

**NOTICE OF A
SPECIAL MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS**

REVISED AGENDA

**THURSDAY, JUNE 27, 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
Michael Schrader

CHIEF COUNSEL
Gary Crockett

**INTERIM
CLERK OF THE BOARD**
Sharon Dwiers

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. [Chief Executive Officer Report](#)
 - Homeless Health Initiative
 - CalOptima Website Redesign

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 June 6, 2019 Regular Meeting of the CalOptima Board of Directors
3. [Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network](#)
4. [Consider Ratification of Amendment to CHOC Physicians Network Medi-Cal Health Network Contract](#)
5. [Consider Reappointment to the CalOptima Board of Directors' Investment Advisory Committee](#)

REPORTS

6. [Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts, Except Those Associated with St. Joseph Health and the University of California, Irvine](#)
7. [Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts Associated with the University of California, Irvine](#)
8. [Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts Associated with St. Joseph Health](#)
9. [Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with the University of California, Irvine](#)
10. [Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Hospital Contracts Except Those Associated with Kindred Healthcare](#)

11. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Hospital Contracts Associated with Kindred Healthcare
12. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts, Except Those Associated with St. Joseph Health, Children’s Hospital of Orange County and the University of California, Irvine
13. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts, Associated with the University of California, Irvine
14. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts Associated with St. Joseph Health
15. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts Associated with Children’s Hospital of Orange County
16. Consider Authorizing Amended and Restated Medi-Cal Shared Risk Group Health Network Contract for AltaMed Health Services Corporation, ARTA Western California, Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group, Inc., and United Care Medical Group, Inc.
17. Consider Authorizing Amended and Restated Medi-Cal Physician Hospital Consortium Health Network Contract for CHOC Physicians Network and Children's Hospital of Orange County
- S17a. Consider Funding Allocations Related to Supervisor Do’s Homeless Healthcare Proposal

INFORMATION ITEMS

18. Consider Homeless Health Initiatives and Next Steps

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

MEMORANDUM

DATE: June 27, 2019

TO: CalOptima Board of Directors

FROM: Michael Schrader, CEO

SUBJECT: CEO Report

COPY: Sharon Dwiers, Interim Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiative Making Progress Through Collaborative Efforts

CalOptima's \$100 million commitment to homeless health remains a priority initiative, with several actions this month designed to enhance access to services and collaboration among engaged parties. Guided by your Board's ad hoc committee, which is meeting regularly to spearhead the effort, selected activities are summarized below.

- **Clinical Field Team Access:** CalOptima is now accepting referrals for clinical field team services from shelters and City Net. When representatives at these organizations identify an individual who is homeless and needs urgent care, they can use a special phone line to reach the CalOptima Homeless Response Team, which will then dispatch a clinical field team to provide care. Clinical field team services are available for eight hours a day, six days a week, in all parts of Orange County.
- **Clinical Field Team/Shelter Meeting:** Clinical field team representatives and shelter providers will gather on Friday, June 28, to discuss opportunities for collaboration. This meeting is designed to pave the way toward partnerships that enable clinical services to be offered at shelters on a regular schedule.
- **Community Alliances Forum:** On June 18, CalOptima hosted a well-attended Community Alliances Forum focused on homeless health and the 2019 OC Point in Time Count. I provided an update about CalOptima's work in homeless health care, followed by presentations by two Orange County leaders: Melissa Tober on the Whole-Person Care program and Susan Price on the Point in Time Count.
- **Stakeholder Outreach:** The Board ad hoc committee continues to engage with stakeholders to gain insights about the next steps in the initiative. The committee had a recent call with representatives from the San Bernardino County Whole-Person Care program. Additional stakeholder outreach activities are planned for July.
- **Tri Parish/Diocese Homeless Collaborative:** On June 18, CalOptima Chief Medical Officer David Ramirez, M.D., spoke to members of the Tri-Parish/Diocese Homeless Collaborative. The group includes Father Dennis Kriz, who has made many public comments about Orange County's homeless crisis. Dr. Ramirez provided a general update about our homeless health initiative. His presentation was well-received, and a few days later, Father Kriz wrote a complimentary editorial about CalOptima's effort to better serve the homeless population.
- **Medication-Assisted Treatment (MAT) Meeting:** On June 11, CalOptima and Orange County Health Care Agency representatives met to collaborate on the topic of MAT, which is a key component of the Drug Medi-Cal program and a leading response to the opioid epidemic.

MAT is also an important aspect of serving the homeless population, which has a higher incidence of substance use disorder. A separate Board ad hoc committee is considering expanding access to MAT through Intergovernmental Transfer funding.

- **Be Well OC:** CalOptima is committed to improved access to well-coordinated mental health care for individuals who are homeless through our investment in Be Well OC. A group of Orange County leaders, including CalOptima Board members and staff, recently traveled to Phoenix to visit two organizations considered to offer best-practice mental health crisis response systems. To guide the development of Be Well OC, the group learned about Arizona's Crisis Response Network, which offers centralized crisis response services via a single phone line, and about RI International, a provider of crisis stabilization services and respite beds.
- **Housing for a Healthy California:** As part of AB 74 passed in 2017, the Department of Housing and Community Development is authorized to boost the availability of supportive housing through the new Housing for a Healthy California program, with funding opportunities for developer and county applicants. The total available statewide is \$93 million, with no more than \$20 million per application. The target populations are Medi-Cal beneficiaries who are chronically homeless or homeless high-cost health users. The Orange County Health Care Agency, Orange County Community Resources and CalOptima are collaborating on the development of a supportive services plan, which is part of the application due August 13, 2019. The County agencies and CalOptima are also developing a related Memorandum of Understanding (MOU), and staff plans to request Board authority to enter into the MOU at your August meeting.

Upgraded CalOptima Website Features Streamlined Content, Responsive Design

On June 18, CalOptima proudly debuted our upgraded and updated CalOptima.org website. Communications and Information Services teams worked diligently and tested the new website thoroughly. Response from users of the new site has been overwhelmingly positive. Board Member Alexander Nguyen, M.D., shepherded this redesign, which makes the site more accessible on a wide range of devices, including smartphones and tablets.

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 6, 2019

A Regular Meeting of the CalOptima Board of Directors was held on June 6, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:06 p.m. Director DiLuigi led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Ria Berger, Lee Penrose, Supervisor Andrew Do

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; David Ramirez, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Sharon Dwiars, Interim Clerk of the Board

Chair Yost announced that he was reordering the agenda to hear Agenda Item 39, Homeless Health Update, immediately following Agenda Item 1, Chief Executive Officer Report. Chair Yost also noted that the Board would consider Agenda Item 36, Election of Officers for the upcoming fiscal year, ahead of the Closed Session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader updated the Board on the progress being made on CalOptima's homeless health initiatives and provided an overview of the Homeless Health Board Ad Hoc Committee's work to date, including meetings with various stakeholders. He also mentioned that several special guests were in attendance to speak on their participation in CalOptima's efforts to address the health care needs of the homeless.

Mr. Schrader also provided an update on the proposed operating and capital budgets that were presented at the May 16, 2019 Finance and Audit Committee and the May 22, 2019 Special Finance and Audit Committee meetings, noting that Nancy Huang, Interim Chief Financial Officer, would be reviewing the staff recommendations with the full Board today.

INFORMATION ITEM

39. Homeless Health Update

David Ramirez, M.D., Chief Medical Officer, presented an update on homeless health care and noting CalOptima's goal to address the trend of homeless deaths, build a better of system of care for members

who are experiencing homelessness, prioritize population health for this group, and reduced health disparities and improve outcomes. Dr. Ramirez commented that CalOptima is making enhancements to the delivery system to provide access for those who have challenges accessing health care in traditional settings and to deliver urgent-care-type services to individuals where they are located via Clinical Field Teams. He also provided details on several specific cases, highlighting the uniqueness of the challenges and needs of each homeless member.

Tracy Hitzeman, R.N., Executive Director, Clinical Outcomes, provided details on what the Clinical Field Teams experience on the streets, parks, or wherever the homeless are agreeing to receive care. Ms. Hitzeman noted that if a relationship has not been built with the a homeless person, it is unlikely that the person will agree to receive services in the field or agree to visit a clinic for a more thorough examination. It is sometimes a process that takes time to build trust with the homeless before they are willing to agree to receive medical care.

Mr. Schrader introduced Rocio Magdaleno, Executive Director of Serve the People Community Health Center, one of the five community health centers that currently partners with CalOptima to provide services through the clinical field teams. Ms. Magdaleno shared her experience in delivering care to the homeless and working with CalOptima members.

Mr. Schrader introduced Omar Moreno, CEO of Central City Community Health Center, which is also a community health center that partners with CalOptima to provide services through the clinical field teams. Central City Community Health Center is Medication-Assisted Treatment (MAT) certified and provides mobile medical and oral health to the homeless population.

After considerable discussion, the Board thanked staff and CalOptima's partners for their work on homeless health and indicated that it was looking forward to hearing more on the progress of the homeless health initiatives at future meetings.

PUBLIC COMMENTS

1. Father Dennis Kriz, OSM, St. Philip Benizi Church – Oral re: Agenda Item 39, Homeless Health Update
2. David Duran, Peoples Homeless Task Force – Oral re: Agenda Item 39, Homeless Health Update
3. Mark Richard Daniels, Housing is a Human Right – Oral re: Agenda Item 39, Homeless Health Update
4. Susan Huang, M.D., University of California Irvine School of Medicine – Oral re: Agenda Item 33, Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

CONSENT CALENDAR

2. Minutes

- a. Approve Minutes of the May 2, 2019 Regular Meeting of the CalOptima Board of Directors
- b. Receive and File: Minutes of the February 28, 2019 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member

Advisory Committee; and the April 11, 2019 Meeting of the CalOptima Board of Directors'
Provider Advisory Committee

3. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year (FY) 2019-20

4. Consider Adopting Resolution Authorizing and Directing Execution of Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program

5. Consider Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Operating Budget for the MCG Health Care Guidelines for Behavioral Health Services and Contract Extension with MCG Health

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

6. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

7. Consider Appointments to the Provider Advisory Committee; Consider Appointment of the PAC Chair and Vice Chair (PAC)

8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

9. Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network

Continued to future meeting due to lack of quorum.

10. Consider Ratification of Amendment to CHOC Physicians Network Medi-Cal Health Network Contract

Continued to future meeting due to lack of quorum.

Supervisor Steel pulled Consent Calendar Item 7 for discussion.

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors approved the balance of the Consent Calendar as presented. (Motion carried 6-0-0; Director Schoeffel did not participate in Item 5 due to potential conflicts of interest)*

7. Consider Appointments to the Provider Advisory Committee; Consider Appointment of the PAC Chair and Vice Chair (PAC)

Supervisor Steel commented that Patty Mouton, who is being recommend for a PAC seat as a Long Term Services and Supports Representative, is already seated on two of CalOptima's advisory committees: the Member Advisory Committee and the OneCare Connect Member Advisory Committee. Consequently, Supervisor Steel suggested that the PAC revisit this item and return with recommendation of a candidate to serve on the Provider Advisory Committee who is not already serving on another advisory committee.

Action: *On motion of Director Nguyen, seconded and carried, the Board of Directors approved the appointments to the Provider Advisory Committee; Consider Appointment of the PAC Chair and Vice Chair with the exception of Patty Mouton for the Long Term Services and Support Representative seat. (Motion carried 6-0-0)*

REPORTS

11. Consider Approval of the CalOptima Fiscal Year 2019-20 Operating Budget

Nancy Huang, Interim Chief Financial Officer, presented the recommended actions to approve the CalOptima Fiscal Year (FY) 2019-20 Operating Budget and authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy.

Action: *On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved the CalOptima Fiscal Year 2019-20 Operating Budget, and authorized the expenditure and appropriated the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 6-0-0)*

12. Consider Approval of the CalOptima Fiscal Year 2019-20 Capital Budget

Ms. Huang presented the recommended actions to approve the CalOptima Fiscal Year 2019-20 Capital Budget and authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2019-20 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. As proposed, the \$11.0 million Capital Budget will enable necessary system upgrades, enhance operational efficiencies, support strategic initiatives, comply with federal and state requirements, and provide expansion of building capacity to accommodate CalOptima's growth.

Action: *On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved the CalOptima Fiscal Year 2019-20 Capital Budget, and authorized the expenditure and appropriated the funds for items listed in Attachment A: Fiscal Year 2019-20 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. (Motion carried 6-0-0)*

13. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts, except those associated with St. Joseph Health and the University of California, Irvine

Continued to a future meeting due to lack of quorum.

14. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts associated with the University of California

Continued to a future meeting due to lack of quorum.

15. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts associated with St. Joseph Health

Continued to a future meeting due to lack of quorum.

16. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician (PCP) Contracts, except those associated with St. Joseph Health and the University of California, Irvine

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 Steel, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel to amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts, except those associated with St. Joseph Health and the University of California, Irvine, to: 1) Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirement; and 2) Reflect changes associated with Proposition 56 program payments to the extent authorized by the Board in a separate Board action. (Motion carried 5-0-0; Director Schoeffel absent)*

17. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician (PCP) Contracts associated with St. Joseph Health

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts associated with St. Joseph Health, to: 1) Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirement; and 2) Reflect changes associated with Proposition 56 program payments to the extent authorized by the Board in a separate Board action. (Motion carried 5-0-0; Director Schoeffel absent)*

18. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts associated with the University of California, Irvine

Continued to a future meeting due to lack of quorum.

19. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Ancillary Contracts and Contracts with MedImpact Healthcare Systems, Inc. and Vision Service Plan

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to: 1) Amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) ancillary contracts, and contracts with MedImpact Healthcare Systems, Inc. (MedImpact) and Vision Service Plan (VSP) to meet regulatory requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements, and 2) Revise fee for service rates for the provision of services to the extent authorized by the Board in a separate Board action. (Motion carried 5-0-0; Director Schoeffel absent)*

20. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Hospital Contracts

Continued to a future meeting due to lack of quorum.

21. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts, except those associated with St. Joseph Health, Children's Hospital of Orange County (CHOC) and the University of California, Irvine (UCI)

Continued to a future meeting due to lack of quorum.

22. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts, associated with the University of California, Irvine (UCI)

Continued to a future meeting due to lack of quorum.

23. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts associated with St. Joseph Health

Continued to a future meeting due to lack of quorum.

24. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts associated with Children's Hospital of Orange County (CHOC)

Continued to a future meeting due to lack of quorum.

25. Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

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 Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into an amended and restated Health Network contract with Kaiser Foundation Health Plan, Inc., effective June 30, 2019 that address the following: a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and b) Amended capitation rates for assigned members effective July 1, 2019. (Motion carried 5-0-0; Director Schoeffel absent)*

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amended and restated Full Risk Health Network contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 that address the following: a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action. (Motion carried 5-0-0; Director Schoeffel absent)*

27. Consider Authorizing Amended and Restated Medi-Cal Share Risk Group Health Network Contract for AltaMed Health Services Corporation, ARTA Western California, Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group, Inc., and United Care Medical Group, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
Continued to a future meeting due to lack of quorum.

28. Consider Authorizing Amended and Restated Medi-Cal Physician Hospital Consortium Health Network Contract for AMVI Care Health Network, Family Choice Medical Group, Inc., and Fountain Valley Regional Hospital and Medical Center and to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amended and restated Medi-Cal Physician Hospital Consortium Health Network contracts with AMVI Care Health Network, Family Choice Medical Group, Inc., and Fountain Valley Regional Hospital and Medical Center effective July 1, 2019 that address the following: a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action. (Motion carried 5-0-0; Director Schoeffel absent)*

29. Consider Authorizing Amended and Restated Medi-Cal Physician Hospital Consortium Health Network Contract for CHOC Physicians Network and Children's Hospital of Orange County to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Continued to a future meeting due to lack of quorum.

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

Action: *On motion of Supervisor Steel, seconded and carried, the Board of Directors: 1) Authorized the expenditure for CalOptima's participation in the following community event: a) Up to \$1,500 and staff participation at the 2019 Collaboration to Assist Motel Families' Back to School Outreach Event in Anaheim on July 27, 2019; and 2) Make a finding that such expenditures are for a public purpose; and 3) Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 6-0-0)*

31. Consider Authorizing Expenditures for CalOptima Staff Wellness Programs from Funding Received from CIGNA HealthCare for Calendar Year 2019

Action: *On motion of Supervisor Steel, seconded and carried, the Board of Directors authorized expenditures for CalOptima staff wellness programs from funding received from CIGNA HealthCare (CIGNA) Wellness/Health Improvement Fund for calendar year 2019. (Motion carried 6-0-0)*

32. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors

Supervisor Steel asked how many Board member is the last year have utilized their National Association of Corporate Directors (NACD) membership. Mr. Schrader responded that Directors DiLuigi, Berger, and Vice Chair Khatibi have attended several of the NACD sessions.

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1) Authorized expenditures of \$9,500 for board membership in the National Association of Corporate Directors (NACD) for Fiscal Year (FY) 2019-20; and 2) Authorized up to \$20,300 for additional seminars and related travel expenses. (Motion carried 5-1-0; Supervisor Steel voting no)*

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Action: *On motion of Director Nguyen, seconded and carried, the Board of Directors: 1) Authorized establishment of a Multi-Drug Resistant Organisms (MDRO) suppression quality initiative; and 2) Authorized the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative. (Motion carried 6-0-0)*

34. Consider Authorizing Extension of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith

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

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors, authorized the Chief Executive Officer, with the assistance of legal counsel, to exercise an option to extend the contract of Edelstein Gilbert Robson & Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2019. (Motion carried 5-0-0; Director Schoeffel absent)*

Agenda Item 35 was considered after Closed Session

36. Election of Officers of the Board of Directors for Fiscal Year 2019-20

Action: *On motion of Chair Yost, seconded and carried, the Board of Directors elected Dr. Nikan Khatibi to serve as Vice Chair for a term effective July 1, 2019 through June 30, 2020, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office. (Motion carried 6-0-0)*

Action: *On motion of Director DiLuigi, seconded and carried, the Board of Directors elected Dr. Paul Yost to serve as Chair for a term effective July 1, 2019 through June 30, 2020, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office. (Motion carried 6-0-0)*

ADVISORY COMMITTEE UPDATES

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

OCC MAC Committee Vice Chair Patty Mouton provided an update on the OCC MAC, noting that the committee is recruiting to fill several seats. She also provided an overview of presentations the OCC MAC members have received, including homeless health. She also noted that the committee had received public comments from homeless advocates.

38. Provider Advisory Committee (PAC) Update

PAC Member Jena Jensen provided an update on PAC activities. Ms. Jensen noted that the next PAC meeting will include a presentation from Ria Berger at Healthy Smiles.

INFORMATION ITEMS

The following Information Items were accepted as presented:

- 40. April 2018 Financial Summary
- 41. Compliance Report
- 42. Federal and State Legislative Advocates Reports
- 43. CalOptima Community Outreach and Program Summary

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 4:41 p.m. pursuant to: 1) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel); 2) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D. and Dr. Nikan Khatibi), Unrepresented Employee: (Chief Counsel); 3) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); and 4) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D. and Dr. Nikan Khatibi), Unrepresented Employee: (Chief Executive Officer).

The Board reconvened to open session at 6:01 p.m.

35. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Modifications to Compensation

Chair Yost reported that the Board met in Closed Session to consider the performance and compensation of our Chief Executive Officer (CEO) and Chief Counsel.

Specific to Chief Counsel, based on input provided by the Board, and the overall rating of fully meets expectations (3.0) for the current review period, it was recommended that the Chief Counsel be awarded a merit increase consistent with CalOptima's merit matrix. The recommended merit is calculated as a function of both the evaluation score and the base salary range, and is the same merit matrix that is used for all employees.

Specific to the Chief Executive Officer, Michael Schrader, the Board gave him an overall rating of fully meets expectations (3.35) for the current review period and merit will be awarded consistent with his contract.

Action: On motion of Chair Yost, seconded and carried, the Board of Directors: 1) Awarded Chief Counsel a merit increase based on an overall rating of fully meets expectations (3.0) based on the input provided by the Board for the current review period, and recommended that the Chief Counsel be awarded a merit increase consistent with CalOptima's Merit matrix; and 2) Awarded Chief Executive Officer an overall rating of fully meets expectations (3.35) for the current review period and merit awarded consistent with his contract. (Motion carried 5-0-0)

Chair Yost noted that in the coming weeks the Board would consider the percentage of performance goals met for the CEO for this review period as well as goals for the next review period.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 6:02 p.m.

/s/ Sharon Dwiars
Sharon Dwiars
Interim Clerk of the Board

Approved: June 27, 2019

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Consent Calendar

3. Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network

Contact

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

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

Recommended Actions

Ratify Medi-Cal health network contract amendments, excluding those involving the CHOC Physicians Network, to address continued payments to individual providers of Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services began in State Fiscal Year (SFY) 2018-19 and all future extensions thereafter provided the State of California continues the enhanced Proposition 56 payments to CalOptima.

Background/Discussion

Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through either direct communication or an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance and rates are not provided until after the fiscal year begins; requiring MCPs to develop initial catch up and ongoing payment distribution processes.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal health network contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance had not been released as of May 8, 2019. Even though the final APL for the current fiscal year had not been released, DHCS instructed MCPs to distribute initial catch up SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019. In a separate Board action, CalOptima staff requested approval of a standardized annual Proposition 56 provider payment process.

The standardized annual Proposition 56 provider payment process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. To continue Proposition 56 provider payments, Staff amended health network contracts to the extend the dates of service eligible for Proposition 56 payments into the current SFY and to ensure payments are made within with the timeframes based on DHCS guidance. CalOptima staff will seek subsequent Board action for further action if any future DHCS Proposition 56 requirements warrant significant changes to the standardized annual process.

Fiscal Impact

The recommended action to ratify amendments to Medi-Cal health network contracts, excluding those involving the CHOC Physicians Network, related to Proposition 56 is projected to be budget neutral to CalOptima. While total disbursement of Proposition 56 funding is dependent upon timely and accurate claims submissions from eligible providers, DHCS has projected Fiscal Year 2018-19 funding at approximately \$102 million. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount, resulting in a budget neutral impact to CalOptima’s operating income.

Rationale for Recommendation

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

Concurrence

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

Attachments

1. Conflicts of Interest List: Medi-Cal Health Networks
2. June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment
3. November 1, 2018 CalOptima Board Action Agenda Referral Report Item 10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

Conflicts of Interest List: Medi-Cal Health Networks

Name	Address	City	State	Zip Code
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CHOC Health Alliance	1120 West La Veta Ave., #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

CalOptima Board Action Agenda Referral
Consider Actions for the Continuation of Proposition 56 Provider
Payments, Including Amendments to Provider Health Network
Contracts Except Those Pertaining to the CalOptima Community
Network Contracts
Page 2

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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99215	Office/Outpatient Visit Est	\$25.00
90791	Psychiatric Diagnostic Eval	\$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00
90863	Pharmacologic Management	\$5.00

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

Discussion

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

Initial Payments

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Consent Calendar

4. Consider Ratification of Amendment to CHOC Physicians Network Medi-Cal Health Network Contract

Contact

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

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

Recommended Actions

Ratify CHOC Physicians Network Medi-Cal health network contract amendment to address continued payments to individual providers of Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services began in State Fiscal Year (SFY) 2018-19 and all future extensions thereafter provided the State of California continues the enhanced Proposition 56 payments to CalOptima.

Background/Discussion

Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through either direct communication or an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance and rates are not provided until after the fiscal year begins; requiring MCPs to develop initial catch up and ongoing payment distribution processes.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal health network contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance had not been released as of May 8, 2019. Even though the final APL for the current fiscal year had not been released, DHCS instructed MCPs to distribute initial catch up SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019. In a separate Board action, CalOptima staff requested approval of a standardized annual Proposition 56 provider payment process.

The standardized annual Proposition 56 provider payment process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. To continue Proposition

56 provider payments, Staff amended health network contracts to the extend the dates of service eligible for Proposition 56 payments into the current SFY and to ensure payments are made within with the timeframes based on DHCS guidance. CalOptima staff will seek subsequent Board action for further action if any future DHCS Proposition 56 requirements warrant significant changes to the standardized annual process.

Fiscal Impact

The recommended action to ratify an amendment to the CHOC Physicians Network Medi-Cal health network contract related to Proposition 56 is projected to be budget neutral to CalOptima. While total disbursement of Proposition 56 funding is dependent upon timely and accurate claims submissions from eligible providers, DHCS has projected Fiscal Year 2018-19 funding at approximately \$102 million. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount, resulting in a budget neutral impact to CalOptima’s operating income.

Rationale for Recommendation

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

Concurrence

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

Attachments

1. Conflict of Interest List: Medi-Cal Health Networks
2. June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment
3. November 1, 2018 CalOptima Board Action Agenda Referral Report Item 10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

Conflicts of Interest List: Medi-Cal Health Networks

Name	Address	City	State	Zip Code
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CHOC Health Alliance	1120 West La Veta Ave., #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

CalOptima Board Action Agenda Referral
Consider Actions for the Continuation of Proposition 56 Provider
Payments, Including Amendments to Provider Health Network
Contracts Except Those Pertaining to the CalOptima Community
Network Contracts
Page 2

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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99213	Office/Outpatient Visit Est	\$15.00
99214	Office/Outpatient Visit Est	\$25.00
99215	Office/Outpatient Visit Est	\$25.00
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90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00
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The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

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

Initial Payments

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Consent Item

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

Contact

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

Recommended Action

Reappoint Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term beginning June 27, 2019.

Background

At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima Investment Advisory Committee (IAC), established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee.

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

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion

The candidate recommended for reappointment, Rodney Johnson, has consistently provided leadership and service to CalOptima's investment strategies through his participation as an IAC member.

Mr. Johnson has served as a member of the IAC since June 6, 2013. Mr. Johnson has extensive experience working with public agencies. He is currently the Senior Director, Finance-Treasury for Los Angeles County Metropolitan Transportation. He previously worked as the Deputy Treasurer of the Orange County Transportation Authority (OCTA). He has been responsible for daily analysis of short-term and long-term cash flow needs, executing investments, and overseeing five (5) different investment management firms. Prior to that, Mr. Johnson held positions at BNY Western Trust Company, Fund Services Associates, Inc., and Muni Financial Services, Inc. Mr. Johnson has a M.P.A. from California State University Long Beach, and a B.A. from California State University

Fullerton. In addition, he was part of CalOptima's investment manager request for proposal (RFP) evaluation team. His current term expired on June 6, 2019.

Mr. Johnson was previously appointed to the IAC by the CalOptima Board of Directors on June 1, 2017, for a two-year term beginning June 7, 2017.

Fiscal Impact

There is no fiscal impact. Individuals appointed to the IAC are responsible for assisting CalOptima in meeting the objectives of CalOptima's annual investment policy, including preservation of capital, meeting the agency's liquidity needs, and obtaining an acceptable return on investment of available funds.

Rationale for Recommendation

The individual recommended for CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidate has already provided outstanding service as a member of the IAC.

Concurrence

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

Attachment

None

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

6. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts, Except Those Associated with St. Joseph Health and 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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinics contracts, except those associated with St. Joseph Health and the University of California, Irvine (UCI), to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
2. Reflect changes associated with Proposition 56 program payments as authorized by the Board; and
3. Revise FFS rates for the provision of services to the extent authorized by the Board.

