NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, AUGUST 1, 2019
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	INTERIM CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Sharon Dwiers

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(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

Back to Agenda

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Whole-Child Model Transition
   b. Homeless Health Initiative
   c. Strategic Planning Session
   d. Pharmacy Carve-Out
   e. Value-Based Payments for Behavioral Health Integration
   f. Assembly Bill 1642 – Medi-Cal Sanctions
   g. Exploration of Dental Integration
   h. Passing of PAC Member Theodore Caliendo, M.D.

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 27, 2019 Special Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the March 14, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee and the May 9, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

REPORTS

3. Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care for the Elderly Primary Care Provider Incentive Program and Related Changes to PCP Contracts

4. Consider Authorizing the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service and Clinic Provider Contracts for CalOptima Program of All-Inclusive Care for the Elderly

5. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

6. Consider Authorizing and Directing the Execution of an Amendment to the Primary Agreement with the California Department of Health Care Services Related to the Addition of Covered Aid Codes

7. Consider Authorizing Approval of Revised Policy GG.1517, Transgender Services

8. Consider Authorizing Amendment to the Vision Service Plan HMO Services Contract

Back to Agenda

9. Consider Ratifying Early Payment of the Prepayment for Services to be Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds

10. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Clinic Contracts Associated with St. Joseph Health

11. Consider Ratifying Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts Associated with St. Joseph Health

12. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Specialist Contracts Associated with Children's Hospital of Orange County

13. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policy

14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

15. Consider Allocation of Intergovernmental Transfer 5 Funds

16. Consider Actions Related to Homeless Health Care Delivery

17. Consider Development of a CalOptima Homeless Clinic Access Program for Homeless Health Initiative

18. Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

19. Consider Actions Related to CalOptima's Health Homes Program

20. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport Provider Services

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

22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

23. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

24. Consider Approval of New CalOptima Policy GA.4010: Service Animals

Back to Agenda

ADVISORY COMMITTEE UPDATES

25. Member Advisory Committee Update

26. Provider Advisory Committee Update

INFORMATION ITEMS

27. CalOptima HealthCare Services Delivery Model Evaluation Update

28. Behavioral Health In-House Transition

29. May and June 2019 Financial Summaries

30. Compliance Report

31. Federal and State Legislative Advocates Report

32. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

Back to Agenda

MEMORANDUM

DATE:	August 1, 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

Active Communication, Collaboration Lead to Smooth Whole-Child Model (WCM) Transition on July 1

CalOptima began providing California Children's Services (CCS) benefits to approximately 11,700 CCS-eligible members under the WCM program on July 1. Ample preparation and frequent communication with members, providers and health networks resulted in a seamless transition. Below are several elements that contributed to the success of this major effort:

- Member Outreach: In advance of the transition, members experienced a high level of outreach. They received a 90-day and 60-day notice prior to July 1, a WCM Member Guide developed by CalOptima, and automated calls during a call campaign that had a 72 percent success rate. Our Case Management department also connected with members to complete Health Needs Assessments. Staff reported that families were eager to engage in conversation and expressed gratitude for the outreach. Additionally, each WCM member was assigned a Personal Care Coordinator from whom they received a welcome letter.
- Member Services and Resources: All eligibility processes are in place and functioning, enabling members to reliably access necessary services, including from out-of-county tertiary care facilities. Members and families who need support with navigation and questions can reach out to a dedicated WCM Member Liaison team at CalOptima or view our member-oriented WCM webpage here. Special thanks to our WCM Family Advisory Committee, which has met bimonthly since 2018 to help guide communication with members and influence our implementation process.
- Engagement: In the months leading up to July, CalOptima, the Orange County Health Care Agency (HCA), providers, health networks and community-based organizations collaborated regularly and became well-oriented to the WCM program. CalOptima partnered with HCA to understand the best practices of the current CCS program and developed processes to continue coordination among HCA, providers, health networks and CalOptima. CalOptima's Provider Relations team held WCM-focused group and individual trainings. A WCM Clinical Advisory Committee, including representatives from HCA, the health networks and CCS-paneled providers, provided critical clinical input. Family Voices, an organization that focuses on children with special health needs, recently acknowledged that our thorough engagement of all affected organizations and members positively contributed to the smooth transition.
- Post-Transition Huddles: In the first few weeks of the transition, CalOptima held separate daily huddle meetings with HCA, health networks and internal staff to ensure any issues

that arose were addressed promptly. The frequency of the meetings was reduced by mid-July when concerns were minimal.

- CCS Advisory Group: On July 24 in Sacramento, leaders from CalOptima and HCA presented an update about Orange County's WCM transition to the advisory group, which is led by DHCS and includes representatives from all counties that have transitioned to WCM. Kristen Rogers, a parent who participates on our WCM Family Advisory Committee, and I are members of the group. Chief Medical Officer David Ramirez, M.D., and Tracy Hitzeman, executive director, clinical operations, presented on CalOptima's recent transition.

