revenue due to delayed start of program, offset by
  - $13.8 million of Coordinated Care Initiative (CCI) revenue due to calendar year (CY) 2018 rate increase
  - $9.8 million prior year (PY) CCI revenue due to CY 2018 true-up rate increase
  - $1.4 million due to favorable MCE rates

MEDICAL EXPENSES are $229.8 million, favorable to budget $17.5 million due to:

- **Provider Capitation** expense is favorable to budget $9.0 million due to:
  - $12.0 million of WCM expenses due to delay of WCM program offset by
  - $2.3 million by capitation expenses for Proposition 56 that was budgeted in Professional Claims
  - $2.0 million of Child Health and Disability Prevention Program (CHDP) that was budgeted in Professional Claims

- **Prescription Drug** expense is favorable to budget $6.4 million
  - $5.7 million due to the delay of WCM program

- **Professional Claims** expense is favorable to budget $4.7 million due to:
  - $2.0 million of CHDP expenses
  - $1.9 million of Behavioral Health Treatment (BHT) expenses
  - $2.6 million of Proposition 56 expenses, offset by
  - $1.7 million of increased Incurred But Not Reported (IBNR) claims liability
  - $0.3 million of Non-Medical Transportation (NMT) expenses

- **Facilities** expense is unfavorable to budget $3.2 million
  - $5.6 million of in-patient claims
  - $1.4 million of crossover claims, offset by
  - $2.7 million of WCM expense
  - $1.2 million favorable volume variance

ADMINISTRATIVE EXPENSES are $8.9 million, favorable to budget $1.3 million, driven by:

- **Salary & Benefits**: $1.0 million favorable to budget due to open positions (126)
- **Other Non-Salary**: $0.4 million favorable to budget

CHANGE IN NET ASSETS is $20.3 million for the month, $8.7 million favorable to budget

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eight Months Ended February 28, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,209	**14,853**	**(644)**	**(4.3%)**	**Member Months**	**116,289**	**119,038**	**(2,749)**	**(2.3%)**
				Revenues				
4,202,235	3,200,296	1,001,939	31.3%	Medi-Cal Capitation revenue	22,083,116	26,303,319	(4,220,203)	(16.0%)
15,968,449	18,650,748	(2,682,299)	(14.4%)	Medicare Capitation revenue part C	136,076,642	138,309,964	(2,233,322)	(1.6%)
5,107,044	4,840,954	266,090	5.5%	Medicare Capitation revenue part D	40,779,566	37,845,266	2,934,300	7.8%
-	-	-	0.0%	Other Income	-	-	-	0.0%
25,277,728	**26,691,998**	**(1,414,270)**	**(5.3%)**	**Total Operating Revenue**	**198,939,324**	**202,458,549**	**(3,519,225)**	**(1.7%)**
				Medical Expenses				
10,519,258	12,416,379	1,897,121	15.3%	Provider capitation	93,222,088	92,982,987	(239,101)	(0.3%)
4,252,795	3,556,571	(696,224)	(19.6%)	Facilities	28,565,640	28,860,063	294,423	1.0%
653,997	653,643	(354)	(0.1%)	Ancillary	5,142,566	5,269,767	127,201	2.4%
1,087,172	1,460,273	373,101	25.6%	Long Term Care	11,083,006	13,138,555	2,055,549	15.6%
4,983,116	4,875,181	(107,935)	(2.2%)	Prescription drugs	42,911,809	42,113,642	(798,167)	(1.9%)
1,055,535	1,247,245	191,710	15.4%	Medical management	8,898,358	10,347,826	1,449,468	14.0%
200,000	139,364	(60,636)	(43.5%)	Other medical expenses	1,780,245	1,153,532	(626,713)	(54.3%)
22,751,872	**24,348,656**	**1,596,784**	**6.6%**	**Total Medical Expenses**	**191,603,711**	**193,866,372**	**2,262,661**	**1.2%**
2,525,856	**2,343,342**	**182,514**	**7.8%**	**Gross Margin**	**7,335,613**	**8,592,177**	**(1,256,564)**	**(14.6%)**
				Administrative Expenses				
745,198	842,463	97,265	11.5%	Salaries, wages & employee benefits	6,061,067	6,949,034	887,967	12.8%
3,524	42,917	39,393	91.8%	Professional fees	218,321	343,333	125,012	36.4%
188,620	251,415	62,795	25.0%	Purchased services	1,443,894	2,011,321	567,426	28.2%
33,006	86,202	53,196	61.7%	Printing and postage	552,917	689,613	136,696	19.8%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
44,721	77,036	32,315	41.9%	Other operating expenses	348,497	616,292	267,795	43.5%
589,123	557,394	(31,729)	(5.7%)	Indirect cost allocation	4,798,423	4,459,152	(339,271)	(7.6%)
1,604,191	**1,857,427**	**253,235**	**13.6%**	**Total Administrative Expenses**	**13,423,120**	**15,068,746**	**1,645,626**	**10.9%**
921,665	**485,915**	**435,750**	**89.7%**	**Change in Net Assets**	**(6,087,507)**	**(6,476,569)**	**389,062**	**6.0%**
90.0%	***91.2%***	***1.2%***	***1.3%***	***Medical Loss Ratio***	***96.3%***	***95.8%***	***(0.6%)***	***(0.6%)***
6.3%	***7.0%***	***0.6%***	***8.8%***	***Admin Loss Ratio***	***6.7%***	***7.4%***	***0.7%***	***9.3%***

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ONECARE CONNECT INCOME STATEMENT – FEBRUARY MONTH:

REVENUES of $25.3 million are unfavorable to budget $1.4 million due to:

- Unfavorable volume related variance of $1.2 million
- Unfavorable price related variance of $0.3 million due to lower than projected rates

MEDICAL EXPENSES of $22.8 million are favorable to budget $1.6 million

- Favorable volume variance of $1.1 million
- Favorable price variance of $0.5 million