Background/Discussion

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 Clinics. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Some of the Clinics contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds. However, Federally Qualified Health Centers, Rural Health Clinics, and American Indian Health Programs (as defined in the MCP contract), as well as Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of the State Plan and California Welfare and Institutions Code Section 14105.24), are not eligible Network Providers for the purposes receiving Proposition 56 funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

On April 4, 2019, the Board authorized extension of CalOptima's Medi-Cal clinic contracts through June 30, 2020. CalOptima staff recommends Board authorization to amend the contracts with Clinics, except those associated with St. Joseph Health and UCI.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

Staff requests authorization to amend the direct clinic provider contracts, except those associated St. Joseph Health, and UCI, to update contract provisions associated with APL 19-001 and other regulatory requirements, the payment provisions of Proposition 56 funds and the revision of FFS rates for the provision of services to the extent authorized by the Board.

Fiscal Impact

The recommended action to amend FFS clinics contracts to comply with requirements in DHCS APL 19-001 and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS clinics contracts to reflect changes associated with Proposition 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

The recommended action to amend FFS clinics contracts to revise FFS rates for the provision of services is included in the CalOptima Fiscal Year 2019-20 Operating Budget and is not expected to have any additional costs.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. All Plan Letter APL 19-001A
2. Board Action dated April 4, 2019, Authorizing Extension of CalOptima Clinic Contracts
3. Board Action dated June 7, 2018, authorizing implementation of initial and ongoing payments for Proposition 56 SFY 17/18
4. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized.

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

ALL PLAN LETTER 19-001
Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

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Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

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Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of Orange County
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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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

7. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service 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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinics contracts associated with the University of California, Irvine (UCI), to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
2. Reflect changes associated with Proposition 56 program payments as authorized by the Board; and
3. Revise FFS rates for the provision of services to the extent authorized by the Board.

Background/Discussion

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 Clinics. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. CalOptima staff requests authority to amend the contracts with Clinics associated with UCI to incorporate necessary changes.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Some of the Clinics contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds. However, Federally Qualified Health Centers, Rural Health Clinics, and American Indian Health Programs (as defined in the MCP contract), as well as Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of the State Plan and California Welfare and Institutions Code Section 14105.24), are not eligible Network Providers for the purposes receiving Proposition 56 funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board

authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

On April 4, 2019, the Board authorized extension of CalOptima's Medi-Cal clinic contracts through June 30, 2020. CalOptima staff recommends Board authorization to amend the contracts with Clinics, associated with UCI.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

Staff requests authorization to amend the direct clinic provider contracts associated with UCI, to update contract provisions associated with APL 19-001 and other regulatory requirements, the payment provisions of Proposition 56 funds and the revision of FFS rates for the provision of services to the extent authorized by the Board.

Fiscal Impact

The recommended action to amend FFS clinics contracts to comply with requirements in DHCS APL 19-001 and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS clinics contracts to reflect changes associated with Proposition 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

The recommended action to amend FFS clinics contracts to revise FFS rates for the provision of services is included in the CalOptima Fiscal Year 2019-20 Operating Budget and is not expected to have any additional costs.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Recommended by this Board Action
2. All Plan Letter APL 19-001
3. Board Action dated April 4, 2019, Authorizing Extension of CalOptima Clinic Contracts
4. Board Action dated June 7, 2018, authorizing implementation of initial and ongoing payments for Proposition 56 SFY 17/18
5. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

CalOptima Board Action Agenda Referral
Consider Authorizing Amendments of the CalOptima
Medi-Cal, OneCare, OneCare Connect and PACE
Fee-for-Service Clinic Contracts Associated with
the University of California, Irvine
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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



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

ALL PLAN LETTER 19-001
Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

ALL PLAN LETTER 19-001
Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
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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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts Associated with St. Joseph Health

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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinics contracts associated with St. Joseph Health to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
2. Reflect changes associated with Proposition 56 program payments as authorized by the Board; and
3. Revise FFS rates for the provision of services to the extent authorized by the Board.

Background/Discussion

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 Clinics. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. CalOptima staff requests authority to amend the contracts with Clinics associated with St. Joseph Health to incorporate necessary changes.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Some of the Clinics contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds. However, Federally Qualified Health Centers, Rural Health Clinics, and American Indian Health Programs (as defined in the MCP contract), as well as Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of the State Plan and California Welfare and Institutions Code Section 14105.24), are not eligible Network Providers for the purposes receiving Proposition 56 funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and

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ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

On April 4, 2019, the Board authorized extension of CalOptima's Medi-Cal clinic contracts through June 30, 2020. CalOptima staff recommends Board authorization to amend the contracts with Clinics associated with St. Joseph Health.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

Staff requests authorization to amend the direct clinic provider contracts associated St. Joseph Health, to update contract provisions associated with APL 19-001 and other regulatory requirements, the payment provisions of Proposition 56 funds and the revision of FFS rates for the provision of services to the extent authorized by the Board.

Fiscal Impact

The recommended action to amend FFS clinics contracts to comply with requirements in DHCS APL 19-001 and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS clinics contracts to reflect changes associated with Proposition 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

The recommended action to amend FFS clinics contracts to revise FFS rates for the provision of services is included in the CalOptima Fiscal Year 2019-20 Operating Budget and is not expected to have any additional costs.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

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Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action dated April 4, 2019, authorizing Extension of CalOptima Clinic Contracts
4. Board Action dated June 7, 2018, authorizing implementation of initial and ongoing payments for Proposition 56 SFY 17/18
5. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized

/s/ Michael Schrader
Authorized Signature

6/20/2019
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



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP’s statutory and/or contractual obligations, nor does it limit an MCP’s oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider’s agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

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Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
Page 3

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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018 **Regular Meeting of the CalOptima Board of Directors**

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

CalOptima Board Action Agenda Referral
Consider Actions for the Continuation of Proposition 56 Provider
Payments, Including Amendments to CalOptima Community
Network Provider Contracts Except Those Associated with
St. Joseph Health and the University of California, Irvine
Page 2

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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99205	Office/Outpatient Visit New	\$50.00
99211	Office/Outpatient Visit Est	\$10.00
99212	Office/Outpatient Visit Est	\$15.00
99213	Office/Outpatient Visit Est	\$15.00
99214	Office/Outpatient Visit Est	\$25.00
99215	Office/Outpatient Visit Est	\$25.00
90791	Psychiatric Diagnostic Eval	\$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00
90863	Pharmacologic Management	\$5.00

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

Discussion

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

Initial Payments

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

9. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care 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 Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Primary Care Physician (PCP) Contracts associated with the University of California, Irvine, to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
2. Reflect changes associated with Proposition 56 program payments to the extent authorized by the Board.

Background/Discussion

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 Primary Care Physicians. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. The specifications of the APL also clarify that in order to continue to receive Proposition 56 funds after July 1, 2019, provider contracts must contain all the required provisions.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. PCP contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has

recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

On April 4, 2019, the Board authorized extension of CalOptima's Primary Care Physician contracts through June 30, 2020. Staff now requests authorization to amend the direct PCP provider contracts associated with UCI, to update contract provisions associated with APL 19-001 and other regulatory requirements and the payment provisions of Proposition 56 funds.

Fiscal Impact

The recommended action to amend FFS PCP contracts to comply with requirements in DHCS APL 19-001 and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS PCP contracts to reflect changes associated with Proposition 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. All Plan Letter APL 19-001
2. Board Action dated April 4, 2019, Authorizing Extension of CalOptima Fee-for-Service Specialist Physician Contracts
3. Board Action dated June 7, 2018, authorizing implementation of initial & ongoing payments for Proposition 56 SFY 17/18
4. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized.

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

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Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
Page 3

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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

CalOptima Board Action Agenda Referral
Consider Actions for the Continuation of Proposition 56 Provider
Payments, Including Amendments to CalOptima Community
Network Provider Contracts Except Those Associated with
St. Joseph Health and the University of California, Irvine
Page 2

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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99204	Office/Outpatient Visit New	\$25.00
99205	Office/Outpatient Visit New	\$50.00
99211	Office/Outpatient Visit Est	\$10.00
99212	Office/Outpatient Visit Est	\$15.00
99213	Office/Outpatient Visit Est	\$15.00
99214	Office/Outpatient Visit Est	\$25.00
99215	Office/Outpatient Visit Est	\$25.00
90791	Psychiatric Diagnostic Eval	\$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00
90863	Pharmacologic Management	\$5.00

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

10. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Hospital Contracts Except Those Associated with Kindred Healthcare

Contact

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

Recommended Actions

Ratify amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service Hospital contracts, except those associated with Kindred Healthcare, to revise fee-for-service rates for the provision of services to the extent authorized by the Board.

Background/Discussion

CalOptima currently contracts with several hospitals to provide services to Medi-Cal members. Costs associated with services are included in the CalOptima operating budget. In a separate staff report, management's proposed CalOptima budget for Fiscal Year (FY) 2019 -2020 is presented. Overall, the budget is based on factors that affect payment to fee-for-service (FFS) hospitals including anticipated utilization levels and decreasing revenue for Medi-Cal Expansion (MCE) members. Based on these factors, the proposed FY2019-20 operating budget incorporates changes to the rates paid to FFS hospitals. As proposed, the revenue decrease for MCE will not affect the rates CalOptima pays for inpatient services in FFS hospitals. As the contracts have been amended, the Hospitals will receive an increase to their level of compensation for FFS inpatient and outpatient services provided under the contracts for CalOptima members.

Staff reviewed the expenditures and utilization associated with FFS hospitals for the Medi-Cal Classic population and has proposed providing increases in certain service categories. Contingent upon Board approval, inpatient hospital fees will receive a trend increase of approximately 2%.

Rates for outpatient hospital services rendered to both MCE and other Medi-Cal CalOptima members will receive a 33% increase. Outpatient services have been compensated at 100% of the Medi-Cal fee schedule for some time. However, through changes in technology, there has been a trend of shifting more services from being provided on an inpatient basis to outpatient. This shift has resulted in higher patient satisfaction and lower overall costs through the reduced use of costly inpatient services. In recognition of this trend and in recognition of the perceived low Medi-Cal fee schedule rates, Staff has proposed the aforementioned increase.

On April 4, 2019, the Board authorized new contracts to be issued to CalOptima's Medi-Cal hospitals effective July 1, 2019, through June 30, 2020. Staff requests ratification of amendments to these hospital contracts, except those associated with Kindred Healthcare, incorporating the new rates effective July 1, 2019 to the extent authorized by the Board. This recommended Board action also increases the Medi-Cal Classic rates with Orange County acute care hospitals contracted for full scope Medi-Cal services by approximately 2% or roughly \$2 million annually, in order to support the

hospital discharge process for CalOptima members experiencing homelessness. The anticipated fiscal impact of this Board action is included in the CalOptima FY 2019-20 Operating Budget.

Fiscal Impact

Management has included costs associated with the amendments to CalOptima Medi-Cal, OneCare, OneCare Connect and PACE FFS hospital contracts, including the revised FFS rates for the provision of services, in the CalOptima FY 2019-20 Operating Budget. The annual fiscal impact of the proposed rate changes for Medi-Cal FFS hospital contracts are as follows:

- 2% increase to FFS inpatient hospital rates are projected to increase hospital claims expenses by \$2 million per year; and
- 33% increase to the hospital outpatient FFS rate to reach 133% of the Medi-Cal fee schedule is projected to increase hospital claims expense by \$10 million per year.

Rationale for Recommendation

CalOptima staff recommends these actions revising compensation rates as presented as part of the FY2019-20 CalOptima operating budget.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Recommended by this Board Action
2. Board Action dated April 4, 2019, Consider authorizing new contracts to be issued to CalOptima's Medi-Cal hospitals

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

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
Children’s Hospital of Los Angeles	4650 W Sunset Blvd	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
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Fountain Valley Regional Hosp & 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
Keck Hospital of USC	1500 San Pablo St	Los Angeles	CA	90033
LAC USC Medical Center	1200 N State St	Los Angeles	CA	90033
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Mission Hospital Regional Medical Center dba Mission Hospital Regional Med 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 Hospital	7901 Walker St	La Palma	CA	90623
Promise Hospital of East Los Angeles LP DBA Suburban Medical Center	16453 S Colorado Ave	Paramount	CA	90723
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

Contracted Entities Covered by this Recommended Board Action (Continued)

Name	Address	City	State	Zip
St Joseph Hospital of Orange	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

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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of Orange County

Page 2

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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
Page 3

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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

11. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Hospital Contracts Associated with Kindred Healthcare

Contact

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

Recommended Actions

Ratify amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service Hospital contracts associated with Kindred Healthcare to revise fee-for-service rates for the provision of services to the extent authorized by the Board.

Background/Discussion

CalOptima currently contracts with several hospitals to provide services to Medi-Cal members. Costs associated with services are included in the CalOptima operating budget. In a separate staff report, management's proposed CalOptima budget for Fiscal Year (FY) 2019 -2020 is presented. Overall, the budget is based on factors that affect payment to fee-for-service (FFS) hospitals including anticipated utilization levels and decreasing revenue for Medi-Cal Expansion (MCE) members. Based on these factors, the proposed FY2019-20 operating budget incorporates changes to the rates paid to FFS hospitals. As proposed, the revenue decrease for MCE will not affect the rates CalOptima pays for inpatient services in FFS hospitals. As the contracts have been amended, the Hospitals will receive an increase to their level of compensation for FFS inpatient and outpatient services provided under the contracts for CalOptima members.

Staff reviewed the expenditures and utilization associated with FFS hospitals for the Medi-Cal Classic population and has proposed providing increases in certain service categories. Contingent upon Board approval, inpatient hospital fees will receive a trend increase of approximately 2%.