There are many individuals and groups responsible for the effective outcome of this project, and CalOptima appreciates everyone's contribution to ensuring that Orange County's CCS-eligible children realize the benefits of integrated care.

Board Makes Allocation Decisions About Homeless Health Initiative; CalOptima Releases Funding for Be Well OC

On June 27, Board members allocated the remaining $60 million of the $100 million Homeless Health Initiative to four distinct areas: clinic health care services in all homeless shelters; mobile health team response to all homeless providers; residential support services and housing navigation; and recuperative care for homeless individuals with chronic physical health issues. The ad hoc committee continues to meet regularly to oversee the effort involved in implementing the new and previously approved activities. Below are two updates of note.

- Be Well OC: CalOptima's partnership with Orange County, St. Joseph Hoag Health and Kaiser Foundation in support of the Be Well OC Regional Mental Health and Wellness Campus moved forward on July 12, when CalOptima released $11.4 million to the County. An item at your August meeting will ratify this action.
- Behavioral Health In-Service: Also on July 12, nearly 30 clinical field team representatives and CalOptima staff participated in a meeting focused on the HCA behavioral health system and services available. The valuable exchange helped the attendees better understand how to work with homeless individuals who have mental health needs.

CalOptima Strategic Planning Session Set for Friday, August 9

CalOptima Board members will begin the strategic planning process for the agency's next three-year plan, setting the course for 2020–22. California Health and Human Services Secretary Mark Ghaly, M.D., has agreed to attend the session on Friday, August 9, to provide an overview of the state's health care landscape. Facilitated by Chapman Consulting, the meeting, scheduled for 9:15 a.m. to 4 p.m. at CalOptima's offices, will be open to the public.

Pharmacy Carve-Out Meeting Allows Health Plans to Air Their Concerns

On July 24, the Department of Health Care Services (DHCS) convened the Pharmacy Carve-Out Advisory Group in Sacramento. It was an important opportunity for Medi-Cal managed care plans to provide feedback regarding the proposed transition of pharmacy to a fee-for-service program. Our state associations were successful in lobbying for a stakeholder process prior to the implementation of the governor's executive order. CalOptima attended, and our message remained the same: We support the idea of lowering pharmacy costs through bulk purchasing and use of a statewide fee schedule but believe care coordination for Medi-Cal members could suffer if the pharmacy benefit is removed from managed care plans. However, the governor

appears intent on this transition, announcing on July 22 that DHCS will soon begin accepting proposals to implement a consolidated state negotiation and purchasing system.

State Exploring Value-Based Payments for Behavioral Health Integration Projects
DHCS is in the process of developing a value-based payment program for behavioral health. The goal is to improve physical and behavioral health outcomes through better coordination and integration. Under the proposal, providers can implement one of six different types of integration projects for the value-based payment, which would flow through the managed care plan. The California Association of Health Plans provided comments on the department's proposal on behalf of member plans, including CalOptima. While we support the idea of providing incentives for integration, there are some questions about the health plans' role in administering value-based payments. More information about this program will be available after the comments are considered.

Assembly Bill Outlines How State Can Implement Sanctions for Medi-Cal Deficiencies
A state audit released in March found deficiencies in Medi-Cal services for children, leading DHCS to implement new quality requirements and financial sanctions. On July 1, Assembly Bill 1642 became the policy bill vehicle for the sanctions language, which expands the regulator's authority. Both of CalOptima's state associations have taken a stance of "oppose unless amended" on the bill. The bill advanced from the Senate Committee on Health on July 11 and will next travel to the Senate Committee on Appropriations following the Legislature's summer recess. More amendments are expected. Given the potential impact on CalOptima, our state advocates, Edelstein Gilbert Robson & Smith, are also working to ensure reasonable controls.

Presentation to Local Dental Society Is Key Step in Exploring Dental Integration
After collecting community letters of support for exploring dental integration, CalOptima has taken the next step to engage leaders in the Orange County Dental Society (OCDS). On July 23, CalOptima presented an overview about our agency and interest in collaborating to explore integrating physical and dental health for our members. Having grassroots support from OCDS will help pave the way to approach the California Dental Society (CDA) next. If CDA is also amenable to exploration of a dental carve-in, CalOptima will approach DHCS to propose a pilot project for a future state budget. A fellow county organized health system, Health Plan of San Mateo is currently working on a state-approved dental integration pilot.

Longtime Provider Advisory Committee Member Dr. Caliendo Passes Away
A member of our Provider Advisory Committee for nearly a decade, pediatrician Theodore Caliendo, M.D., 77, passed away on June 20. His many CalOptima colleagues and friends appreciated his insights about the physician community and willingness to serve by taking on additional roles within the committee. A celebration of his life was held in July.