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million

CHANGE IN NET ASSETS is $0.9 million, $0.4 million favorable to budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,472	**1,324**	**148**	**11.2%**	**Member Months**	**11,336**	**10,592**	**744**	**7.0%**
				Revenues				
1,758,853	1,148,799	610,054	53 1%	Medicare Part C revenue	8,666,712	8,859,356	(192,645)	(2 2%)
319,157	465,181	(146,025)	(31 4%)	Medicare Part D revenue	4,193,146	3,966,446	226,700	5 7%
2,078,009	**1,613,980**	**464,030**	**28.8%**	**Total Operating Revenue**	**12,859,857**	**12,825,802**	**34,055**	**0.3%**
				Medical Expenses				
682,194	455,662	(226,532)	(49 7%)	Provider capitation	3,611,186	3,604,639	(6,548)	(0 2%)
385,769	487,796	102,027	20 9%	Inpatient	3,455,183	4,128,159	672,976	16 3%
110,907	55,059	(55,848)	(101 4%)	Ancillary	319,719	447,026	127,307	28 5%
(32,425)	24,258	56,683	233 7%	Skilled nursing facilities	411,497	210,527	(200,970)	(95 5%)
459,729	406,104	(53,625)	(13 2%)	Prescription drugs	3,724,138	3,506,774	(217,364)	(6 2%)
54,063	33,614	(20,449)	(60 8%)	Medical management	494,732	272,361	(222,370)	(81 6%)
6,202	9,766	3,563	36 5%	Other medical expenses	49,298	58,913	9,616	16 3%
1,666,439	**1,472,259**	**(194,180)**	**(13.2%)**	**Total Medical Expenses**	**12,065,753**	**12,228,399**	**162,646**	**1.3%**
411,570	**141,721**	**269,849**	**190.4%**	**Gross Margin**	**794,104**	**597,403**	**196,701**	**32.9%**
				Administrative Expenses				
28,618	38,515	9,897	25 7%	Salaries, wages & employee benefits	264,647	317,129	52,482	16 5%
14,667	19,600	4,933	25 2%	Professional fees	117,334	156,800	39,466	25 2%
16,850	17,425	575	3 3%	Purchased services	120,942	139,400	18,458	13 2%
5,961	13,206	7,244	54 9%	Printing and postage	70,035	105,647	35,612	33 7%
-	6,883	6,883	100 0%	Other operating expenses	377	55,067	54,690	99 3%
44,020	34,965	(9,055)	(25 9%)	Indirect cost allocation, occupancy expens	307,617	279,720	(27,897)	(10 0%)
110,116	**130,594**	**20,478**	**15.7%**	**Total Administrative Expenses**	**880,951**	**1,053,763**	**172,812**	**16.4%**
301,454	**11,127**	**290,328**	**2609.3%**	**Change in Net Assets**	**(86,847)**	**(456,360)**	**369,513**	**81.0%**
80.2%	***91.2%***	***11.0%***	***12.1%***	***Medical Loss Ratio***	***93.8%***	***95.3%***	***1.5%***	***1.6%***
5.3%	***8.1%***	***2.8%***	***34.5%***	***Admin Loss Ratio***	***6.9%***	***8.2%***	***1.4%***	***16.6%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
308	**319**	**(11)**	**(3.4%)**	**Member Months**	**2,340**	**2,352**	**(12)**	**-0.5%**
				Revenues				
1,867,531	1,784,687	82,844	4 6%	Medi-Cal capitation revenue	13,070,921	13,165,749	(94,828)	(0 7%)
419,301	432,629	(13,328)	(3 1%)	Medicare Part C revenue	3,250,267	3,141,839	108,428	3 5%
133,171	103,565	29,606	28 6%	Medicare Part D revenue	881,384	757,356	124,028	16 4%
2,420,003	**2,320,881**	**99,122**	**4.3%**	**Total Operating Revenue**	**17,202,573**	**17,064,944**	**137,629**	**0.8%**
				Medical Expenses				
634,475	758,012	123,537	16 3%	Medical Management	5,011,385	5,750,975	739,590	12 9%
382,580	492,366	109,786	22 3%	Claims payments to hospitals	3,105,220	3,554,361	449,141	12 6%
438,212	515,479	77,267	15 0%	Professional claims	3,469,062	3,776,052	306,990	8 1%
162,069	142,207	(19,862)	(14 0%)	Patient transportation	1,298,869	1,048,498	(250,371)	(23 9%)
190,281	187,130	(3,151)	(1 7%)	Prescription drugs	1,352,983	1,364,442	11,459	0 8%
6,964	23,960	16,996	70 9%	MLTSS	33,911	115,704	81,793	70 7%
3,080	3,050	(30)	(1 0%)	Other Expenses	23,400	23,000	(400)	(1 7%)
1,817,660	**2,122,204**	**304,544**	**14.4%**	**Total Medical Expenses**	**14,294,831**	**15,633,032**	**1,338,201**	**8.6%**
602,342	**198,677**	**403,665**	**203.2%**	**Gross Margin**	**2,907,741**	**1,431,912**	**1,475,829**	**103.1%**
				Administrative Expenses				
101,852	132,710	30,858	23 3%	Salaries, wages & employee benefits	784,496	1,040,802	256,306	24 6%
77	167	90	54 1%	Professional fees	6,491	1,333	(5,158)	(386 8%)
15,633	21,027	5,393	25 7%	Purchased services	72,845	168,213	95,368	56 7%
-	10,428	10,428	100 0%	Printing and postage	47,523	83,427	35,904	43 0%
2,081	2,091	10	0 5%	Depreciation & amortization	16,642	16,725	83	0 5%
2,984	3,859	875	22 7%	Other operating expenses	20,510	30,869	10,359	33 6%
3,624	3,466	(158)	(4 6%)	Indirect cost allocation, Occupancy Expense	35,228	27,725	(7,502)	(27 1%)
126,250	**173,747**	**47,497**	**27.3%**	**Total Administrative Expenses**	**983,735**	**1,369,096**	**385,361**	**28.1%**
				Operating Tax				
4,571	-	4,571	0 0%	Tax Revenue	33,205	-	33,205	0 0%
4,571	-	(4,571)	0 0%	Premium tax expense	33,205	-	(33,205)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
476,092	**24,930**	**451,162**	**1809.7%**	**Change in Net Assets**	**1,924,006**	**62,816**	**1,861,190**	**2962.9%**
75.1%	***91.4%***	***16.3%***	***17.9%***	***Medical Loss Ratio***	***83.1%***	***91.6%***	***8.5%***	***9.3%***
5.2%	***7.5%***	***2.3%***	***30.3%***	***Admin Loss Ratio***	***5.7%***	***8.0%***	***2.3%***	***28.7%***

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CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 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				
30,074	22,982	(7,092)	(30.9%)	Purchase services	268,594	183,853	(84,741)	(46.1%)
166,102	162,934	(3,168)	(1.9%)	Depreciation & amortization	1,304,337	1,303,476	(861)	(0.1%)
15,816	15,917	101	0.6%	Insurance expense	126,527	127,334	807	0.6%
88,477	173,136	84,659	48.9%	Repair and maintenance	783,162	1,385,088	601,926	43.5%
26,560	1,635	(24,925)	(1524.5%)	Other Operating Expense	360,107	13,080	(347,027)	(2653.1%)
(327,029)	(376,604)	(49,575)	(13.2%)	Indirect allocation, Occupancy	(2,842,726)	(3,012,831)	(170,105)	(5.6%)
0	**-**	**(0)**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
(0)	**-**	**(0)**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

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OTHER STATEMENTS– FEBRUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $301.5 thousand, $290.3 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $476.1 thousand, $451.2 thousand favorable to budget