Rates for outpatient hospital services rendered to both MCE and other Medi-Cal CalOptima members will receive a 33% increase. Outpatient services have been compensated at 100% of the Medi-Cal fee schedule for some time. However, through changes in technology, there has been a trend of shifting more services from being provided on an inpatient basis to outpatient. This shift has resulted in higher patient satisfaction and lower overall costs through the reduced use of costly inpatient services. In recognition of this trend and in recognition of the perceived low Medi-Cal fee schedule rates, Staff has proposed the aforementioned increase.

On April 4, 2019, the Board authorized new contracts to be issued to CalOptima's Medi-Cal hospitals effective July 1, 2019, through June 30, 2020. Staff requests ratification of amendments to the hospital contracts associated with Kindred Healthcare, incorporating the new rates effective July 1, 2019 to the extent authorized by the Board. This recommended Board action also increases the Medi-Cal Classic rates with Orange County acute care hospitals contracted for full scope Medi-Cal services by approximately 2% or roughly \$2 million annually, in order to support the hospital discharge process

for CalOptima members experiencing homelessness. The anticipated fiscal impact of this Board action is included in the CalOptima FY 2019-20 Operating Budget.

Fiscal Impact

Management has included costs associated with the amendments to CalOptima Medi-Cal, OneCare, OneCare Connect and PACE FFS hospital contracts, including the revised FFS rates for the provision of services, in the CalOptima FY 2019-20 Operating Budget. The annual fiscal impact of the proposed rate changes for Medi-Cal FFS hospital contracts are as follows:

- 2% increase to FFS inpatient hospital rates are projected to increase hospital claims expenses by \$2 million per year; and
- 33% increase to the hospital outpatient FFS rate to reach 133% of the Medi-Cal fee schedule is projected to increase hospital claims expense by \$10 million per year.

Rationale for Recommendation

CalOptima staff recommends these actions revising compensation rates as presented as part of the FY2019-20 CalOptima operating budget.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Recommended by this Board Action
2. Board Action dated April 4, 2019, Consider authorizing new contracts to be issued to CalOptima's Medi-Cal hospitals

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

Contracted Entities Covered by this Recommended Board Action

Name	Address	City	State	Zip
THC-Orange County LLC, dba Kindred Hospital Brea	875 N Brea Blvd	Brea	CA	92821
THC-Orange County LLC, dba Kindred Hospital Westminster	200 Hospital Circle	Westminster	CA	92683
Southern California Specialty Care LLC dba Kindred Hospital- La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Southern California Specialty Care LLC, dba Kindred Hospital Santa Ana	1901 N College Ave	Santa Ana	CA	92706

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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of Orange County

Page 2

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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
Page 3

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
Authorized Signature

3/27/2019
Date

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
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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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

12. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts, Except Those Associated with St. Joseph Health, Children's Hospital of Orange County and 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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts, except those associated with St. Joseph Health, Children's Hospital of Orange County (CHOC) and University of California, Irvine (UCD)to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
2. Reflect changes associated with Proposition 56 program payments as authorized by the Board; and
3. Revise FFS rates for the provision of services to the extent authorized by the Board.

Background/Discussion

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 specialist providers. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. The specifications of the APL also clarify that in order to continue to receive Proposition 56 funds after July 1, 2019, provider contracts must contain all the required provisions.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Specialist physicians contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has

recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

On April 4, 2019, the Board authorized extension of CalOptima’s Medi-Cal specialist physician contracts through June 30, 2020. Staff now requests authorization to amend the direct specialist provider contracts, except those associated St. Joseph Health, CHOC, and UCI, to update contract provisions associated with APL 19-001 and other regulatory requirements and the payment provisions of Proposition 56 funds. _Staff also requests authorization to amend rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action

Fiscal Impact

The recommended action to amend FFS specialist contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS specialist contracts to reflect changes associated with Prop 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

Costs associated with the recommended action to amend FFS specialist contracts to revise FFS rates for the provision of services are included in the CalOptima Fiscal Year 2019-20 Operating Budget. The annual fiscal impact of the proposed rate changes to Medi-Cal FFS specialist contracts is projected at approximately \$450,000. There are no rate changes proposed for the OneCare, OneCare Connect, and PACE FFS specialist contracts.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Consider Authorizing Amendments of the CalOptima Medi-Cal,
OneCare, OneCare Connect and PACE Fee-for-Service
Specialist Contracts, Except Those Associated with St. Joseph
Health, Children’s Hospital of Orange County and the
University of California, Irvine
Page 3

Attachments

1. All Plan Letter APL 19-001
2. Board Action dated April 4, 2019, authorizing extension of CalOptima Fee-for-Service Specialist physician contracts
3. Board Action dated June 7, 2018, authorizing implementation of initial & ongoing payments for Proposition 56 SFY 17/18
4. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized.

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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Page 5

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

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Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
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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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

CalOptima Board Action Agenda Referral
Consider Actions for the Continuation of Proposition 56 Provider
Payments, Including Amendments to CalOptima Community
Network Provider Contracts Except Those Associated with
St. Joseph Health and the University of California, Irvine
Page 2

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 Special Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist 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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts associated with University of California, Irvine, to:

Rev.
6/27/19

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
2. Reflect changes associated with Proposition 56 program payments to the extent authorized by the Board.

Background/Discussion

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 specialist providers. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. The specifications of the APL also clarify that in order to continue to receive Proposition 56 funds after July 1, 2019, provider contracts must contain all the required provisions.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Specialist physicians contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

On April 4, 2019, the Board authorized extension of CalOptima's Medi-Cal specialist physician contracts through June 30, 2020. Staff now requests authorization to amend the direct specialist provider contracts associated UCI, to update contract provisions associated with APL 19-001 and other regulatory requirements and the payment provisions of Proposition 56 funds.

Fiscal Impact

The recommended action to amend FFS specialist contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS specialist contracts to reflect changes associated with Prop 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. All Plan Letter APL 19-001
2. Original Prop APL –COBAR in separate board action.
3. Board Action dated April 4, 2019, authorizing extension of CalOptima Fee-for-Service Specialist physician contracts
4. Board Action dated June 7, 2018, authorizing implementation of initial & ongoing payments for Proposition 56 SFY 17/18
5. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized.

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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Page 5

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

ALL PLAN LETTER 19-001
Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact

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

Recommended Actions

Ratify standardized annual Proposition 56 provider payment process.

Background

Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion

In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medical covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.
- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medical covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.
- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima’s expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact

The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima’s operating income.

Rationale for Recommendation

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

Concurrence

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

Attachment

June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader
Authorized Signature

5/29/2019
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
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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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts Associated with St. Joseph Health.

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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts associated with St. Joseph Health to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
2. Reflect changes associated with Proposition 56 program payments to the extent authorized by the Board; and
3. Revise FFS rates for the provision of services to the extent authorized by the Board.

Background/Discussion

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 specialist providers. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. The specifications of the APL also clarify that in order to continue to receive Proposition 56 funds after July 1, 2019, provider contracts must contain all the required provisions.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Specialist physicians contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board

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authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

On April 4, 2019, the Board authorized extension of CalOptima's Medi-Cal specialist physician contracts through June 30, 2020. Staff now requests authorization to amend the direct specialist provider contracts associated with St. Joseph Health to update contract provisions associated with APL 19-001 and other regulatory requirements and the payment provisions of Proposition 56 funds. Staff also requests authorization to amend rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action

Fiscal Impact

The recommended action to amend FFS specialist contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS specialist contracts to reflect changes associated with Proposition 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

Costs associated with the recommended action to amend FFS specialist contracts to revise FFS rates for the provision of services are included in the CalOptima Fiscal Year 2019-20 Operating Budget. The annual fiscal impact of the proposed rate changes to Medi-Cal FFS specialist contracts is projected at approximately \$450,000. There are no rate changes proposed for the OneCare, OneCare Connect, and PACE FFS specialist contracts.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Continued to a Future Board Meeting

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Attachments

1. All Plan Letter APL 19-001
2. Board Action dated April 4, 2019, authorizing extension of CalOptima Fee-for-Service Specialist physician contracts
3. Board Action dated June 7, 2018, authorizing implementation of initial & ongoing payments for Proposition 56 SFY 17/18
4. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized.

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP’s statutory and/or contractual obligations, nor does it limit an MCP’s oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider’s agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

ALL PLAN LETTER 19-001
Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

ALL PLAN LETTER 19-001
Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
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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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist 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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service (FFS) Specialist Contracts associated with Children's Hospital of Orange County (CHOC) to:

1. Include all necessary language requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
2. Reflect changes associated with Proposition 56 program payments as authorized by the Board; and
3. Revise FFS rates for the provision of services to the extent authorized by the Board.

Background/Discussion

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 specialist providers. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in provider contracts to meet state and federal contracting requirements. The specifications of the APL also clarify that in order to continue to receive Proposition 56 funds after July 1, 2019, provider contracts must contain all the required provisions.

Proposition 56 increases the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care programs administered by the DHCS. DHCS releases guidance to Medi-Cal managed care plans (MCP) regarding the distribution of Proposition 56 provider payments through an APL. The APL includes guidance regarding providers eligible for payment, and the service codes eligible for reimbursement. Specialist physicians contracted with the CalOptima for Medi-Cal services are eligible to receive these supplemental funds.

On May 1, 2018, DHCS released a Proposition 56 APL for State Fiscal Year (SFY) 2017-18. On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. On November 1, 2018 the Board authorized contract amendments to Medi-Cal provider contracts to continue Proposition 56 SFY 2017-

Continued to a Future Board Meeting

CalOptima Board Action Agenda Referral
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18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. The state has recently provided updated guidance for the payment of Proposition 56 funds the details of which are covered in a separate Board action.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions in the proposed amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

On April 4, 2019, the Board authorized extension of CalOptima's Medi-Cal specialist physician contracts through June 30, 2020. Staff now requests authorization to amend the direct specialist provider contracts associated with CHOC to update contract provisions associated with APL 19-001 and other regulatory requirements and the payment provisions of Proposition 56 funds. Staff also requests authorization to amend rates effective July 1, 2019 to the extent authorized by the Board.

Fiscal Impact

The recommended action to amend FFS specialist contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

The recommended action to amend FFS specialist contracts to reflect changes associated with Proposition 56 program payments is projected to be budget neutral. Staff anticipates that Proposition 56 funding will be sufficient to cover all costs associated with the program.

Costs associated with the recommended action to amend FFS specialist contracts to revise FFS rates for the provision of services is included in the CalOptima Fiscal Year 2019-20 Operating Budget. The annual fiscal impact of the proposed rate changes to Medi-Cal FFS specialist contracts is projected at approximately \$450,000. There are no rate changes proposed for the OneCare, OneCare Connect, and PACE FFS specialist contracts.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Consider Authorizing Amendments of the CalOptima
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Attachments

1. All Plan Letter APL 19-001
2. Board Action dated April 4, 2019, authorizing extension of CalOptima Fee-for-Service Specialist physician contracts
3. Board Action dated June 7, 2018, authorizing implementation of initial & ongoing payments for Proposition 56 SFY 17/18
4. Board Action dated November 1, 2018, authorizing contract amendments to continue Proposition 56 SFY 17/18 provisions for DOS in SFY 18/19 until guidance is finalized.

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

ALL PLAN LETTER 19-001
Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

CalOptima Board Action Agenda Referral

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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children's Hospital of 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.

CalOptima Board Action Agenda Referral
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 DHCS Hospital Directed Payments and Whole Child Model Programs; and Consider Ratification of Contract Amendment with Children’s Hospital of Orange County
Page 3

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
Authorized Signature

3/27/2019
Date

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

Attachment to April 4, 2019 Board of Directors Meeting – Agenda Item 18

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 June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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

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

Discussion

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

Initial Payments

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

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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

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

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

CalOptima Board Action Agenda Referral
Consider Actions for the Continuation of Proposition 56 Provider
Payments, Including Amendments to CalOptima Community
Network Provider Contracts Except Those Associated with
St. Joseph Health and the University of California, Irvine
Page 2

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

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

/s/ Michael Schrader
Authorized Signature

10/24/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018

Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Action

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

Background

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

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

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

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99204	Office/Outpatient Visit New	\$25.00
99205	Office/Outpatient Visit New	\$50.00
99211	Office/Outpatient Visit Est	\$10.00
99212	Office/Outpatient Visit Est	\$15.00
99213	Office/Outpatient Visit Est	\$15.00
99214	Office/Outpatient Visit Est	\$25.00
99215	Office/Outpatient Visit Est	\$25.00
90791	Psychiatric Diagnostic Eval	\$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00
90863	Pharmacologic Management	\$5.00

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

Discussion

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

Initial Payments

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

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

Ongoing Processing

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/30/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

16. Consider Authorizing Amended and Restated Medi-Cal Shared Risk Group Health Network Contract for AltaMed Health Services Corporation, ARTA Western California, Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group, Inc., and United Care Medical Group, Inc.

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Shared Risk Group Health Network Contracts with AltaMed Health Services Corporation, ARTA Western California, Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group, Inc., and United Care Medical Group, Inc. effective July 1, 2019 that address the following:

- a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
- b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board.

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid Managed Care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

CalOptima Board Action Agenda Referral
Consider Authorizing Amended and Restated Medi-Cal
Shared Risk Group Health Network Contract for AltaMed Health
Services Corporation, ARTA Western California, Inc.,
Orange County Physicians IPA Medical Group, Inc. dba
Noble Community Medical Associates, Inc. of Mid-Orange County,
Talbert Medical Group, Inc., and United Care Medical Group, Inc.
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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts are included in the CalOptima FY 2019-20 Operating Budget. The budget includes increases of 4% to the Adult TANF and SPD Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately \$7.5 million in FY 2019-20.