Back to Agenda

MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 27, 2019

A Special Meeting of the CalOptima Board of Directors was held on June 27, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Vice Chair Khatibi led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Alexander Nguyen, M.D.; Supervisor Michelle Steel

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 Dwiers, Interim Clerk of the Board

Chair Yost announced that he was reordering the agenda to hear Agenda Item 1, Chief Executive Officer Report after Agenda Item 17.

PUBLIC COMMENTS

None

CONSENT CALENDAR

2. Minutes
   a. Approve 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 Physician Network

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

Back to Agenda

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

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 7-0-0; Director Schoeffel recused for Items 3 and 4 due to potential conflicts of interest; Chair Yost recused for Item 4 due to his affiliation with CHOC as a physician anesthesiologist)***

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

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

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 Clinic contracts, except those associated with the 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 All Plan Letter 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 fee-for-service rates for the provision of services to the extent authorized by the Board. (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained)***

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

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 Berger, 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 Clinic 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 All Plan Letter 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 fee-for-service rates for the provision of services to the extent authorized by the Board. (Motion carried 6-0-0; Director Schoeffel absent)

8. 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.

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
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

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 Primary Care Physician 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 All Plan Letter 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. (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained)***

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
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director Penrose did not participate in this item due to his affiliation with Providence St. Joseph Health.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized ratification of 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. (Motion carried 5-0-0; Director Schoeffel absent; Director Penrose recused)***

11. Consider Ratifying Amendments to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Hospital Contracts Associated with Kindred Healthcare
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Chair Yost did not participate in this item due to his wife's affiliation with Kindred as a pharmacist and left the room during discussion and vote.

Back to Agenda

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized ratification of 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. (Motion carried 5-0-0; Director Schoeffel and Chair Yost absent)***

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 (CHOC) and the University of California, Irvine (UCI)

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

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 Specialist contracts except those associated with St. Joseph Health, Children's Hospital of Orange County and University of California, Irvine to: 1) Include all necessary language requirements as set forth in the California Department of Health Care Services All Plan Letter 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 fee-for-service rates for the provision of services to the extent authorized by the Board. (Motion carried 5-0-1; Director Schoeffel absent and Supervisor Do abstained)***

13. 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)

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

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 amend CalOptima Medi-Cal, OneCare, OneCare Connect and PACE fee-for-services Specialist Contracts associated with University of California, Irvine to 1.) Include all necessary language requirements as set forth in the California Department of Health Care Services All Plan Letter 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. (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained)***

Back to Agenda

14. 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.

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 (CHOC)
Continued to a future meeting due to lack of quorum.

16. 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.
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 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) Amend capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board. (Motion carried 6-0-0; Director Schoeffel absent)***

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
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Chair Yost did not participate in this item due to his affiliation with CHOC as a physician anesthesiologist.

Action: ***On motion of Supervisor Do, 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 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. (Motion carried 5-0-0; Director Schoeffel absent; Chair Yost recused)

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader announced that CalOptima's new website has been launched and that feedback has been positive.

Mr. Schrader also provided an update on the Homeless Health Board Ad Hoc Committee's work including meetings with various stakeholders, and a trip to Phoenix, Arizona organized by Be Well/Mind OC that included site visits to several entities that are implementing innovative approaches to coordinating care for the homeless population.

Chair Yost reordered the agenda to hear Agenda Item 18 immediately following Agenda Item 1 and before Agenda Item S17a.

INFORMATION ITEMS

18. Consider Homeless Health Initiatives and Next Steps

David Ramirez, M.D., Chief Medical Officer, provided an overview of the Homeless Health Ad Hoc activities, including meeting with homeless advocates, health network representatives, and various organizations including United Way and Kaiser Permanente.

Tracy Hitzeman, R.N., Executive Director, provided additional information on how the clinical field teams coordinate care in various settings, including shelters, and how they are working with external entities to ensure access to health care services for the homeless population.

REPORTS

S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Supervisor Do introduced the item, requesting allocation of $60 million as noted in the supplemental report item. Chair Yost reminded the Board that the use of Medi-Cal funds is limited to covered Medi-Cal benefits for members, and that recuperative care is not currently a covered Medi-Cal benefit.

After considerable discussion, the Board took the following action.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized 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; and 4) Extend recuperative care for homeless individuals with chronic***

physical health issue - $20 million. (Motion carried 4-3-0; Supervisor Do, Vice Chair Khatibi, and Directors Berger and Schoeffel voting in favor of the motion; Chair Yost and Directors DiLuigi and Penrose voting no)

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:01 p.m.