CalOptima
Balance Sheet
February 28, 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$254,989,251	Accounts Payable	$28,207,047
Investments	489,775,756	Medical Claims liability	751,085,844
Capitation receivable	445,247,613	Accrued Payroll Liabilities	11,946,403
Receivables - Other	23,017,885	Deferred Revenue	53,194,800
Prepaid expenses	6,802,558	Deferred Lease Obligations	69,947
		Capitation and Withholds	80,436,376
Total Current Assets	**1,219,833,063**	**Total Current Liabilities**	**924,940,416**
Capital Assets			
Furniture & Equipment	38,297,211		
Building/Leasehold Improvements	5,721,219		
505 City Parkway West	50,260,097		
	94,278,527		
Less: accumulated depreciation	(46,108,158)		
Capital assets, net	48,170,369	Other (than pensions) post employment benefits liability	25,547,203
Other Assets		Net Pension Liabilities	25,305,373
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	27,874,816	**TOTAL LIABILITIES**	**975,792,993**
Long-term Investments	521,739,666		
Total Board-designated Assets	549,614,481	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	549,914,481		
TOTAL ASSETS	**1,817,917,913**	TNE	81,928,057
		Funds in Excess of TNE	768,000,533
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	849,928,590
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,829,050,963**	**TOTAL LIABILITIES & FUND BALANCES**	**1,829,050,963**

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CalOptima
Board Designated Reserve and TNE Analysis
as of February 28, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	150,338,977				
	Tier 1 - Logan Circle	150,182,421				
	Tier 1 - Wells Capital	149,707,190				
Board-designated Reserve		450,228,589	314,171,327	483,928,207	136,057,261	(33,699,618)
TNE Requirement	Tier 2 - Logan Circle	99,385,893	81,928,057	81,928,057	17,457,836	17,457,836
	Consolidated:	**549,614,481**	**396,099,385**	**565,856,264**	**153,515,097**	**(16,241,782)**
	Current reserve level	*1.94*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
February 28, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	25,354,755	88,297,023
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	862,133	4,819,012
Changes in assets and liabilities:		
Prepaid expenses and other	25,122	(505,211)
Catastrophic reserves		
Capitation receivable	(116,872,435)	(147,114,482)
Medical claims liability	37,628,847	(81,533,769)
Deferred revenue	(32,357,375)	(60,508,150)
Payable to providers	(42,467,677)	(16,012,515)
Accounts payable	12,188,629	21,496,358
Other accrued liabilities	421,264	1,035,887
Net cash provided by/(used in) operating activities	(115,216,736)	(190,025,847)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(93,174,249)	90,523,192
Change in Property and Equipment	(327,564)	(2,231,131)
Change in Board designated reserves	(1,028,893)	(11,366,809)
Net cash provided by/(used in) investing activities	(94,530,706)	76,925,252
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(209,747,442)	(113,100,596)
CASH AND CASH EQUIVALENTS, beginning of period	464,736,693	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**254,989,251**	**254,989,251**

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BALANCE SHEET:

ASSETS increased $0.8 million from January

- **Capitation Receivables** increased $115.3 million or 35.0% due to timing of Department of Healthcare Services (DHCS) capitation payments and periodic retro payments or takebacks
- **Investments** increased $93.2 million or 23.5% due to transfer timing requirements for operating cash funding, along with variability of market gains and interest earnings
- **Operating Cash** decreased by $209.7 million or 45.1% for retro state dual member DHCS recoupments and the variability of transfers to investments for operating cut-off date requirements

LIABILITIES decreased $24.6 million from January or 2.5%

- **Capitation and Withholds** decreased $42.5 million due to February shared risk pool payment
- **Claims Liability** increased $37.6 million due to an increase in service-related reserves
- **Deferred Revenue** decreased $32.4 million due to release of prior year deferred revenue
- **Accounts Payable** increased $11.7 million due to the quarterly Managed Care Organization (MCO) tax liability

NET ASSETS are $849.9 million, an increase by February net change of $25.4 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 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	49,474	49,474	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	23,878	23,878	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	7,334	1,838,718	1,831,384	99.6%
917	239,009	238,092	99.6%	**Total Operating Expenditures**	7,334	1,912,070	1,904,736	99.6%
21,170	0	21,170	0.0%	**Investment Income**	21,475	0	21,475	0.0%
20,253	**(239,009)**	**259,261**	**108.5%**	**Program Income**	**14,141**	**(1,912,070)**	**1,926,211**	**100.7%**

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CalOptima Foundation
Balance Sheet
February 28, 2019

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,864,614	Accounts payable-Current	7,334
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,864,614**	Grants-Foundation	0
		Total Current Liabilities	**7,334**
		Total Liabilities	**7,334**
		Net Assets	**2,857,280**
TOTAL ASSETS	**2,864,614**	**TOTAL LIABILITIES & NET ASSETS**	**2,864,614**

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CalOptima Foundation- Consolidated
Narrative Explanations for Budget Variances
February 28, 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 $917 for February and $7,334 YTD for audit fees.
Major Actual to Budget variance was in "Other" category - $228,923 for February and $1,831,384 favorable variance YTD

Investment Income
$21.2 thousand received in investment income

Balance Sheet:
Assets
Cash - $2.9 million remains from the FY14 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

Liabilities
Accounts Payable - $7,334 YTD for audit fees

Budget Allocation Changes
Reporting Changes for February 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	Reallocate $60,000 from Office 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
February	No Reported Changes					

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
April 4, 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

- CY 2018 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 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 (4) appeals measures.

  On March 4, 2019, CMS notified CalOptima of its participation in the Timeliness Monitoring Project. CMS has scheduled the ODAG and CDAG validation webinars for April 2, 2019 and April 9, 2019, respectively.

- 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. On February 28, 2019, the CMS submission window opened and CalOptima was notified that only one (1) enrollee with six (6) hierarchical condition categories (HCCs) was selected for validation. The deadline for submission of medical records for the selected enrollee is June 20, 2019.

- 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. On February 4, 2019, CMS requested that CalOptima upload its provider and facility network for an informal review. CalOptima will have between February and May 2019 to remediate any deficiencies before the formal

submission is due in June 2019. In June 2019, CalOptima will receive instructions on how to upload the entire network for its OneCare program for CMS to begin the formal review.

- Medicare Data Validation Audit (OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. In preparation for the audit, CalOptima has collected the required Parts C and D reporting data and worked with all impacted business areas to ensure the accuracy of the data prior to submission in February 2019. The validation audit is expected to take place starting in March and conclude in June 2019. The audit includes an onsite audit and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medication Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review Controls

- CY 2014 Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit:

  On February 26, 2019, CMS notified CalOptima of its selection to participate in the CY 2014 Contract-Level Risk Adjustment Data Validation (RADV) audit. CMS will be conducting a medical records review to validate the accuracy of the CY 2014 Medicare Part C risk adjustment data and payments.

- CMS Program Audit Readiness (OneCare and OneCare Connect):

  CalOptima anticipates receiving an audit engagement letter from CMS for its OneCare and OneCare Connect programs as early as March of 2019. If engaged for this audit, CMS will be performing a full-scale program audit using the Medicare Parts C and D Audit Protocols and the Program Audit Protocols for Medicare-Medicaid Plans (MMPs). In preparation, the Office of Compliance has created a workplan outlining audit activities, deliverables and responsible parties. CMS indicates that it will be sending scheduled program audit engagement letters to selected plans from March through July 2019.