In addition, the budget included a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be \$95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Consider Authorizing Amended and Restated Medi-Cal
Shared Risk Group Health Network Contract for AltaMed Health
Services Corporation, ARTA Western California, Inc.,
Orange County Physicians IPA Medical Group, Inc. dba
Noble Community Medical Associates, Inc. of Mid-Orange County,
Talbert Medical Group, Inc., and United Care Medical Group, Inc.
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Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
ARTA Western California, Inc.	3390 Harbor Blvd	Costa Mesa	CA	92626
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, Inc.	3390 Harbor Blvd	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

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Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

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Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
 - a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
 - b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
 - c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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
Authorized Signature

11/28/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018 **Regular Meeting of the CalOptima Board of Directors**

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data.

CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately \$274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

CalOptima Board Action Agenda Referral
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
Page 4

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network
Capitation Methodology and Rate Allocations

/s/ Michael Schrader
Authorized Signature

7/25/2018
Date

*Attachment to August 2, 2018 Board of Directors Meeting –
Agenda Item 5*

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

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:
 - 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.~~

Rev.
6/7/2018

6/7/2018:
Continued
to future
Board
meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
 - a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
 - b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

- c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
 - a. Community-based organizations; or
 - b. Consumer advocates.

While two (2) of the WCM-FAC’s eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California’s 1115 “Bridge to Reform” Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima’s Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima’s health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima’s direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model

CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations

CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy

The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

Memorandum of Understanding (MOU)

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.

Whole Child Model Family Advisory Committee (WCM FAC)

In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:

Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

CBO/Advocate Representatives

1. ~~Michael Arnot for a two year term ending June 30, 2020;~~
2. ~~Sandra Cortez Schultz for a one year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two year term ending June 30, 2020; and~~
4. ~~Diane Key for a one year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

Staff recommends Board approval of the proposed nominees for the WCM FAC.

6/7/2018:
Continued
to future
Board
meeting.

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



CalOptima
Better. Together.

Whole-Child Model (WCM) Implementation Plan

**Board of Directors Meeting
June 7, 2018**

**Candice Gomez, Executive Director
Program Implementation**



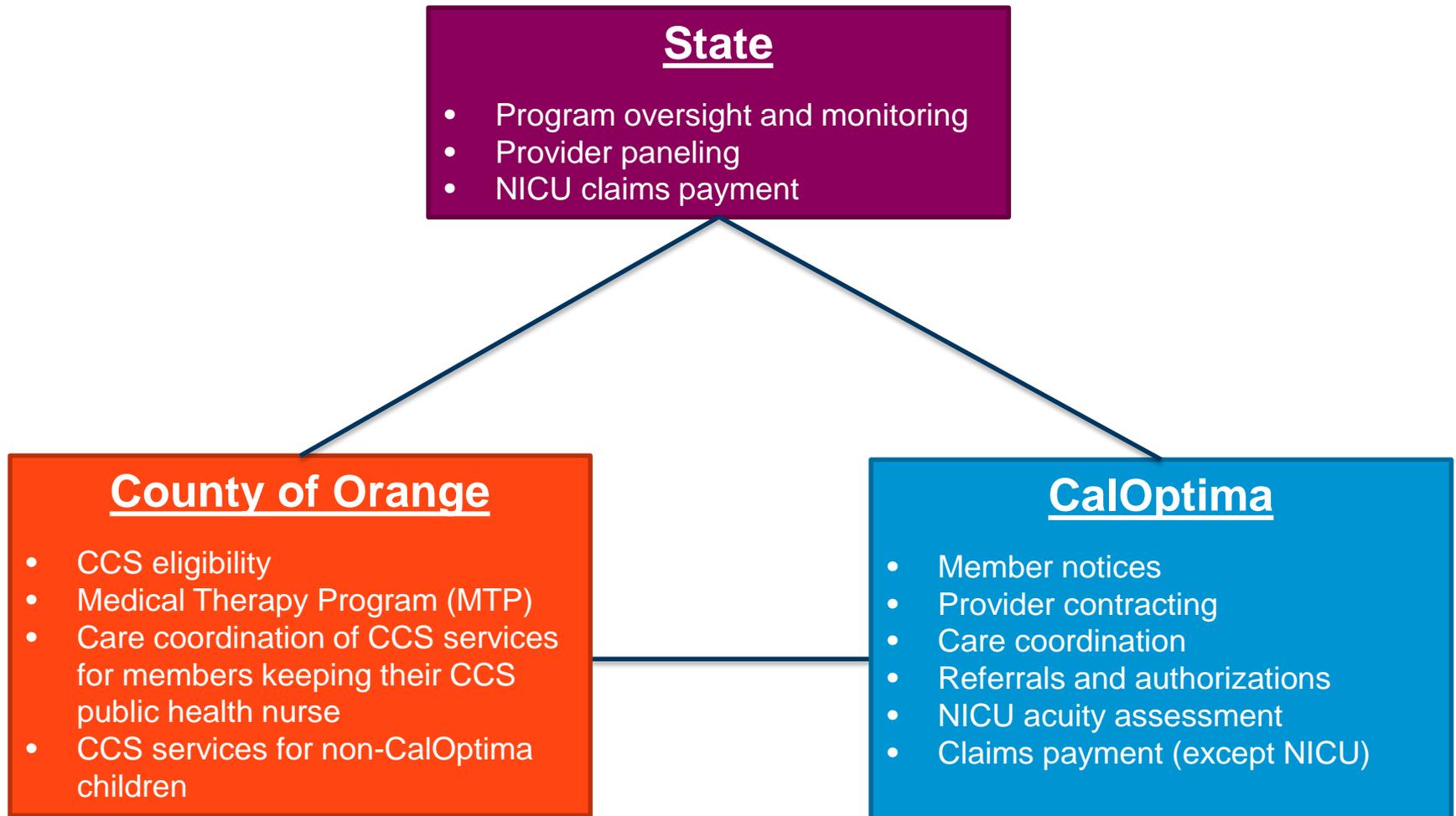
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Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
 - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
 - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
 - 90 percent are CalOptima members

Languages

- Spanish = 48 percent
- English = 44 percent
- Vietnamese = 4 percent
- Other/unknown = 4 percent

City of Residence (Top 5)

- Santa Ana = 23 percent
- Anaheim = 18 percent
- Garden Grove = 8 percent
- Orange = 6 percent
- Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
 - Hospital Association of Southern California
 - Safety Net Summit - Coalition of Orange County Community Health Centers
 - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
 - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings



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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
 - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system
- Using existing model creates several advantages
 - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
 - Improves clinical outcomes and health care experience for members and their families
 - Decreases inappropriate medical and administrative costs
 - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
 - Follow current fee-for-service methodology and policy
 - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
 - Keep health network risk and payment structure similar to current methodologies in place
 - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations
- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)
- Facilitating transitions of care
 - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
 - Between CalOptima, OC HCA and other counties
 - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
 - CCS panel status will be part of credentialing process
 - CCS members will be able to select their CCS specialists as primary care provider
 - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
 - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
 - Leverage DHCS template
 - Outlines responsibilities related:
 - CCS eligibility and enrollment
 - Case management
 - Continuity of care
 - Advisory committees
 - Data sharing
 - Dispute management
 - NICU
 - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
 - Eleven voting seats
 - Seven to nine family representative seats
 - Two to four community-based organizations or consumer advocates
 - Priority to family representatives
 - Two-year terms, with no term limits
 - Staggered terms
 - In first year, five seats for one-year term and six seats for two-year term
 - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
 - All eligible applicants in family category were selected
 - One applicant was ineligible as she has no prior CCS experience
 - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	Michael Arnot Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	Sandra Cortez – Schultz Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	Gabriela Huerta Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks
- Planned stakeholder engagement
 - Community-based organization focus groups in June
 - General event in July
 - Family events in Fall
- Future Board actions
 - Update policies and procedures
 - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017 Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Actions

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).

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Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
 - i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
 - ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
 - iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
 - i. Community-based organizations; or
 - ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is \$3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is \$13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader
Authorized Signature

10/23/2017
Date

RESOLUTION NUMBER 17-1102-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE

WHEREAS, the CalOptima Board of Directors (hereinafter “the Board”) would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter “CalOptima Whole-Child Model Family Advisory Committee”; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter “WCM-FAC”) is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
 - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
 - CalOptima members age 18-21 who are current recipients of CCS services; or
 - Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
 - Community-based organizations (CBOs); or
 - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/ _____

Title: Chair, Board of Directors

Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:

/s/ _____

Suzanne Turf, Clerk of the Board



Policy #: AA.1271PP
Title: **Whole Child Model Family Advisory Committee**
Department: General Administration
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 06/07/18
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

1 **I. PURPOSE**

2
3 This policy describes the composition and role of the Family Advisory Committee for Whole Child
4 Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates
5 to the Whole Child Model Family Advisory Committee (WCM FAC).
6

7 **II. POLICY**

- 8
9 A. As directed by CalOptima’s Board of Directors (Board), the WCM FAC shall report to the
10 CalOptima Board and shall provide advice and recommendations to the CalOptima Board and
11 CalOptima staff in regards to California Children’s Services (CCS) provided by CalOptima Medi-
12 Cal's implementation of the WCM.
13
14 B. CalOptima’s Board encourages Member and community involvement in CalOptima programs.
15
16 C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of
17 interest may exist and shall abide by CalOptima’s conflict of interest code and, in accordance with
18 CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.
19
20 D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested
21 by the Department of Health Care Services (DHCS).
22
23 E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health
24 care consumers within the Whole-Child Model population. WCM FAC members shall have direct
25 or indirect contact with CalOptima Members.
26
27 F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be
28 comprised of eleven (11) voting members representing CCS family members, as well as consumer
29 advocates representing CCS families. Except as noted below, each voting member shall serve a two
30 (2) year term with no limits on the number of terms a representative may serve. The initial
31 appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to
32 stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a
33 one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term.
34 The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve
35 two (2) year terms thereafter.
36
37

- 1 1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following
2 categories, with a priority to family representatives (i.e., if qualifying family representative
3 candidates are available, all nine (9) seats will be filled by family representatives):
4
 - 5 a. Authorized representatives, including parents, foster parents, and caregivers, of a
6 CalOptima Member who is a current recipient of CCS services;
7
 - 8 b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients
9 of CCS services; or
 - 10 c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS
11 services.
- 12 2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services,
13 including:
 - 14 a. Community-based organizations; or
 - 15 b. Consumer advocates.
- 16 3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based
17 organizations or consumer advocates, an additional two (2) WCM FAC candidates representing
18 these groups may be considered for these seats in the event that there are not sufficient family
19 representative candidates to fill the family member seats.
- 20 4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC
21 member or family member representative.
- 22 5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to
23 serve on a statewide stakeholder advisory group.

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32 G. Stipends

- 33 1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem
34 payment to a member or family representative serving on the WCM FAC. CalOptima shall
35 maintain a log of each payment provided to the member or family representative, including type
36 and value, and shall provide such log to DHCS upon request.
37
 - 38 a. Representatives of community-based organizations and consumer advocates are not eligible
39 for stipends.
40

41
42 H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring
43 seats, in accordance with this Policy.

44
45 I. WCM FAC Vacancies

- 46 1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated
47 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.

- 1 1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.
2

3 **III. PROCEDURE**
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5 A. WCM FAC meeting frequency
6

- 7 1. WCM FAC shall meet at least quarterly.
8
9 2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or
10 after January of each year.
11
12 3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum
13 must be present for any votes to be valid.
14

15 B. WCM FAC recruitment process
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- 17 1. CalOptima shall begin recruitment of potential candidates in March of each year. In the
18 recruitment of potential candidates, the ethnic and cultural diversity and special needs of
19 children and/or families of children in CCS which are or are expected to transition to
20 CalOptima's Whole-Child Model population shall be considered. Nominations and input from
21 interest groups and agencies shall be given due consideration.
22
23 2. CalOptima shall recruit for potential candidates using one or more notification methods, which
24 may include, but are not limited to, the following:
25
26 a. Outreach to family representatives and community advocates that represent children
27 receiving CCS;
28
29 b. Placement of vacancy notices on the CalOptima website; and/or
30
31 c. Advertisement of vacancies in local newspapers in Threshold Languages.
32
33 3. Prospective candidates must submit a WCM Family Advisory Committee application, including
34 resume and signed consent forms. Candidates shall be notified at the time of recruitment
35 regarding the deadline to submit their application to CalOptima.
36
37 4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its
38 membership whether there are interested candidates who wish to be considered as a chair or
39 vice chair for the upcoming fiscal year.
40
41 a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested
42 candidates who wish to be considered as a chair for the first year.
43

44 C. WCM FAC nomination evaluation process
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- 46 1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not
47 being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the
48 first nomination process, Member Advisory Committee (MAC) members shall serve on the
49 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

Policy #: AA.1271

Title: Whole Child Model Family Advisory Committee

Effective Date: 06/07/18

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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

DRAFT

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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 (21) 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.

4

DRAFT

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____
 Address: _____ Secondary Phone: _____
 City, State, ZIP: _____ Fax: _____
 Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- CalOptima members age 18–21 who are current recipients of CCS services; or
- Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

Please provide a brief description of your knowledge or experience with California Children's Services: _____

Please explain why you wish to serve on the WCM FAC: _____

Describe why you would be a qualified representative for service on the WCM FAC: _____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? Yes No

Please supply two references (professional, community or personal):

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Address: _____

Address: _____

City, State, ZIP: _____

City, State, ZIP: _____

Phone: _____

Phone: _____

Email: _____

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**.

[Back to Agenda](#)

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

1 I understand that a revocation will not affect the ability of CalOptima or any health care provider to use
2 or disclose the health information to the extent that it has acted in reliance on this authorization.