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

Approved: August 1, 2019

Back to Agenda

MINUTES

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

March 14, 2019

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on March 14, 2019, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Molnar called the meeting to order at 2:35 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Sandra Finestone; Diana Cruz-Toro; Connie Gonzalez; Jaime Munoz; Ilia Rolon; Sr. Mary Therese Sweeney; Christine Tolbert

Members Absent: Mallory Vega; Jacquelyn Ruddy;

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Dr. David Ramirez, Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Sesha Mudunuri, Executive Director, Operations; Betsy Ha, Executive Director, Quality Analytics, Tracy Hitzeman, Executive Director Clinical Operations; Dr. Donald Sharps, Medical Director, Behavioral Health; Belinda Abeyta, Director, Customer Service; Mauricio Flores, Manager Customer Service; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Specialist, Customer Service

MINUTES

Approve the Minutes of the January 10, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Sandra Finestone, seconded and carried, the MAC approved the minutes as submitted. (9-0-0, Ruddy and Vega absent)***

PUBLIC COMMENT
Brenda Deeley, In Representation of a Family Member, Oral re: Behavioral Health

REPORTS

Consider Recommendation of Member Advisory Candidate for Children Representative and Long-Term Services and Supports Representative

At the January 10, 2019 meeting, Chair Molnar formed a Nominations Ad Hoc Committee (Ad Hoc) comprised of herself and Members Finestone and Tolbert to review applicants for the Children Representative and the Long-Term Services and Supports (LTSS) open seats. On February 20,

2019, the Ad Hoc committee met via conference call to review and score the applicants. On behalf of the Ad Hoc, Chair Molnar reviewed the open seats and noted that the Children Representative had received two applicants and the LTSS Representative had one applicant. The Ad Hoc was unanimous in their recommendation of Pamela Pimentel to fulfill the term remaining through June 30, 2020 upon Board approval. The Ad Hoc also recommended that the MAC continue the recruiting efforts for the LTSS Representative.

Action: ***On motion of Member Sr. Mary Therese Sweeney, seconded and carried, the MAC approved the Recommendation of Pamela Pimentel for the Children Representative seat. Recommendation will be forwarded to the CalOptima Board of Directors for consideration at the May 2, 2019 meeting. (9-0-0, Ruddy and Vega absent)***

Chair Molnar having been advised that the Provider Advisory Committee (PAC) would be forming an Ad Hoc Committee to review the candidate application process prior to the next annual recruitment in 2020 suggest that MAC would also be interested in joining the PAC in this endeavor.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer (COO) Update

Ladan Khamseh, Chief Operating Officer (COO), provided a verbal update to the committee on the open nomination process for MAC and PAC and requested that the MAC members assist with recruitment for the open positions in both advisory committees. In addition, Ms. Khamseh provided an update on the Qualified Medical Beneficiaries (QMB) annual project. She also noted that the Health Homes launch was deferred from July 1, 2019 to January 1, 2020 at the request of CalOptima.

Chief Medical Officer (CMO) Update

Dr. David Ramirez, CMO, provided a verbal update on access to care and obtaining necessary care. He noted CalOptima is changing the member survey methodology and what the solutions are that are being implemented.

INFORMATION ITEMS

Chair Molnar rearranged the agenda to hear VII.B before continuing with the agenda

Healthy Smiles for Kids of Orange County Presentation

Harvey Lee, DDS, Chief Dental Officer and Ligia Hallstrom, Vice President of Field Operations provided a comprehensive presentation on Healthy Smiles for Kids of Orange County. Dr. Lee and Ms. Hallstrom noted that one in three children suffer from tooth decay in Orange County. They explained their mission was to improve the oral health of children in Orange County through collaborative programs directed at prevention, outreach and education, access to treatment and advocacy. They also estimated that over 100,000 children and parents are treated each year and that their goal is to have treated one million children by the year 2020.

MAC Member Updates

Chair Molnar noted the following seats expire on June 30, 2019: Medi-Cal Beneficiaries Representative, Adult Beneficiaries Representative, Family Support Representative, Persons with Disabilities, Recipients of CalWORKs Representative, and Seniors Representative. Members must reapply for their seat to be considered for reappointment. The Chair and Vice Chair positions are also up for nominations. In response to the annual recruitment, Chair Molnar formed a Nominations Ad Hoc Committee to meet before May 9, 2019 to evaluate and score applications. Members Gonzalez and Tolbert agreed to participate on the Ad Hoc.

Homeless Health Update

Michael Schrader, Chief Executive Officer, provided a verbal report on the Homeless Health Initiative by providing a summary of the issues that have currently been identified and the steps that are being developed to address them. He noted that CalOptima is working closely with five to six Federally Qualified Health Centers (FQHCs) to support clinical field teams. CalOptima is also seeking legal opinions on the use of Intergovernmental Transfer (IGT) Funds for non-Medi-Cal services. He also mentioned there are two paths to support housing initiatives: 1) build housing and rent assistance. CalOptima is waiting for guidance from the DHCS on this initiative and 2) offer case management to help coordinate and refer homeless people to housing services.