2. OneCare Connect

- CY 2017 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 prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2017 payments. On January 31, 2019, CMS hosted the first training teleconference in preparation for the validation audit, with a

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second teleconference to occur in March 2019. CalOptima has begun to gather the supporting documentation for this audit. All documentation must be submitted by the final deadline of 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.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of February 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
October 2018	90%	93%	100%	100%
November 2018	97%	100%	100%	100%
December 2018	100%	100%	97%	100%

➢ No significant trends to report.

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- 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
October 2018	98%	98%	100%	100%	100%
November 2018	100%	83%	100%	100%	100%
December 2018	100%	80%	100%	100%	95%

  - The lower compliance score of 80% for resolution of PDRs for December 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, 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
October 2018	100%	100%	100%	100%	100%	100%	100%
November 2018	100%*	100%*	100%*	100%*	100%*	100%*	100%*
December 2018	100%	100%	100%	100%	100%	100%	100%

  - No significant trends to report.

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➢

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2018	100%	100%	100%	100%
November 2018	100%	100%	100%	90%
December 2018	100%	90%	100%	100%

➢ The lower compliance score of 90% for paid claims accuracy for December 2018 was due to one (1) misclassified claim.

➢ 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, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
October 2018	100%	100%	100%
November 2018	Nothing to Report	Nothing to Report	Nothing to Report
December 2018	Nothing to Report	Nothing to Report	Nothing to Report

➢ No significant trends to report.

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3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2018	90%	90%	100%	100%
November 2018	100%	100%	100%	100%
December 2018	100%	100%	100%	100%

  - ➢ No significant trends to report.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy	Check Lag
October 2018	100%	67%	100%	N/A
November 2018	100%	100%	100%	N/A
December 2018	100%	67%	100%	N/A

  - ➢ The lower compliance score of 67% for timeliness of PDRs for December 2018 was due to one (1) PDR not processed within thirty (30) days of the PDR received date.

  - ➢ 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, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of PDRs within regulatory requirements.

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4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
October 2018	100%	100%	100%	100%
November 2018	100%	100%	100%	100%
December 2018	100%	100%	100%	100%

➢ No significant trends to report.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
October 2018	100%	100%	100%	N/A
November 2018	100%	100%	100%	N/A
December 2018	100%	100%	100%	N/A

➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

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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
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%
December 2018	71%	78%	87%	81%	64%	88%	91%	56%	91%	87%	38%	35%	53%

- 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 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:
  - 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 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 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

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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 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
October 2018	100%	83%	97%	93%
November 2018	100%	87%	100%	91%
December 2018	100%	86%	99%	77%

- The compliance rate for paid claims accuracy decreased from 87% in November 2018 to 86% in December 2018 due to missing documents that are required for processing accurate payment on claims.

- The compliance rate for denied claims timeliness decreased from 100% in November 2018 to 99% in December 2018 due to untimely processing of multiple claims.

- The compliance rate for denied claims accuracy decreased from 91% in November 2018 to 77% in December 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.

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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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
October 2018	90%	100%	95%	100%	83%	100%	89%	93%
November 2018	93%	67%	91%	100%	98%	100%	75%	89%
December 2018	93%	100%	87%	90%	91%	100%	84%	92%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for member notification
  - Failure to meet timeframe for provider notification

- The lower letter scores were due to the following reasons:
  - Failure to use approved CMS template
  - Failure to use CalOptima logo
  - Failure to provide letter with description of services 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
October 2018	89%	100%	97%	100%
November 2018	89%	100%	100%	94%
December 2018	92%	85%	100%	89%

- The compliance rate for paid claims accuracy decreased from 100% in November 2018 to 85% in December 2018 due to missing documents that are required for processing accurate payment on claims.

- The compliance rate for denied claims accuracy decreased from 94% in November 2018 to 89% in December 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
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%
December 2018	83%	79%	84%	84%	88%	44%	57%	58%	68%	89%	78%

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- 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 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 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 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
  - 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
  - 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.

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

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2018	82%	96%	95%	98%
November 2018	81%	96%	98%	90%
December 2018	87%	93%	100%	94%

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- The compliance rate for paid claims accuracy decreased from 96% in November 2018 to 93% in December 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.