3 **RESTRICTIONS:**

4
5 I understand that anything that occurs in the context of a public meeting, including the meetings of the
6 Whole Child Model Family Advisory Committee, is a matter of public record that is required to be
7 disclosed upon request under the California Public Records Act. Information related to, or relevant to,
8 information disclosed pursuant to this authorization that is not disclosed at the public meeting remains
9 protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and
10 will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by
11 HIPAA without authorization, or is required by law.

12 **MEMBER RIGHTS:**

- 13 • I understand that I must receive a copy of this authorization.
- 14 • I understand that I may receive additional copies of the authorization.
- 15 • I understand that I may refuse to sign this authorization.
- 16 • I understand that I may withdraw this authorization at any time.
- 17 • I understand that neither treatment nor payment will be dependent upon my refusing or agreeing
18 to sign this authorization.
- 19

20 **ADDITIONAL COPIES:**

21
22 Did you receive additional copies? Yes No

23 **SIGNATURE:**

24
25 By signing below, I acknowledge receiving a copy of this authorization.

26 Member Signature: _____ Date: _____

27 Signature of Parent or Legal Guardian: _____ Date: _____

28
29
30 ***If Authorized Representative:***

31 Name of Personal Representative: _____

32 Legal Relationship to Member: _____

33 Signature of Personal Representative: _____ Date: _____

34
35 ***Basis for legal authority to sign this Authorization by a Personal Representative***

36 (If a personal representative has signed this form on behalf of the member, a copy of the Health Care
37 Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

- 1 administrator of a deceased member's estate), or other legal documentation demonstrating the authority
- 2 of the personal representative to act on the individual's behalf must be attached to this form.)



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

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
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

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

**Instructions: Please answer all questions. You may handwrite or type your answers.
Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.**

Name: _____ Work Phone: _____
 Address: _____ Mobile Phone: _____
 City, State ZIP: _____ Fax Number: _____
 Date: _____ Email: _____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children’s Services (CCS), including:

- Community-based organizations
- Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

4. Please explain why you wish to serve on the WCM FAC:

5. Describe why you would be a qualified representative for service on the WCM FAC:

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? Yes No

8. Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State ZIP: _____	City, State ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868

Attn: Becki Melli

Email: bmelli@caloptima.org

For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima’s website, and even if not presented to the Board, will be available on request to members of the public.

Signature

Date

Print Name



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

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
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
_____ Name of Evaluator	Back to Agenda	Total Points Awarded _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2009 Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Approve Health Network Contract Rate Methodology

Contact

Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action

Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background

Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or “rebase” these payment rates.

The purpose of this year’s rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima’s delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year’s rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity “kick” payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion

CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact

CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation

Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachments

None

/s/ Richard Chambers
Authorized Signature

5/27/2009
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003 **Special Meeting of the CalOptima Board of Directors**

Report Item

VI. A. Approve Modifications to the CalOptima Health Network Capitation
Methodology and Rate Allocations

Contact

Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action

Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background

CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate “pass throughs” as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima’s health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continue 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
Authorized Signature

12/9/2003
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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Report Item

17. Consider Authorizing Amended and Restated Medi-Cal Physician Hospital Consortium Health Network Contract for CHOC Physicians Network and 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 enter into Amended and Restated Medi-Cal Physician Hospital Consortium Health Network Contracts with CHOC Physicians Network, and Children's Hospital of Orange County, effective July 1, 2019 that address the following:

- a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements; and
- b) Amend capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board.

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid Managed Care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to: emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts are included in the CalOptima FY 2019-20 Operating Budget. The budget includes proposed increases of 4% to the Adult TANF and SPD Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately \$7.5 million in FY 2019-20.

In addition, the budget includes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be \$95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Consider Authorizing Amended and Restated
Medi-Cal Physician Hospital Consortium Health
Network Contract for CHOC Physicians Network and
Children's Hospital of Orange County
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Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader
Authorized Signature

6/20/2019
Date

Attachment to June 27, 2019 Special Board of Directors Meeting – Agenda Item 17

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868



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



JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).¹

BACKGROUND:

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).² The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.³ In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to “Subcontracts” into compliance with the new and more stringent federal requirements.⁴ As of now, and consistent with historical practice and Title 22 of the California Code of

¹ 42 CFR, Part 438 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rqn=div5>

² See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

³ See 42 CFR 438.2, “Definitions.”

⁴ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Regulations (CCR) Section 53250,⁵ DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.⁶

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.⁷

POLICY:

I. Required Characteristics of Network Providers

Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,⁸ the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

⁵ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."

⁷ The DHCS directed payment web page is available at:
<https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>

⁸ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate

Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867. ¹
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

¹ Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

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Attachment A

7	<p>Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.</p>
8	<p>Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:</p> <p>a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees.</p> <p>b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.</p> <p>c) In a form maintained in accordance with the general standards applicable to such book or record keeping.</p> <p>d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.</p> <p>e) Including all Encounter Data for a period of at least ten (10) years.</p> <p>f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.</p> <p>g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud.</p> <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).</p>

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Attachment A

9	<p>Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.</p>
10	<p>Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider:</p> <ul style="list-style-type: none"> a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.</p>
11	<p>Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.</p>
12	<p>Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.</p>
13	<p>Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.</p>
14	<p>Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.</p>
15	<p>Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.</p>

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Attachment A

16	<p>Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.</p>
17	<p>Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.</p>
18	<p>Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.</p>
19	<p>Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.</p>
20	<p>If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p>Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum:</p> <ol style="list-style-type: none"> 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. <p>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.</p>
21	<p>Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.</p>
22	<p>Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.</p>

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Attachment A

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
 - a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
 - b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
 - c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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
Authorized Signature

11/28/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018 **Regular Meeting of the CalOptima Board of Directors**

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data.

CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately \$274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

CalOptima Board Action Agenda Referral
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
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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
Authorized Signature

7/25/2018
Date

*Attachment to August 2, 2018 Board of Directors Meeting –
Agenda Item 5*

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

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:
 - 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.~~

Rev.
6/7/2018

6/7/2018:
Continued
to future
Board
meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
 - a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
 - b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

- c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
 - a. Community-based organizations; or
 - b. Consumer advocates.

While two (2) of the WCM-FAC’s eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California’s 1115 “Bridge to Reform” Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima’s Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima’s health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima’s direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model

CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations

CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy

The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

Memorandum of Understanding (MOU)

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.

Whole Child Model Family Advisory Committee (WCM FAC)

In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:

Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

CBO/Advocate Representatives

1. ~~Michael Arnot for a two year term ending June 30, 2020;~~
2. ~~Sandra Cortez Schultz for a one year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two year term ending June 30, 2020; and~~
4. ~~Diane Key for a one year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

Staff recommends Board approval of the proposed nominees for the WCM FAC.

6/7/2018:
Continued
to future
Board
meeting.

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**



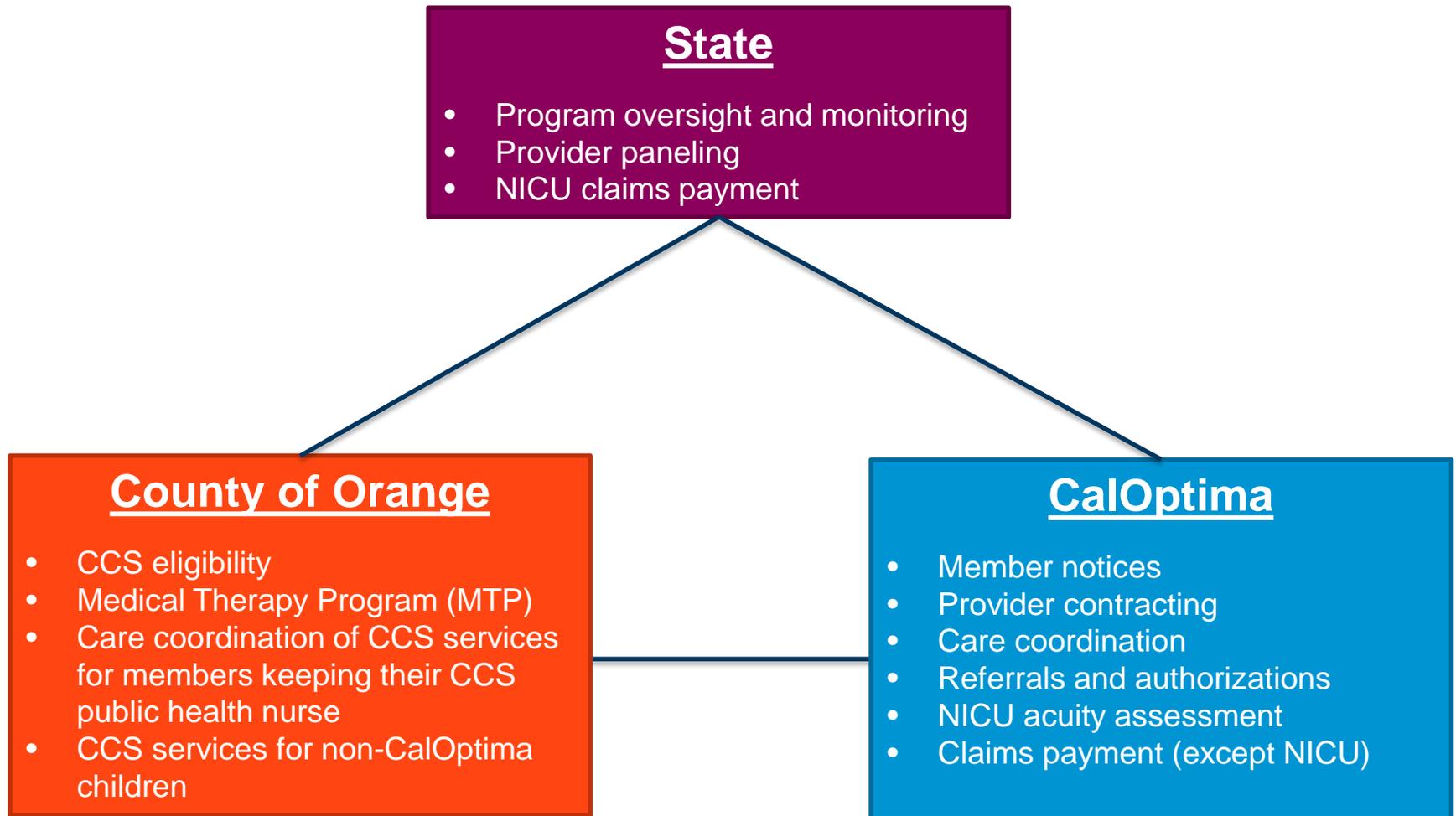
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Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
 - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
 - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
 - 90 percent are CalOptima members

Languages

- Spanish = 48 percent
- English = 44 percent
- Vietnamese = 4 percent
- Other/unknown = 4 percent

City of Residence (Top 5)

- Santa Ana = 23 percent
- Anaheim = 18 percent
- Garden Grove = 8 percent
- Orange = 6 percent
- Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
 - Hospital Association of Southern California
 - Safety Net Summit - Coalition of Orange County Community Health Centers
 - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
 - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings



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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
 - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system
- Using existing model creates several advantages
 - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
 - Improves clinical outcomes and health care experience for members and their families
 - Decreases inappropriate medical and administrative costs
 - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
 - Follow current fee-for-service methodology and policy
 - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
 - Keep health network risk and payment structure similar to current methodologies in place
 - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations
- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)
- Facilitating transitions of care
 - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
 - Between CalOptima, OC HCA and other counties
 - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
 - CCS panel status will be part of credentialing process
 - CCS members will be able to select their CCS specialists as primary care provider
 - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
 - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
 - Leverage DHCS template
 - Outlines responsibilities related:
 - CCS eligibility and enrollment
 - Case management
 - Continuity of care
 - Advisory committees
 - Data sharing
 - Dispute management
 - NICU
 - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
 - Eleven voting seats
 - Seven to nine family representative seats
 - Two to four community-based organizations or consumer advocates
 - Priority to family representatives
 - Two-year terms, with no term limits
 - Staggered terms
 - In first year, five seats for one-year term and six seats for two-year term
 - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
 - All eligible applicants in family category were selected
 - One applicant was ineligible as she has no prior CCS experience
 - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	Michael Arnot Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	Sandra Cortez – Schultz Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	Gabriela Huerta Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks
- Planned stakeholder engagement
 - Community-based organization focus groups in June
 - General event in July
 - Family events in Fall
- Future Board actions
 - Update policies and procedures
 - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017 Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

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

Recommended Actions

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).