Opioid Crisis Presentation

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

Behavioral Health Presentation

Donald Sharps, M.D., Medical Director, Behavioral Health, presented a Behavioral Health update on the 2018 transition of the Medi-Cal behavioral health management from Magellan to CalOptima. He noted that Magellan continues to manage OneCare and OneCare Connect (OC/OCC) mental health.

State Budget Presentation

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

Back to Agenda

Dental Initiatives Presentation

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

ADJOURNMENT

Chair Molnar announced that the next MAC meeting is scheduled for Thursday, May 9, 2019 at 2:30 p.m.

Hearing no further business, Chair Molnar adjourned the meeting at 5:00 p.m.

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

Approved: June 13, 2019

Member Advisory Committee
FY 2018-2019 Accomplishments

During FY 2018-19, the Member Advisory Committee (MAC) of the CalOptima Board of Directors provided input on member issues to ensure that CalOptima members receive high quality health care services. The following list highlights the accomplishments:

- MAC members wrote letters of support to for the Denti-Cal Initiative to the Department of Health Care Services

- MAC members reviewed the intergovernmental transfer (IGT) projects and supported the funding of the proposed programs, as well as the proposed recommendations for the use of the remaining IGT funds.

- MAC Members at the request of the Board gave input into the Delivery System and the Auto Assisgnment. MAC came together with the Provider Advisory Committee (PAC) to review the items and listen to public comment before providing the Board with the requested recommendation.

- MAC participated in two joint advisory committee meetings during FY 2018-19. The first joint meeting was a Special MAC/ Provider Advisory Committee (PAC) on October 11, 2018 and the second was a MAC/OneCare Connect MAC (OCC MAC)/PAC and Whole-Child Model Family Advisory Committee (WCM FAC) on November 8, 2019. MAC hopes to continue to participate in joint advisory committee meetings on a yearly basis.

- MAC's Seniors' representative continues to participate on the PACE Advisory Committee to provide input and reports to the Quality Assurance Committee of the Board regarding the PACE Center.

- MAC held a special recruitment to identify candidates for several vacant positions. The MAC convened a special ad hoc committee to review the candidates for the vacant positions and submitted their recommendation at the May 2019 Board meeting.

- A MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates, Chair and Vice Chair for the positions due to expire on June 30, 2019. The MAC reviewed the proposed candidates at its special June 13, 2019 meeting and forwarded their recommendations to the Board for consideration and approval at its August 1, 2019 meeting.

Back to Agenda
Back to Agenda

- MAC members and individuals from the community gave informative presentations at MAC meetings to help MAC stay connected to those they represent. Topics included: Healthy Smiles, Early Identification and Intervention within Pediatric Primary Care and Optometry's Role in Patient Care.

- Several MAC members attended CalOptima sponsored community education events, such as Community Alliance Forums and Awareness and Education Seminars.

- All MAC members completed the annual Compliance Training.

- MAC Chair or Vice Chair presented a bi-monthly MAC Report at CalOptima Board of Directors' meetings to provide the Board with input and updates on the MAC's activities.

- MAC members contributed at least 205 "official" hours to CalOptima during FY 2018-19, including MAC meetings, ad hoc meetings, and Board meetings which is equivalent to 26 days per year. These hours do not account for the innumerable hours that MAC members dedicate to members on a day-to-day basis.

- MAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2018–19.

The MAC thanks the CalOptima Board for the opportunity to provide updates on the MAC's activities. The MAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

Back to Agenda
Back to Agenda

Member Advisory Committee

FY 2019-2020 Meeting Schedule

August
Thursday, August 8, 2019

October
Thursday, October 10, 2019

December
Thursday, December 12, 2019

February
Thursday, February 13, 2020

April
Thursday, April 9, 2020

June
Thursday, June 11, 2020

Regular Meeting Location and Time
CalOptima
www.caloptima.org
505 City Parkway West, 1st Floor
Orange, CA 92868
Conference Room 109-N
2:30 p.m. – 5:00 p.m.

All meetings are open to the public. Interested parties are encouraged to attend.

MINUTES

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

May 9, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, May 9, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:04 a.m. Craig Myers led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.; Pat Patton.
Members Absent:	Anjan Batra, M.D.; Jena Jensen; Brian Lee, Ph.D.
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Nancy Huang, Interim Chief Financial Officer; Gary Crockett, Chief Counsel; Michelle Laughlin, Executive Director, Network Operations; Betsy Ha, Executive Director, Quality & Population Health; Tracy Hitzeman, Executive Director, Clinical Operations; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant.