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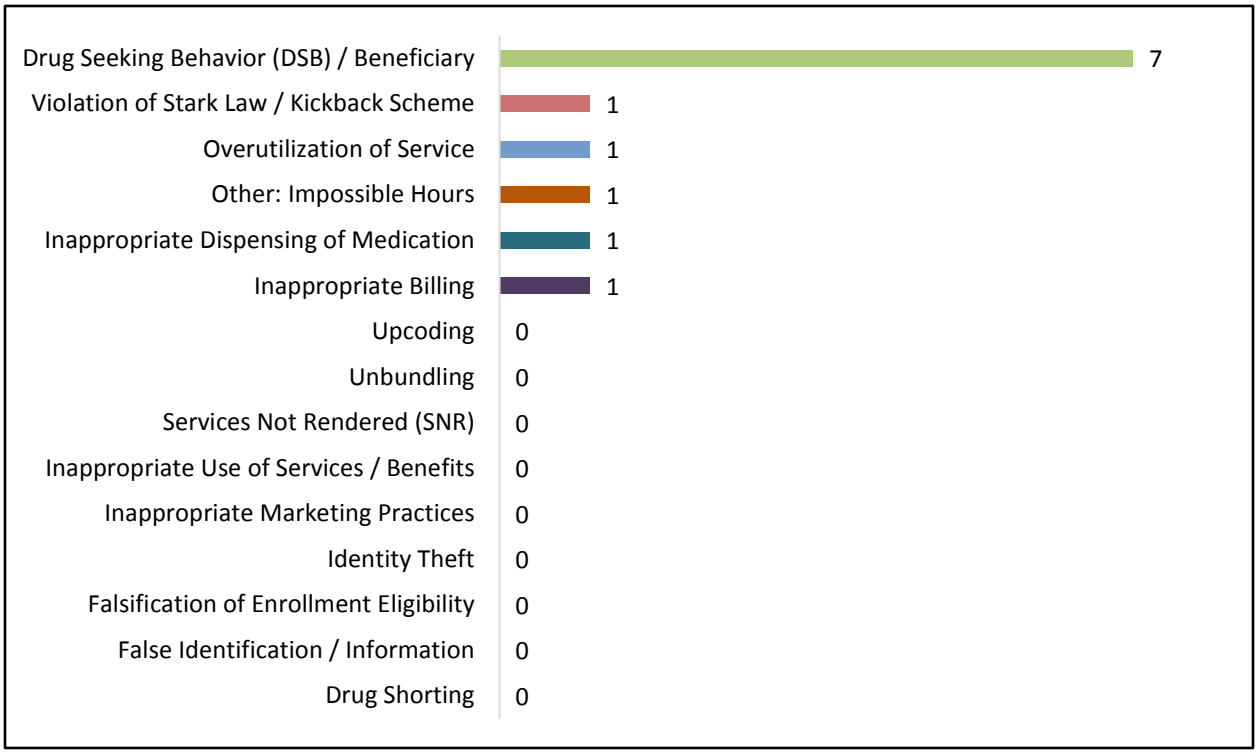
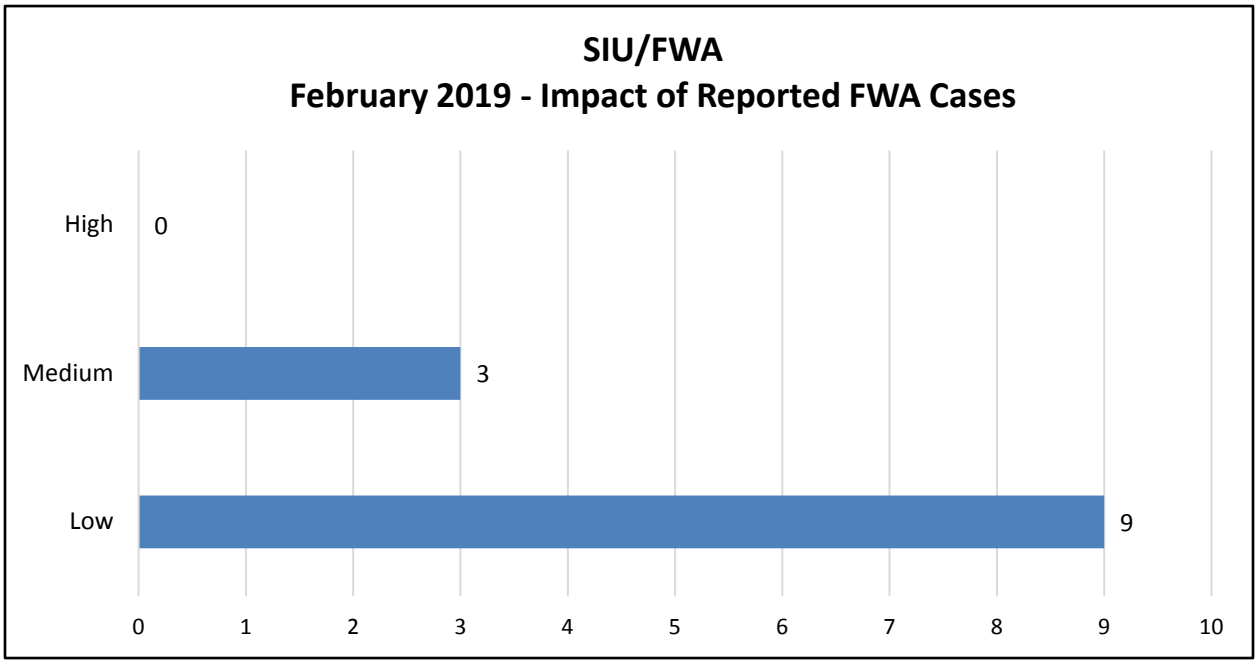
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in February 2019)





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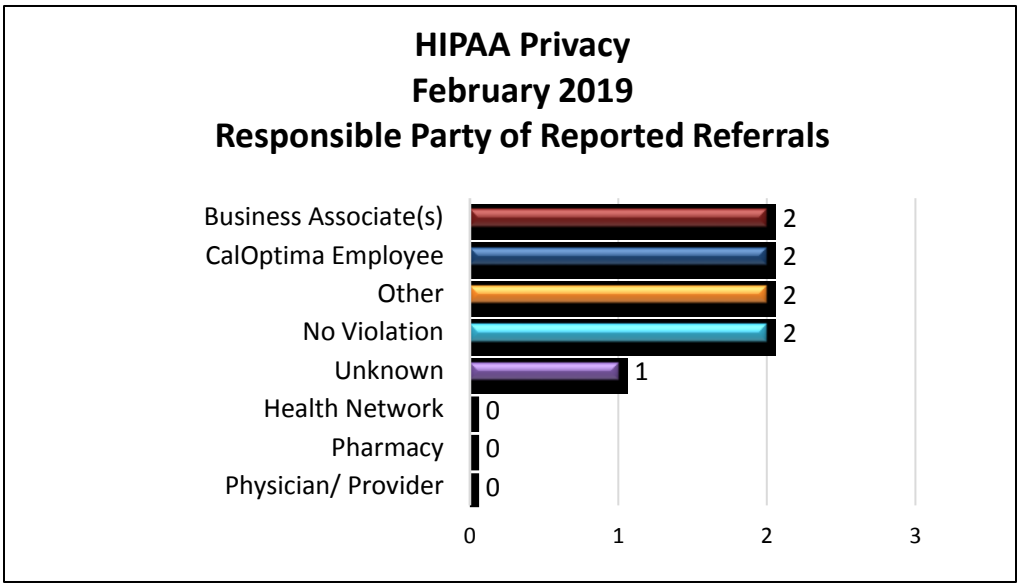
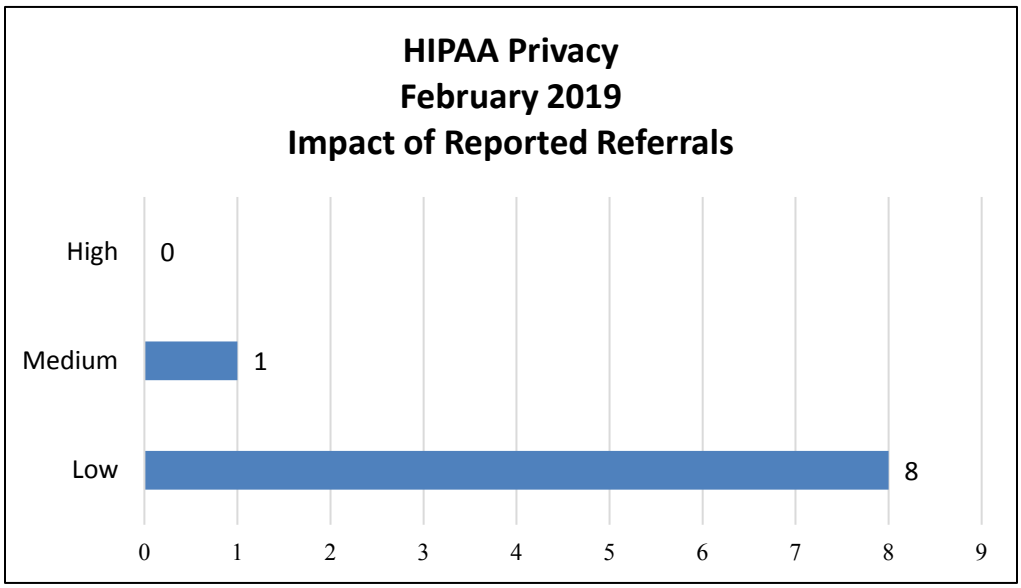
E. Privacy Update (February 2019)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1
Total Number of Referrals Reported	**9**

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Federal & State Legislative Advocate Reports

Board of Directors Meeting

April 4, 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

March 15, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: March Board of Directors Report

The Fiscal Year (FY) 2020 appropriations cycle kicked off this week with the release of the President's Budget request, featuring an array of proposals to overhaul Medicaid and tight topline spending figures that could complicate this year's funding fight in Congress. Meanwhile, House and Senate committees have continued their sharp focus on prescription drug pricing issues. This report provides an update on legislative activities through March 14, 2019.