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Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
 - i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
 - ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
 - iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
 - i. Community-based organizations; or
 - ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is \$3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is \$13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader
Authorized Signature

10/23/2017
Date

RESOLUTION NUMBER 17-1102-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE

WHEREAS, the CalOptima Board of Directors (hereinafter “the Board”) would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter “CalOptima Whole-Child Model Family Advisory Committee”; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter “WCM-FAC”) is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
 - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
 - CalOptima members age 18-21 who are current recipients of CCS services; or
 - Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
 - Community-based organizations (CBOs); or
 - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/ _____

Title: Chair, Board of Directors

Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:

/s/ _____

Suzanne Turf, Clerk of the Board



Policy #: AA.1271PP
Title: **Whole Child Model Family Advisory Committee**
Department: General Administration
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 06/07/18
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

1 **I. PURPOSE**

2
3 This policy describes the composition and role of the Family Advisory Committee for Whole Child
4 Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates
5 to the Whole Child Model Family Advisory Committee (WCM FAC).
6

7 **II. POLICY**

- 8
9 A. As directed by CalOptima’s Board of Directors (Board), the WCM FAC shall report to the
10 CalOptima Board and shall provide advice and recommendations to the CalOptima Board and
11 CalOptima staff in regards to California Children’s Services (CCS) provided by CalOptima Medi-
12 Cal's implementation of the WCM.
13
14 B. CalOptima’s Board encourages Member and community involvement in CalOptima programs.
15
16 C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of
17 interest may exist and shall abide by CalOptima’s conflict of interest code and, in accordance with
18 CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.
19
20 D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested
21 by the Department of Health Care Services (DHCS).
22
23 E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health
24 care consumers within the Whole-Child Model population. WCM FAC members shall have direct
25 or indirect contact with CalOptima Members.
26
27 F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be
28 comprised of eleven (11) voting members representing CCS family members, as well as consumer
29 advocates representing CCS families. Except as noted below, each voting member shall serve a two
30 (2) year term with no limits on the number of terms a representative may serve. The initial
31 appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to
32 stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a
33 one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term.
34 The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve
35 two (2) year terms thereafter.
36
37

- 1 1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following
2 categories, with a priority to family representatives (i.e., if qualifying family representative
3 candidates are available, all nine (9) seats will be filled by family representatives):
4
 - 5 a. Authorized representatives, including parents, foster parents, and caregivers, of a
6 CalOptima Member who is a current recipient of CCS services;
7
 - 8 b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients
9 of CCS services; or
 - 10 c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS
11 services.
- 12 2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services,
13 including:
 - 14 a. Community-based organizations; or
 - 15 b. Consumer advocates.
- 16 3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based
17 organizations or consumer advocates, an additional two (2) WCM FAC candidates representing
18 these groups may be considered for these seats in the event that there are not sufficient family
19 representative candidates to fill the family member seats.
- 20 4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC
21 member or family member representative.
- 22 5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to
23 serve on a statewide stakeholder advisory group.

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32 G. Stipends

- 33 1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem
34 payment to a member or family representative serving on the WCM FAC. CalOptima shall
35 maintain a log of each payment provided to the member or family representative, including type
36 and value, and shall provide such log to DHCS upon request.
37
 - 38 a. Representatives of community-based organizations and consumer advocates are not eligible
39 for stipends.
40

41
42 H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring
43 seats, in accordance with this Policy.

44
45 I. WCM FAC Vacancies

- 46 1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated
47 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.

- 1 1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.
2

3 **III. PROCEDURE**
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5 A. WCM FAC meeting frequency
6

- 7 1. WCM FAC shall meet at least quarterly.
8
9 2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or
10 after January of each year.
11
12 3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum
13 must be present for any votes to be valid.
14

15 B. WCM FAC recruitment process
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- 17 1. CalOptima shall begin recruitment of potential candidates in March of each year. In the
18 recruitment of potential candidates, the ethnic and cultural diversity and special needs of
19 children and/or families of children in CCS which are or are expected to transition to
20 CalOptima's Whole-Child Model population shall be considered. Nominations and input from
21 interest groups and agencies shall be given due consideration.
22
23 2. CalOptima shall recruit for potential candidates using one or more notification methods, which
24 may include, but are not limited to, the following:
25
26 a. Outreach to family representatives and community advocates that represent children
27 receiving CCS;
28
29 b. Placement of vacancy notices on the CalOptima website; and/or
30
31 c. Advertisement of vacancies in local newspapers in Threshold Languages.
32
33 3. Prospective candidates must submit a WCM Family Advisory Committee application, including
34 resume and signed consent forms. Candidates shall be notified at the time of recruitment
35 regarding the deadline to submit their application to CalOptima.
36
37 4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its
38 membership whether there are interested candidates who wish to be considered as a chair or
39 vice chair for the upcoming fiscal year.
40
41 a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested
42 candidates who wish to be considered as a chair for the first year.
43

44 C. WCM FAC nomination evaluation process
45

- 46 1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not
47 being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the
48 first nomination process, Member Advisory Committee (MAC) members shall serve on the
49 nominations ad hoc subcommittee to review candidates for WCM FAC.
50

- 1 a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME),
2 may be included on the subcommittee to provide consultation and advice.
3
- 4 2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC
5 nomination ad hoc subcommittee).
6
- 7 a. Ad hoc subcommittee members shall individually evaluate and score the application for
8 each of the prospective candidates using the applicant evaluation tool.
9
- 10 b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair
11 from among the interested candidates.
12
- 13 c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a
14 prospective candidate’s references for additional information and background validation.
15
- 16 3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate
17 for each of the expiring seats by using the findings from the applicant evaluation tool, the
18 attendance record if relevant and the prospective candidate’s references.
19
- 20 D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC
21 candidates:
22
- 23 1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair,
24 and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval.
25 Following WCM FAC’s approval (or in the first year, the MAC), the proposed chair, vice chair
26 and slate of candidates shall be submitted to CalOptima’s Board for approval.
27
- 28 2. The WCM FAC members’ terms shall be effective upon approval by the CalOptima Board.
29
- 30 a. In the case of a selected candidate filling a seat that was vacated mid-term, the new
31 candidate shall attend the immediately following WCM FAC meeting.
32
- 33 3. WCM FAC members shall attend a new advisory committee member orientation.
34

35 **IV. ATTACHMENTS**

- 36
- 37 A. Whole-Child Model Member Advisory Committee Application
- 38 B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
- 39 C. Whole-Child Model Community Advisory Committee Application
- 40 D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool
- 41

42 **V. REFERENCES**

- 43
- 44 A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- 45 B. CalOptima Board Resolution 17-1102-01
- 46 C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
- 47 D. Welfare and Institutions Code §14094.17(b)
- 48

49 **VI. REGULATORY AGENCY APPROVALS**

Policy #: AA.1271

Title: Whole Child Model Family Advisory Committee

Effective Date: 06/07/18

1 None to Date
2

3 **VII. BOARD ACTIONS**
4

5 A. 11/02/17: Regular Meeting of the CalOptima Board of Directors
6

7 **VIII. REVIEW/REVISION HISTORY**
8

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

9
10

DRAFT

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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 (21) 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.

4

DRAFT

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____
 Address: _____ Secondary Phone: _____
 City, State, ZIP: _____ Fax: _____
 Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- CalOptima members age 18–21 who are current recipients of CCS services; or
- Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

Please provide a brief description of your knowledge or experience with California Children's Services: _____

Please explain why you wish to serve on the WCM FAC: _____

Describe why you would be a qualified representative for service on the WCM FAC: _____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? Yes No

Please supply two references (professional, community or personal):

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Address: _____

Address: _____

City, State, ZIP: _____

City, State, ZIP: _____

Phone: _____

Phone: _____

Email: _____

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**.

[Back to Agenda](#)

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

1 I understand that a revocation will not affect the ability of CalOptima or any health care provider to use
2 or disclose the health information to the extent that it has acted in reliance on this authorization.

3 **RESTRICTIONS:**

4
5 I understand that anything that occurs in the context of a public meeting, including the meetings of the
6 Whole Child Model Family Advisory Committee, is a matter of public record that is required to be
7 disclosed upon request under the California Public Records Act. Information related to, or relevant to,
8 information disclosed pursuant to this authorization that is not disclosed at the public meeting remains
9 protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and
10 will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by
11 HIPAA without authorization, or is required by law.

12 **MEMBER RIGHTS:**

- 13
- 14 • I understand that I must receive a copy of this authorization.
 - 15 • I understand that I may receive additional copies of the authorization.
 - 16 • I understand that I may refuse to sign this authorization.
 - 17 • I understand that I may withdraw this authorization at any time.
 - 18 • I understand that neither treatment nor payment will be dependent upon my refusing or agreeing
19 to sign this authorization.

20 **ADDITIONAL COPIES:**

21
22 Did you receive additional copies? Yes No

23 **SIGNATURE:**

24
25 By signing below, I acknowledge receiving a copy of this authorization.

26 Member Signature: _____ Date: _____

27 Signature of Parent or Legal Guardian: _____ Date: _____

28
29
30 ***If Authorized Representative:***

31 Name of Personal Representative: _____

32 Legal Relationship to Member: _____

33 Signature of Personal Representative: _____ Date: _____

34
35 ***Basis for legal authority to sign this Authorization by a Personal Representative***

36 (If a personal representative has signed this form on behalf of the member, a copy of the Health Care
37 Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

- 1 administrator of a deceased member's estate), or other legal documentation demonstrating the authority
- 2 of the personal representative to act on the individual's behalf must be attached to this form.)



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

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
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

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

**Instructions: Please answer all questions. You may handwrite or type your answers.
Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.**

Name: _____ Work Phone: _____
 Address: _____ Mobile Phone: _____
 City, State ZIP: _____ Fax Number: _____
 Date: _____ Email: _____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children’s Services (CCS), including:

- Community-based organizations
- Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

4. Please explain why you wish to serve on the WCM FAC:

5. Describe why you would be a qualified representative for service on the WCM FAC:

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? Yes No

8. Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State ZIP: _____	City, State ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868

Attn: Becki Melli

Email: bmelli@caloptima.org

For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima’s website, and even if not presented to the Board, will be available on request to members of the public.

Signature

Date

Print Name



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

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
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
_____ Name of Evaluator	Back to Agenda	Total Points Awarded _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2009 Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Approve Health Network Contract Rate Methodology

Contact

Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action

Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background

Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or “rebase” these payment rates.

The purpose of this year’s rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima’s delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year’s rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity “kick” payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion

CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact

CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation

Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachments

None

/s/ Richard Chambers
Authorized Signature

5/27/2009
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003 **Special Meeting of the CalOptima Board of Directors**

Report Item

VI. A. Approve Modifications to the CalOptima Health Network Capitation
Methodology and Rate Allocations

Contact

Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action

Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background

CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate “pass throughs” as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima’s health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continue 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
Authorized Signature

12/9/2003
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

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019 **Special Meeting of the CalOptima Board of Directors**

Supplemental Report Item

S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions

Authorize the \$60 million identified for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Background

Supervisor Do is requesting consideration to allocate the \$60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:

1. Clinic health care services in all homeless shelters – \$10 million
2. Authorize mobile health team to respond to all homeless providers – \$10 million
3. Residential support services and housing navigation – \$20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – \$20 million

Attachments

1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, \$60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the \$60 million allocated:

- Clinic health care services in all homeless shelters - \$10 million
- Authorize mobile health team to respond to all homeless providers - \$10 million
- Residential support services and housing navigation - \$20 million
- Extend recuperative care for homeless individuals with chronic physical health issue-\$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,



ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of \$100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately \$100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved \$60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - \$10 million*
As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - \$10 million*
Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - \$20 million*
The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - \$20 million*
CalOptima has twice allocated funds for recuperative care, bringing the total to \$11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

Supervisor Andrew Do
June 5, 2019
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In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the “urgent” elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,



Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors



ANDREW DO

SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS

333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687

PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the \$60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the \$60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of \$10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services “eventually” will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

A handwritten signature in blue ink that reads "Andrew Do". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors



CalOptima
Better. Together.

Homeless Health Initiatives and Next Steps

**Special Meeting of the Board of Directors
June 27, 2019**

**David Ramirez, M.D., Chief Medical Officer
Tracy Hitzeman, RN, Executive Director, Clinical Operations**

Background

- Goals
 - Reverse trend of homeless deaths
 - Build a better system of care for members who are homeless
 - Prioritize population health for this group
 - Reduce health disparities and improve outcomes
- Homeless Health Initiative, guided by Board Ad Hoc
 - Deliver urgent-care-type services to individuals where they are
 - Develop health system for those unable to access traditional health care settings
 - Bridge care to existing system for routine and preventive services

Current Focus Areas

- Expand CalOptima's reach
 - Increase access to clinical field teams
 - Expand mobile clinic services at shelters
 - Outreach to potentially homeless members
- Engage stakeholders
- Gather data
- Enhance existing and integrate new programs
 - Whole-Person Care (WPC)
 - Health Homes Program (HHP)

Expand CalOptima's Reach

- Increase access to clinical field teams for the hardest-to-reach homeless individuals
 - CalOptima now accepting referrals from shelters and City Net
 - Informational flier developed and distributed
 - Dedicated CalOptima phone line
- Expand mobile clinic services at shelters
 - June 28 meeting to connect shelters and clinics
 - Creating incentives to support improved access
 - Ensure coordination with health networks
- Outreach to potentially homeless members
 - In-person visits at shelters and hot spots
 - Call campaign