MINUTES

Approve the Minutes of the April 11, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the April 11, 2019 meeting. (Motion carried 10-0-0; Members Batra, Jensen, and Lee absent)***

PUBLIC COMMENTS

There were no requests for public comment.

REPORTS

Consider Approval of FY 2019-2020 Meeting Schedule

PAC members reviewed the proposed FY 2019-20 meeting schedule. As proposed, the PAC will meet on a monthly basis on the second Thursday of the month except during the months of July 2019 and January 2020 when no meetings are scheduled.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the FY 2019-2020 Meeting Schedule. (Motion carried 10-0-0; Members Batra, Jensen, and Lee absent)***

Consider Recommendation of PAC Slate of Candidates, PAC Chair and Vice Chair

Member Pham summarized the recommendations of the PAC Nominations Ad Hoc Subcommittee, which consisted of Members Myers, Pham and Sweidan. The ad hoc met on April 11, 2019 to review the applications to fill six expiring seats and one vacant Nurse Representative seat. The six seats expiring are two Long-Term Services and Supports Representative seats, one Non-Physician Medical Practitioner seat, one Pharmacy Representative seat, and two Physician Representative seats.

The ad hoc reviewed 15 applications: three for the Long-Term Services and Support Representative seats; one for the Non-Physician Medical Practitioner Seat; three for the Pharmacy Representative seat; six for the Physician Representative seats and two for the Nurse Representative seat.

The ad hoc subcommittee recommended the following candidates for the six expiring seats: Donald Bruhns (reappointment) for one of the Long-Term Services and Supports seat and Patty Mouton (new appointment) for the second Long-Term Services and Supports seat; John Nishimoto, O.D. (reappointment) for the Non-Physician Medical Practitioner seat; Loc Tran, Pharm.D. (new appointment) for the Pharmacy seat; and Anjan Batra (reappointment) for one of the Physician Representative and John P. Kelly, M.D. (new appointment) as the second Physician Representative.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the Recommended PAC Slate of Candidates (Motion carried 10-0-0; Members Batra, Jensen, and Lee absent)***

The ad hoc subcommittee recommended Tina Bloomer, WHNP, FNP, MSN (new appointment) to fulfill the remaining term for the Nurse Representative effective immediately upon Board approval, with the term expiring on June 30, 2021.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the recommendation of Tina Bloomer, WHNP, FNP, MSN to fulfill the term for the Nurse Representative (Motion carried 10-0-0; Members Batra, Jensen, and Lee absent)***

Member Pham reported that John Nishimoto, O.D., Non-Physician Medical Practitioner Representative was the only applicant for the PAC Chair position.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved John Nishimoto, O.D. to fulfill a second term as PAC Chair. (Motion carried 10-0-0; Members Batra, Jensen, and Lee absent)***

Member Pham also reported that the current Vice Chair, Teri Miranti was the only applicant for the Vice Chair position and requested a motion to approve.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved Teri Miranti to fulfill a second term as the PAC Vice Chair. (Motion carried 10-0-0; Members Batra, Jensen, and Lee absent)***

CEO & MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Shrader, Chief Executive Officer, provided an update on the Homeless Health program and noted that the clinical field teams had begun treatment of the homeless on April 10, 2019. Mr. Schrader also noted that CalOptima has met with the City of Anaheim, the Orange County Health Care Agency (OCHCA), and City Net to assist the homeless individuals at a newly discovered encampment. He also noted the Board's approval on a $100M commitment to the homeless initiative of which $40M has already been allocated. At the conclusion of Mr. Schrader's report, PAC members requested that he update them on homeless health on an ongoing basis as part of his report.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided an update on Proposition 56 (Tobacco Tax) rates and noted that the Department of Health Care Services (DHCS) had released the 2018-19 rates and that CalOptima was still waiting on the All Plan Letter (APL) for guidance. She noted that payments to providers must take place no later than June 12, 2019. Ms. Khamseh also discussed the Medical Respite Program for those members in recuperative care who need care for more than 90-days and noted that the Board had approved this item at their May 2, 2019 meeting.

She also noted that the consultant who is preparing the 2020-22 Strategic Plan had asked to meet with the advisory committees and a tentative date to hold a joint meeting for all committees in October 2019 was discussed.

Ms. Khamseh also discussed the Whole-Child Model noting that the 60-day notices had been sent and that the 30-day notice would be by phone call to each member transitioning to CalOptima.

Chief Financial Officer Update
Nancy Huang, Interim Chief Financial Officer, provided a verbal FY 2019-20 budget update and noted that there was a delay in receiving the rates from DHCS. She also noted that the new budget was being prepared on estimates/assumptions until the rates are released.