President's FY 2020 Budget Request

On March 11, the Office of Management and Budget (OMB) released President Trump's FY 2020 Budget overview. Full budget details – including a complete request for the Department of Health and Human Services (HHS) – are expected the week of March 18.

As expected, the President's $4.7 trillion plan proposes to balance the budget in 15 years by cutting domestic spending by five percent compared to FY 2019 estimated levels. The Budget requests $87.1 billion in discretionary funding for HHS in FY 2020, a 12.1-percent decrease from FY 2019. The National Institutes of Health (NIH) is among those HHS divisions hit hardest by the cuts, with the budget proposing a nearly 12-percent cut to discretionary funding. The Food and Drug Administration (FDA) would receive a funding boost of $643 million, including a new fee on e-cigarette manufacturers. The HHS Budget also allocates more than $290 million for a new initiative to end HIV transmission in the United States.

Notably, the President's Budget proposes dramatic cuts of nearly $1.5 trillion to Medicaid over the next decade. Much of these savings stem from a proposal to move away from the Affordable Care Act (ACA), replacing the law's Medicaid expansion and premium tax credits with "Market Based Health Care Grants." In Medicaid, states would be given the option between a per capita cap and a block grant. Growth rates for the Market Based Health Care Grant Program and Medicaid per capita cap and block grant would be tied to the Consumer Price Index for All Urban Consumers (CPI-U). The Budget also proposes uniform work requirements for all federally funded public assistance programs, including Medicaid and Temporary Assistance for Needy Families (TANF), a change the White House estimates would save $130 billion over ten years. Additionally, the Budget would allow states to conduct more frequent Medicaid eligibility

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redeterminations and permit states to apply asset tests to "able-bodied adults" as determined by the Modified Adjusted Gross Income (MAGI) standard.

Democrats were quick to condemn the President's Budget, with House Speaker Nancy Pelosi (D-CA) calling it "cruel and shortsighted." House Democrats plan to unveil their draft budget this month, though Leadership may avoid a floor vote that could highlight intraparty divisions over Medicare for All and the Green New Deal.

Meanwhile, Congressional Leaders are working on a bipartisan, bicameral basis to reach agreement on a two-year budget deal that would increase discretionary spending caps. Any increases are expected to be modest and in line with inflation at approximately two percent. Absent a budget deal, discretionary spending caps will go into effect at the start of FY 2020, resulting in $126 billion in cuts. President Trump's budget rejects the idea of increasing the spending caps. The Administration's position limits the possibility of a budget deal and suggests potential trouble in advancing FY 2020 appropriations bills.

Drug Pricing

Committees continued their focus on consumer health care costs over the past month, holding additional hearings on prescription drug pricing. A February 12 House Ways and Means Committee hearing struck 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. On February 26, seven major pharmaceutical executives testified before the Senate Finance Committee. Apart from a fiery opening statement by Ranking Member Ron Wyden (D-OR), however, there were few fireworks at the hearing. Notably, most of the drug makers on the panel expressed support for some version of the CREATES Act (S. 340/H.R. 965), which is designed to prohibit brand drug makers from blocking generic manufacturers' access to samples.

The CREATES Act and six other bills related to generic competition were examined during a March 13 legislative hearing of the House Energy and Commerce Committee Health Subcommittee. Democrats and Republicans were in broad agreement about the need to get more generics and biosimilars on the market, though some Members raised concerns about altering the 180-day exclusivity period for first filer generics.

The House Ways and Means Committee Health Subcommittee held a hearing on March 7 on Medicare drug spending. The hearing focused heavily on Subcommittee Chairman Lloyd Doggett's (D-TX) bill, the Medicare Negotiation and Competitive Licensing Act (H.R. 1046).

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The legislation would allow Medicare to negotiate prices directly with drug makers and, if the manufacturer does not come to an agreement on reasonable price, would also allow HHS to issue a competitive license for the product. Republican lawmakers criticized the proposal as allowing government "theft" of intellectual property.

The Ways and Means Committee is expected to hold a markup of drug pricing legislation in April.

Other Health Care Legislation

On February 27, Democrats unveiled the Medicare for All Act of 2019 (H.R. 1384). Introduced by Rep. Pramila Jayapal (D-WA-07), co-chair of the Congressional Progressive Caucus, the bill would move the health care system to a single-payer model that would provide universal coverage within two years. More moderate Democrats, meanwhile, are backing a proposal (S. 470) from Sen. Debbie Stabenow (D-MI) that would allow Americans age 50 to 64 to buy into Medicare. The House Rules and Budget committees are expected to hold hearings on Medicare for All proposals this month, but other panels – such as the Energy and Commerce Committee and the Ways and Means Committee – have yet to commit to hold hearings on the issue.

On February 14, Reps. Kathy Castor (D-FL), Gus Bilirakis (R-FL), Anna Eshoo (D-CA), and Jaime Herrera Beutler (R-WA) reintroduced the Advancing Care for Exceptional (ACE) Kids Act (H.R. 1226). The legislation was passed in the House last year as part of a Medicaid package but was not taken up by the Senate before the end of the 115th Congress.

CalOptima Congressional Meetings

Akin Gump recently secured meetings with CalOptima's entire Congressional delegation for its leadership visit to Washington, D.C. Michael Schrader, Chief Executive Officer, and Arif Shaikh, Director of Public Policy and Government Affairs, met with the House and Senate Orange County representatives to educate Congress on CalOptima's successful model and three key health initiatives for 2019: children's health, mental health, and homelessness. The meetings also conveyed to Members of Congress and staff that CalOptima has been recognized as the top Medi-Cal plan in California by the National Committee for Quality Assurance (NCQA) for the fifth consecutive year.

On March 12, Michael and Arif met with the staff from the offices of Sen. Kamala Harris (D-CA) and Dianne Feinstein (D-CA). Sen. Feinstein's health staffer was especially interested in CalOptima's work to address homelessness.

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Michael and Arif had meetings with CalOptima's U.S. House delegation on March 13, including several new Members of Congress elected in November 2018. The group met with new Rep. Mike Levin (D-CA-49) to educate him on the CalOptima model. Rep. Levin's district is home to 21,822 CalOptima members. Michael and Arif met with new Rep. Katie Porter (D-CA-45), whose district contains 125,179 plan members. Rep. Lou Correa (D-CA-46) stepped out of a hearing to meet with the group, where they discussed CalOptima's efforts to deliver care to homeless populations. Rep. Correa's district is home to 270,526 CalOptima members. Michael and Arif had a positive meeting with the district director in new Rep. Gil Cisneros' (D-CA-39) office, who sought to build a long-term relationship with CalOptima leadership. California's 39th Congressional District contains 106,141 CalOptima members. The group provided an update on CalOptima to Rep. Alan Lowenthal (D-CA-47), including initiatives on homelessness and mental health care. Rep. Lowenthal's district is home to 101,531 members. Finally, Michael and Arif met with the chief of staff for Rep. Linda Sanchez (D-CA-38) to refresh the office on CalOptima's model and policy priorities. The 38th Congressional District is home to 2,594 CalOptima members.