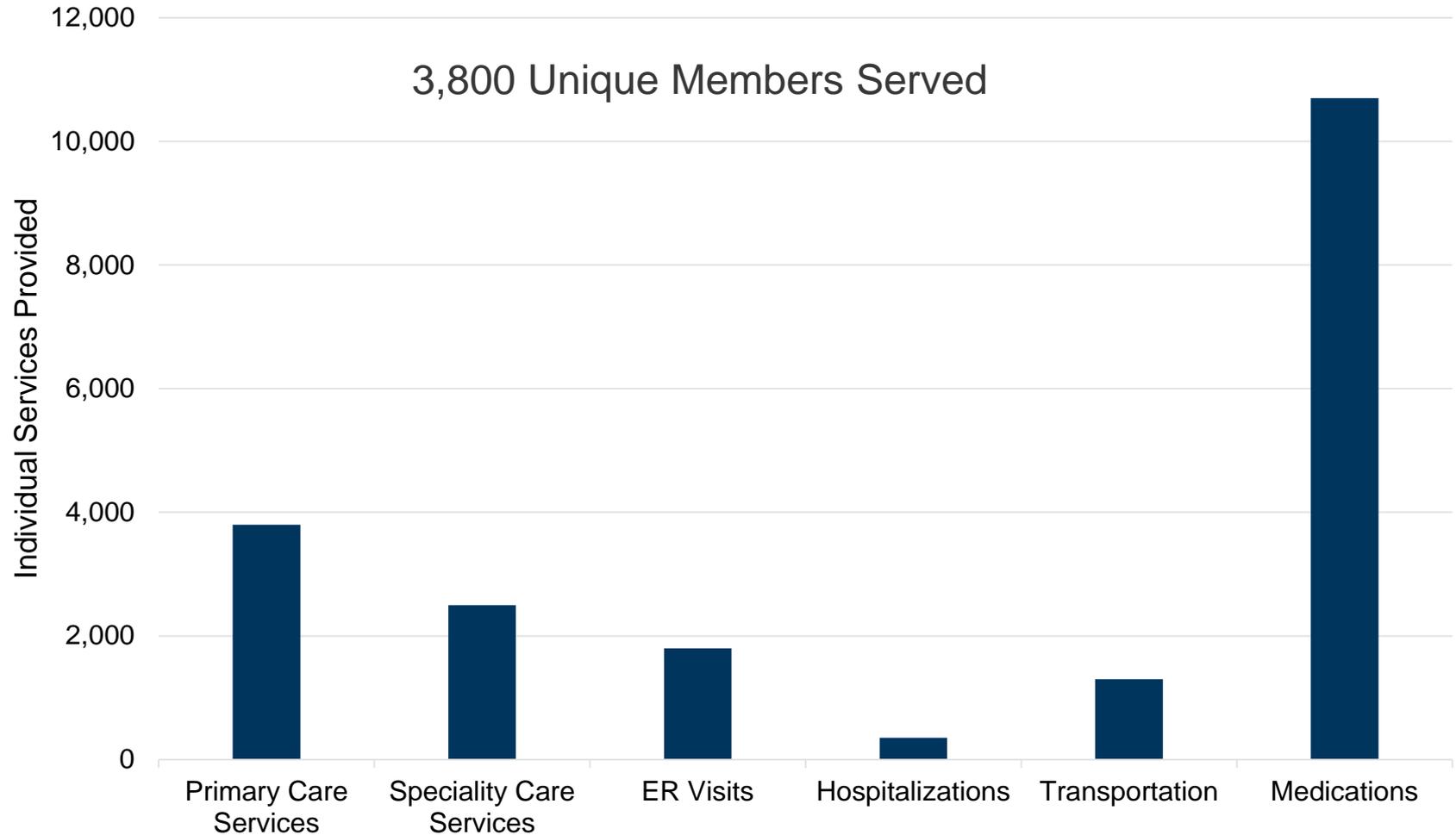
Engage Stakeholders

- Ad Hoc and staff are actively meeting with stakeholders, for example:
 - United Way
 - Kaiser Health Foundation
 - Homeless advocates
 - Elected officials
 - WPC representatives from San Bernardino County
 - Tri Parish/Diocese Homeless Collaborative
 - Community Alliances Forum
 - Anaheim Homeless Collaborative
 - Collaborative to Assist Motel Families
 - Continuum of Care Homeless Provider Forum
 - WPC Collaborative and WPC Steering Committee

Gather Data

- CalOptima data
 - Current utilization
 - Network distribution
 - Conditions and outcomes
- Experience of clinical field teams
 - Common conditions
 - Coordination needs
 - Patient refusal
- External data sources
 - Coroner data
 - Coordinated Entry System (HMIS)

Utilization Data for January 2019



Existing and New Programs

- Existing Programs

- Special population Personal Care Coordinators

- 514 in-person visits since January 2019
 - Sites visited include Courtyard, La Mesa Shelter, IFRC Buena Park and IFRC Midway
 - Meeting with community-based and social support services organizations to improve coordination for members

- WPC

- Increased number of collaborative partners
 - Working on data alignment with WPC Connect

- New Programs

- HHP

- Enhanced services for members who qualify and elect to participate
 - Launching January 1, 2020, for members with chronic conditions only
 - Launching July 1, 2020, for members with serious mental illness

HHP Background

- Federal: Authorized under Section 2703 of the Affordable Care Act
 - State option to implement; may be in phases and in specific geographies
 - 90% federal funding for eight quarters and 50% thereafter
 - Must be available to dual eligibles
- State: Authorized under California's AB 361 (2013)
 - Establishes HHP as a Medi-Cal benefit in limited geographic areas
 - Permits implementation if no General Fund dollars are used
 - Requires Department of Health Care Services (DHCS) evaluation within two years of initial implementation

HHP Member Eligibility

- Medi-Cal members eligible for HHP

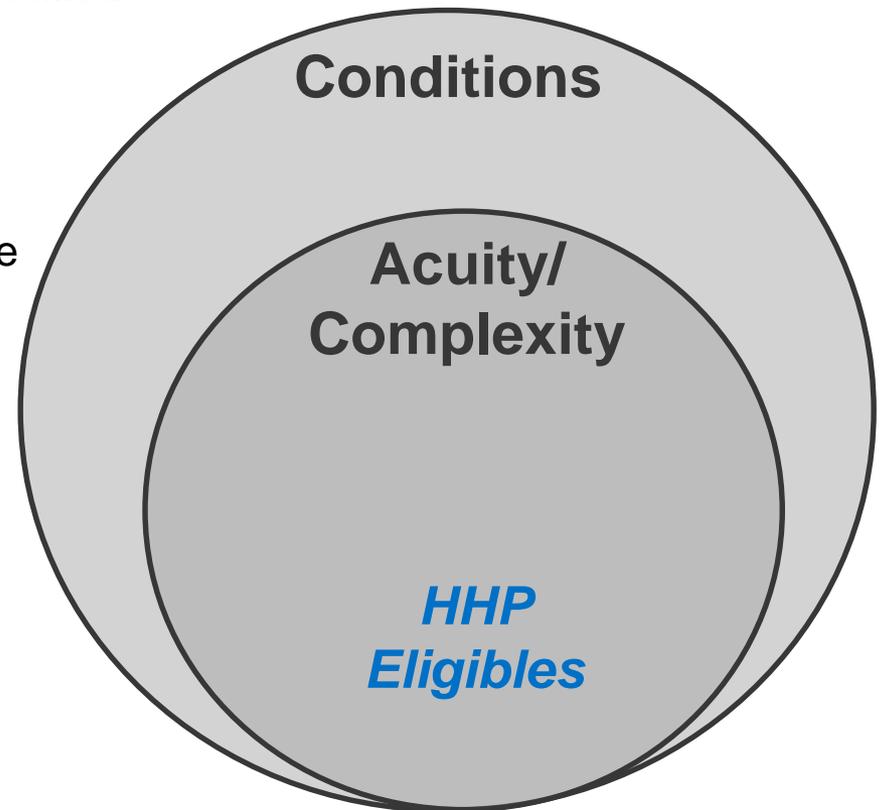
1. Conditions/combination of conditions specified by DHCS

- Chronic physical conditions, or
- Substance use disorder, or
- Serious mental illness

➤ Member must have at least two separate services on different dates within 16 months for the identified condition

2. Acuity/Complexity (one of the below):

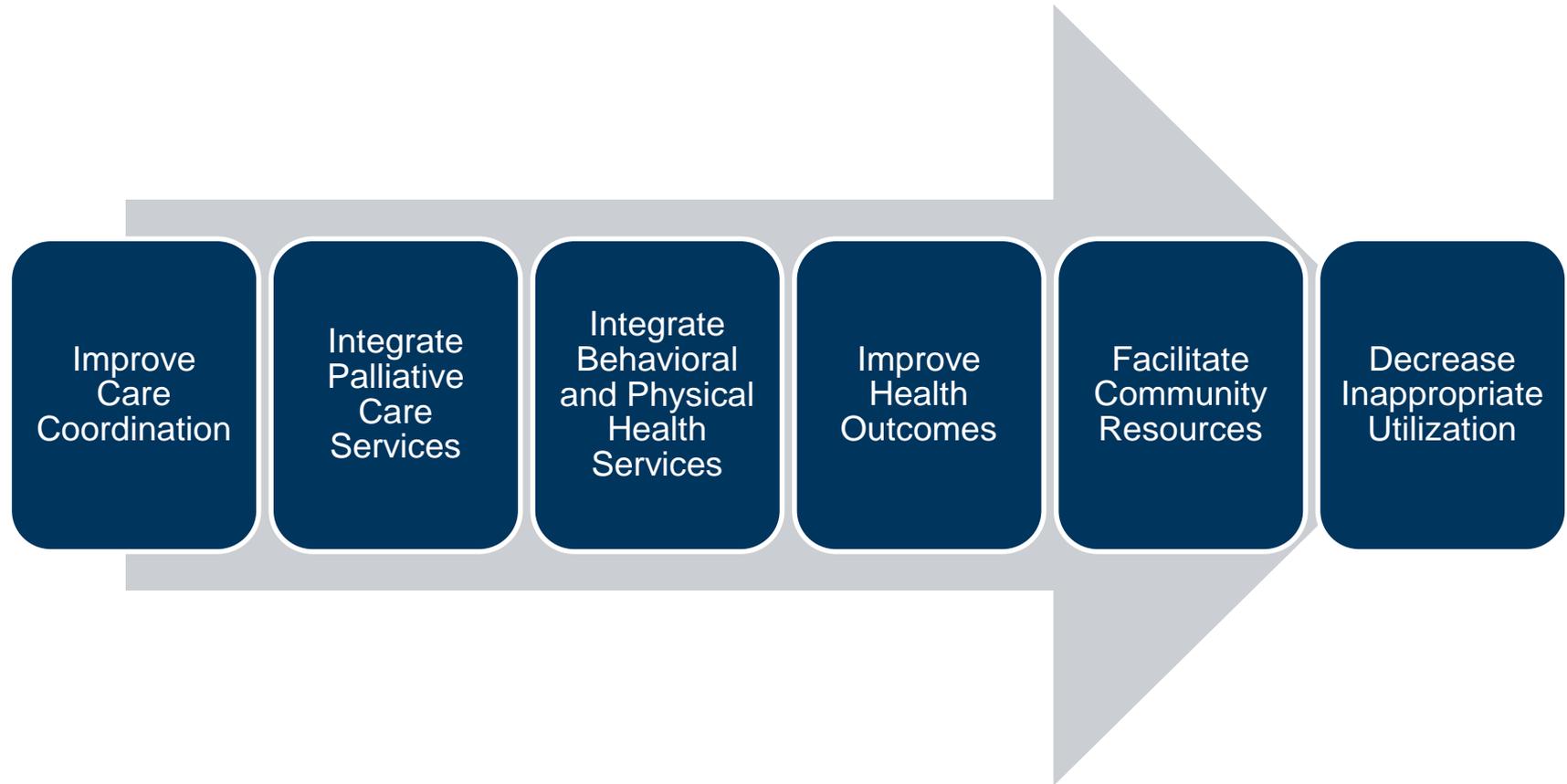
- Three specified conditions, or
- One inpatient stay, or
- Three ED visits in year, or
- Chronic homelessness



Homeless Potentially Eligible for HHP

Health Network	Estimated Medi-Cal Members Eligible for HHP	Number of Estimated Members Eligible for HHP who are Homeless	Percentage of Estimated Members Eligible for HHP who are Homeless
CCN/COD	5,558	964	17%
Monarch	4,185	416	10%
Arta Western	2,752	352	13%
AltaMed	1,949	341	17%
Prospect	1,654	148	9%
Kaiser	1,599	56	4%
Family Choice	1,410	93	7%
Talbert	1,133	105	9%
Noble	1,015	155	15%
CHOC	881	40	5%
United Care	876	77	9%
AMVI	437	55	13%
HPN-Regal	270	20	7%
Total	23,719	2,725	11%

HHP Objectives and Goals



HHP Service Requirements

Core Service Categories

Provide comprehensive care management

Conduct health assessments and develop action plans

Provide comprehensive transitional care

Offer care coordination and health promotion

Offer individual and family support

Make referrals to community and social support services

New Services

Follow up on referrals to ensure services are offered and accessed

Accompany participants to appointments

Assist homeless members with housing navigation

Manage transitions from non-hospital or nursing facility settings, such as jail and residential treatment programs

Assess the family/caregiver support

Apply trauma-informed care standards

Exploration of Delivery Model

- Worked with consultants, health networks and advisory groups to develop initial approach
 - CalOptima acts as primary community-based care management entity (CB-CME) for members
 - Exception: Health networks may elect to provide CB-CME services for their assigned members
 - Members electing to participate in HHP will move to CCN or elect a participating health network
 - CalOptima to “buy” select “new” services that may be leveraged by health networks, e.g., housing-related services and accompaniment
- Per DHCS requirements, potential delivery model considerations submitted for review
 - DHCS provided feedback that required modifications to network and care delivery models

DHCS Feedback on the Model

- Plan cannot require member to change PCP or health network
- Plan must support care management at point of care in the community
- DHCS requested additional clarification regarding how CalOptima will ensure:
 - Face-to-face care coordination in the community when appropriate
 - Strong direct connection and coordination with member's PCP

Modified Network Delivery Model

- All health networks will participate as CB-CMEs for their assigned members
 - Members participating in HHP are able to keep their PCP and other providers
 - Health networks will have increased visibility to all medical records to plan and coordinate appropriate care
- CalOptima will engage a vendor for selected services (e.g., medical appointment accompaniment and housing navigation/sustainability)
 - Contract will require the vendor to extend the same terms regarding vendor performance, duties and obligations, and rates to health networks

HHP/WPC Collaboration

- CalOptima partnering with County's WPC pilot to:
 - Develop criteria and systematic approach to identify HHP-eligible members within WPC population
 - Develop training for WPC providers to proactively identify members who meet HHP eligibility criteria and refer them to CalOptima for HHP eligibility approval
 - Build off the services already developed by WPC for the HHP population
- WPC pilot:
 - Cannot duplicate services for the same beneficiaries as the HHP
 - Care coordination provided through HHP

Bridging to Existing System

Nontraditional Settings

- Clinical Field Teams
- Mobile Clinics

Transitional Settings

- Clinics in Shelters
- On-Site Supportive Services

Existing System

- Clinics
- Office-Based Providers
- Telephonic Case Management

CalOptima's Mission

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



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.