Chief Medical Officer Update
David Ramirez, M.D. Chief Medical Officer announce that beginning January 1, 2020, CalOptima would manage the OneCare and OneCare Connect Behavioral Health that is currently being managed by Magellan Health.

Dr. Ramirez also notified the Members that DHCS would be looking at the quality measures and new recommendations would be forthcoming and that DHCS was looking at the measure sets changing. He noted that some of the minimum requirements per quartile would be moved from 25% to 50% and that these measure would be retroactive to January 1, 2019.

Dr. Ramirez also discussed how DHCS was finalizing the guidance for Telehealth.

Network Operations Update
Michelle Laughlin, Executive Director, Network Operations provide an update on the re-contracting efforts for over 8,00 providers who contracts will expire on July 1, 2019.

She also notified the members that the Board had extended the deadline for Medi-Cal enrollment to the end of the year for providers who had submitted their applications to DHCS before January 1, 2019.

INFORMATION ITEMS

Member Portal Demonstration
Acecy Buensueso, IS Sr. Project Specialist, gave an interactive presentation on the new member portal that has been added to the CalOptima website. She noted that without having advertised the availability of the member portal that approximately 150 members had already signed up to use it.

PAC Member Updates
Chair Nishimoto asked the PAC members to submit any accomplishments that they wanted to add to the PAC accomplishments to send it in to the Staff to the Advisory Committees for inclusion in the report. This report will be brought to the June PAC meeting.

ADJOURNMENT
There being no further business, Chair Nishimoto adjourned the meeting at 9:56 a.m.

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

Approved: June 13, 2019

Provider Advisory Committee
FY 2018 - 2019 Accomplishments

During FY 2018-19 the Provider Advisory Committee (PAC) of the CalOptima Board of Directors provided input on provider issues to ensure that CalOptima members continue to receive high quality health care services. The following list highlights their accomplishments:

- PAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2018–19.

- One of the three PAC Physician Representatives (Dr. Sweidan) serves on the CalOptima's Quality Improvement Committee (QIC). This committee provides overall direction for the continuous improvement process and oversees activities that are consistent with CalOptima's strategic goals and priorities; promotes an interdisciplinary approach to driving continuous improvement and makes certain that adequate resources are committed to the program; supports compliance with regulatory and licensing requirements and accreditation standards related to quality improvement projects, activities and initiatives; also monitors and evaluates the care and services members are provided to promote quality of care.

- PAC Long-Term Services and Supports (LTSS) Representative continues to participate in the Long-Term Services and Supports Quality Subcommittee (LTSS QISC). His role is to provide input in CalOptima LTSS Quality Program. This has resulted in improvements to the quality metrics used to measure LTSS providers and the educational programs used to improve knowledge and services at the provider level.

- The PAC Health Network Representative shared information with all the health networks at the monthly Health Network Forum. She continues to gather feedback from them on topics to bring forward to the PAC for discussion. Topics included: rate discussions, IGT funding, difficult to access providers, transgender services, Proposition 56 (Tobacco Tax) and the Opioid Epidemic.

- PAC's Behavioral Health Representative (a CalOptima provider) participated in a legislative training day with the California Association for Behavior Analysis. The day was spent meeting with legislators to garner their support for Assembly Bill 189 in February 2019. Until this bill, there was no legislation that specifically identified behavioral health providers as mandated reporters. In addition, the day was spent educating legislators on behavioral health treatment for autism and other developmental disabilities. She shared this information with the constituents she represents on the PAC.

Back to Agenda

- All PAC members completed the annual Compliance Training for 2018/19 by the deadline.

- PAC attended two joint meetings during FY 2018-2019. The first meeting was a Member Advisory Committee (MAC)/PAC meeting that was held on October 11, 2018 to discuss the Board's directive to provide feedback on the CalOptima Delivery System and Auto Assignment. The second joint meeting was held November 8, 2018 with the MAC, OneCare Connect Member Advisory Committee (OCC MAC) and the Whole-Child Model Family Advisory Committee (WCM FAC). PAC hopes to continue to share feedback with the other advisory committees on a yearly basis.

- 2019 PAC Nomination Ad Hoc subcommittee met on April 11, 2019, to recommend a slate of candidates for the six PAC vacancies consisting of Long-Term Services and Supports (2 positions), Non-Physician Medical Practitioner, Pharmacy and Physician (2 positions) Representatives, The ad hoc members presented the slate of candidates to the full PAC on May 9, 2019 with their recommendations. PAC also held special nominations and formed an ad hoc for the Hospital and Nurse Representative seats that opened up during the year. PAC members also assisted by reaching out to their constituents to help fill these vacancies. PAC also approved a Chair and Vice Chair for 2019-20.