In addition, CalOptima met with Rep. Harley Rouda (D-CA-48) last month to discuss the company's mission and policy priorities.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

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

CALOPTIMA LEGISLATIVE REPORT

By Don Gilbert and Trent Smith
March 11, 2019

The deadline to introduce new bills was February 22. Legislators introduced over 2,500 bills. This is approximately 1,000 bills more than average. Many of the newly introduced bills are "intent" or "spot" bills that can be amended at a later date to include more specific and detailed changes in law. Some of these bills will never be amended, but we must watch all of the health-related spot bills to make sure they are not amended to include language that is of concern to CalOptima.

Below is a brief summary of some of the bills that we are monitoring closely for CalOptima.

AB 4 (Arambula) – This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status. The Governor has proposed a scaled down and less expensive version of this proposal as part of his State Budget proposal. The Governor's plans extend Medi-Cal benefits to undocumented immigrants between the ages of 19-26.

AB 166 (Gabriel) – This bill makes violence preventive services provided by a qualified violence prevention professional a covered Medi-Cal benefit.

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AB 515 (Mathis) – This bill would prohibit DHCS from assessing or collecting interest on the recovery of an overpayment from a federally qualified health center or a rural health clinic located in a medically underserved area.

AB 537 (Arambula) – This bill would require DHCS to establish both a quality assessment and performance improvement program and a value-based financial incentive program to ensure that a Med-Cal managed care plan achieves a Minimum Performance Level (MPL)

AB 577 (Eggman) – Under existing law, an individual is eligible for Medi-Cal benefits for pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy. This bill would extend Medi-Cal postpartum care for up to one year beginning on the last day of the pregnancy for an eligible individual diagnosed with a maternal mental health condition.

AB 678 (Flora) – This measure would restore podiatric services as a covered Medi-Cal benefit as of January 1, 2020.

AB 781 (Maienschein) – This bill would specify that pediatric day healthcare services may be provided at any time of the day and on any day of the week, so long as the total number of authorized hours is not exceeded.

AB 848 (Gray) – This bill would add continuous glucose monitors and related supplies required for use with those monitors to the schedule of benefits under the Medi-Cal program for the treatment of diabetes mellitus when medically necessary, subject to utilization controls.

AB 977 (Stone) – This bill would declare the intent of the Legislature to enact legislation to ensure that children enrolled in the Medi-Cal program receive timely access to care and preventative care services, based upon the findings of the California State Auditor.

AB 990 (Gallagher) – Existing law authorizes a Medi-Cal managed care contractor to offer nonmonetary incentives to promote good health practices by its Medi-Cal enrollees. This bill would express the intent of the Legislature to enact legislation that would require Medi-Cal managed care plans to offer financial incentives to enrollees for their improved wellness activities.

AB 1058 (Salas) – This bill would declare the intent of the Legislature to enact legislation to establish a pilot program in several counties to support the integration of specialty mental health services and substance use disorder treatment provided under the Medi-Cal program.

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AB 1088 (Wood) – This bill would provide that an aged, blind, or disabled individual who would otherwise be eligible for Medi-Cal benefits would be eligible for Medi-Cal without a share of cost if their income and resources otherwise meet eligibility requirements. The bill would authorize DHCS to implement this provision by provider bulletins or similar instructions until regulations are adopted.

AB 1494 (Aguiar-Curry) – This bill would make telehealth services, telephonic services, and other specified services reimbursable under the Medi-Cal program when provided by a community clinic during or immediately following a State of Emergency.

SB 66 (Atkins) – This bill would authorize reimbursement for a maximum of two visits taking place at a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit.

SB 175 (Pan) – This bill is similar to AB 414 in that it requires a California resident and their dependents to maintain a minimum level of essential health coverage. Like AB 414, the bill would impose a penalty for the failure to maintain minimum essential coverage.

SB 207 (Hurtado) – This bill would include asthma preventive services as a covered Medi-Cal benefit.

SB 446 (Stone) – This bill would make hypertension medication management services a covered pharmacist service under the Medi-Cal program.

Finally, we want to highlight SB 714 (Umberg). This measure is a spot bill, but will soon be amended to address recently adopted regulations at the Department of Managed Health Care (DMHC). The amendments, drafted by the California Hospital Association (CHA), will clarify that low-risk financial arrangements between health care providers, health plans, and employers are exempt for the DMHC licensing requirements, and create a clear process to receive an exemption.

CalOptima was instrumental in getting Senator Umberg to introduce SB 714. While the new DMHC regulations may not directly impact CalOptima, these regulations could require some of CalOptima's health care providers to obtain new licenses. Shortly after a presentation at one of CalOptima's board meetings where providers shared their concerns with the DMHC proposed regulations, Michael Schrader visited Sacramento. Our firm arranged meetings with several Orange County legislators, including Senator

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Umberg. Mr. Schrader shared how important providing some clarification to the DMHC regulations is for CalOptima's health care provider partners. We believe CalOptima's support was a key factor in Senator Umberg introducing SB 714. CalOptima will support SB 714 and our firm will work with others in the health care provider community lobbying for the passage of SB 714.

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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

2019 Federal Legislative Dates

January 3	116th Congress convenes 1st session
April 15–26	Spring recess
July 29–September 6	Summer recess
September 30–October 11	Fall recess

2019 State Legislative Dates

January 7	Legislature reconvenes
February 22	Last day for legislation to be introduced
April 26	Last day for policy committees to hear and report bills to fiscal committees
May 3	Last day for policy committees to hear and report non-fiscal bills to the floor
May 17	Last day for fiscal committees to report fiscal bills to the floor
May 28–31	Floor session only
May 31	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 12–August 9	Summer recess
August 30	Last day for fiscal committees to report bills to the floor
September 3–13	Floor session only
September 13	Last day for bills to be passed. Final recess begins upon adjournment
October 13	Last day for Governor to sign or veto bills passed by the Legislature
December 2	Convening of the 2020–21 session

Sources: 2019 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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
April 4, 2019

CalOptima Community Outreach Summary – March 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

February 5, 2019 was the beginning of a week-long celebration of the Lunar New Year. According to the lunar calendar and Chinese zodiac, 2019 celebrates the year of the Earth Pig. The Lunar New Year is an important holiday for many Asian communities including the Chinese, Korean and Vietnamese cultures. The holiday is celebrated with bright red and gold decorations, lighting of firecrackers, the lion and dragon dance, the giving of gifts and red envelopes, and eating traditional foods at family gatherings.

In celebration of the Lunar New Year, Community Relations collaborated with various internal departments to host resource tables at two Tet festivals. The events were hosted at the OC Fairground and Event Center in Costa Mesa and Mile Square Park in Fountain Valley. Both events started on Friday, February 8, and ended on Sunday, February 10, 2019.

Staff had an opportunity to engage with our Vietnamese-speaking members, who comprise approximately 12 percent of CalOptima's membership. Staff shared information about CalOptima's programs and services, answered questions and shared fliers about services available to support our members' health care needs. Hundreds of attendees patiently waited in line to test their luck by spinning a prize wheel for CalOptima-branded promotional items. Senior Community Relations Specialist Lisa Nguyen provided a CalOptima

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presentation, highlighting our OneCare Connect program at Mile Square Park's Freedom Hall on Sunday, February 10, 2019.

Community Relations thanks the following departments for making these events a success: Customer Service, Member Liaison, MSSP, Strategic Development, Long-Term Care, Cultural and Linguistics, PACE, Case Management and GARS.

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 March 2019, CalOptima participated in 38 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
3/01/19	• 18th Annual Health Care Symposium hosted by Coalition of Orange County Community Health Centers (Sponsorship Fee: $500 included two staff to attend the symposium) • Orange County Hispanic Chamber of Commerce Meeting
3/04/19	• Orange County Health Care Agency Mental Health Services Act Steering Committee
3/06/19	• Orange County Strategic Plan for Aging Leadership Council Meeting
3/08/19	• Senior Citizens Advisory Council General Board Meeting • Orange County Diabetes Collaborative Meeting
3/11/19	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
3/12/19	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting
3/13/19	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting • Orange County Communications Workgroup
3/14/19	• FOCUS Collaborative Meeting • Kid Healthy Community Advisory Committee Meeting • Orange County Women's Health Project Advisory Meeting • State Council on Developmental Disabilities Regional Advisory Committee Meeting
3/19/19	• Unidos Contra el Cancer Meeting
3/20/19	• Vietnamese-American Human Services Providers Quarterly Networking Luncheon Meeting • Covered Orange County Steering Committee Meeting

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	• Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Community Collaborative Meeting • Orange County Communication Workgroup
3/21/19	• Orange County Children's Partnership Committee Meeting
3/25/19	• Oral Health Collaborative Meeting • Stanton Collaborative Meeting
3/26/19	• Orange County Senior Roundtable
3/27/19	• Disability Coalition of Orange County Meeting
3/28/19	• Orange County Care Coordination for Kids Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
3/02/19	4	• Orange County Asian and Pacific Islander Youth and Family Mental Health Summit hosted by St. Joseph Health
3/03/19	1	• Winter Health Fair hosted by UCLA Vietnamese Community Health
3/07/19	2	• Spirituality Conference hosted by Alzheimer's Family Center (Sponsorship Fee: $750 included one resource table at the event and two staff to attend the conference)
3/09/19	2	• Wellness Fair hosted by Placentia-Yorba Linda Unified School District
3/10/19	0	• 2019 Health Summit hosted by Family Voices of California (Sponsorship Fee: $2,500 included verbal recognition at the summit, logo on summit materials, inclusion in social media marketing and attendee packets and summit attendance for two representatives)
3/11/19	1	• Roadmap to Success hosted by Garden Grove Unified School District
3/13/19	1	• Knowledge and Health Fair Expo hosted by City of Costa Mesa (Registration Fee: $350 included one resource table at event)
	1	• Community Expo hosted by Garden Grove Unified School District
3/24/19	2	• Nowruz 2019 Persian New Year Celebration hosted by Iranian American Community Group (Sponsorship Fee: $2,000 included one resource table, company's name and logo on recognized banner and event program, announcement of sponsorship on stage and invitation to VIP tent at event)

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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:

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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.

April

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Monday, 4/1 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

Wednesday, 4/3 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 4/3 10am-12pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Family Justice Center 150 W. Vermont Anaheim
Wednesday, 4/3 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 4/3 3-5:30pm	*Health Education Workshop Shape Your Life	Open to the Public *Registration required.*	N/A	Boys and Girls Club of Garden Grove 10861 Acacia Pkwy Garden Grove
Thursday, 4/4 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Friday, 4/5 1-4pm	++Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Monday, 4/8 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, 4/8 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 4/9 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, 4/10 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 4/10 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim

+ Exhibitor/Attendee
++ Meeting Attendee

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Wednesday, 4/10 1:30-3:30pm	++State Council on Developmental Disabilities Health Care Task Force Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Wednesday, 4/10 3:30-4:30pm	++OC Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Wednesday, 4/10 3-5:30pm	*Health Education Workshop Shape Your Life	Open to the Public *Registration required.*	N/A	Boys and Girls Club of Garden Grove 10861 Acacia Pkwy Garden Grove
Thursday, 4/11 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Thursday, 4/11 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, 4/11 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, 4/11 4-6pm	+Clinic in the Park Health Fair	Health/Resource Fair Open to the public	1 Staff	Danbrook Elementary School 320 S. Danbrook Dr. Anaheim
Friday, 4/12 9:30-11:30am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Saturday, 4/13 9am-3pm	+City of Westminster Spring Festival	Health/Resource Fair Open to the public	1 Staff	Westminster Civic Center 8200 Westminster Blvd. Westminster
Tuesday, 4/16 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave.

				Placentia
Tuesday, 4/16 10-11:30am	++OC Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Cancer Society 1940 E. Deere Ave. Santa Ana
Wednesday, 4/17 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, 4/17 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 4/17 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
Wednesday, 4/17 3-5:30pm	*Health Education Workshop Shape Your Life	Open to the Public *Registration required.*	N/A	Boys and Girls Club of Garden Grove 10861 Acacia Pkwy Garden Grove
Thursday, 4/18 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
Thursday, 4/18 1-2:30pm	++Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center in Central Park 18041 Goldenwest St. Huntington Beach
Saturday, 4/20 8am-12pm	+Spring Family Eggstravaganza and Family Health Fair	Health/Resource Fair Open to the public	2 Staff	La Bonita Park 1440 Whittier Blvd. La Habra
Saturday, 4/20 9am-12pm	+City of Stanton Easter Egg Hunt and Resource Fair	Health/Resource Fair Open to the public	2 Staff	Stanton Central Park 10660 Western Ave. Stanton

Monday, 4/22 9-11am	++Community Health Research and Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Tuesday, 4/23 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Wednesday, 4/24 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
Wednesday, 4/24 3-5:30pm	*Health Education Workshop Shape Your Life	Open to the Public *Registration required.*	N/A	Boys and Girls Club of Garden Grove 10861 Acacia Pkwy Garden Grove
Thursday, 4/25 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
Saturday, 4/27 9am-2pm	+Cal State Fullerton Center for Healthy Neighborhoods Clinic in the Park	Health/Resource Fair Open to the public	2 Staff	CSUF Center for Healthy Neighborhoods 320 W. Elm Ave. Fullerton
Saturday, 4/27 10am-1pm	+Families Forward Annual Community Resource Fair	Health/Resource Fair Open to the public	2 Staff	Irvine Valley College 5500 Irvine Center Dr. Irvine