- PAC members continued to support the intergovernmental transfer (IGT) projects that are in process, as well as the proposed recommendations for the use of the IGT funds.

- The PAC Chair or Vice Chair submitted and presented the PAC Report at CalOptima's Board of Directors' monthly meetings to provide the Board with input and updates on the PAC's current activities.

- The PAC Chair solicited discussion topics/presentations from other PAC members which led to sharing their expertise about cutting edge programs being developed. The Chair and Vice Chair monitored and documented the quarterly PAC Goals and Objectives. The Chair and Vice Chair spent on average three hours a month working with the Staff to the Advisory Committees to formalize the meeting agenda and review and edit PAC's Report to the Board.

- PAC members attendance equals on average over 73% of members attending each monthly meeting. Currently there are 11 out of 15 members attending each meeting.

- Four PAC members created and made presentations to the PAC and one PAC member presented to all committees. It is estimated that a total of ten (10) hours were spent on preparation for these presentations.

- In addition to meeting monthly during FY 2018-19, PAC members have participated in at least four (4) ad hoc subcommittees and dedicated approximately 246 hours or the equivalent of 25 business days. This does not account for the time spent preparing for

meetings, reviewing reports, participating in their professional associations and communicating with CalOptima staff and their respective constituencies.

- Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities during the monthly Board Meetings. In addition, the PAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

Provider Advisory Committee
FY 2019-2020 Meeting Schedule

July
Thursday, July 11, 2019
No Meeting

August
Thursday, August 8, 2019

September
Thursday, September 12, 2019

October
Thursday, October 10, 2019

November
Thursday, November 14, 2019

December
Thursday, December 12, 2019

January
Thursday, January 9, 2020
No Meeting

February
Thursday, February 13, 2020

March
Thursday, March 12, 2020

April
Thursday, April 9, 2020

May
Thursday, May 14, 2020

June
Thursday, June 11, 2020

Regular Meeting Location and Time
CalOptima
www.caloptima.org
505 City Parkway West, 1st Floor
Orange, CA 92868
Conference Room 109-N
8:00 a.m. – 10:00 a.m.

All meetings are open to the public. Interested parties are encouraged to attend.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care for the Elderly Primary Care Provider Incentive Program and Related Changes to PCP Contracts

Contact

David Ramirez, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Specific to the CalOptima PACE Program, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Revise the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
2. Ratify the amendment to CalOptima's current PACE PCP contracts to modify the PACE PCP Incentive Program; and
3. Include the PACE PCP Incentive Program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of the PACE program are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima's program is the first PACE program offered to Orange County residents

At its September 7, 2017 meeting, the Board authorized amendment to the physician services contract with UCI to include the UCI PACE PCP Incentive Program. At that meeting, the Board also authorized staff to submit the PACE community-based physician waiver which allows members to continue to see their current PCPs while also participating in the PACE program (reference Attachment A: Board Action dated September 7, 2017). This waiver was approved by CMS in March 2018.

At its June 7, 2018 meeting, the Board authorized the revision of the UCI PACE PCP Incentive Program, subsequently renamed the PACE PCP Incentive Program, along with its expansion to all the PACE PCP contracts including community-based PACE PCPs (reference Attachment B: Board Action dated June 7, 2018).

PCPs have traditionally provided both clinic and non-clinic-based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE center clinic. Non-clinic-based PCP services are those provided outside of an outpatient clinic such as in an emergency room (ER), nursing facility or hospital. Although it is less common to find community PCPs who provide both clinic and non-clinic-based care, it is common within PACE organizations.

The current PACE PCP Incentive Program includes both Quality Improvement (QI) and Utilization Management (UM) measures. Additionally, the incentive program allows those PACE PCPs involved in non-clinic-based care to participate, including those involved with inpatient care, nursing facility care, home visits and after-hours on-call. This has resulted in an increase in the number of after-hour and weekend in person evaluations at members' homes and an increase in the number of diversions from emergency rooms to nursing facilities for workups, which has led to a decrease in our inpatient utilization. With the QI measures, we have seen a decrease in the number of participants with dementia who are on a tricyclic antidepressant or an anticholinergic agent and a decrease in those participants with a history of falls who are on a tricyclic antidepressant or antipsychotic medication.

The current incentive program allocates up to $10 per member per month (PMPM) to the five QI incentive measures. As a comparison, management's recommended budget for CalOptima's Community Care Network (CCN) allocates $20 PMPM in Fiscal Year (FY) 2018-19.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Including the PACE PCPs involved in non-clinic-based care has led to more thorough after-hours evaluations which has improved the of quality care, reduced inpatient utilization and has promoted appropriate use of healthcare resources. Staff is proposing to continue the UM element of this incentive program for FY 2019-2020.

Staff is proposing to slightly revise the QI measures in the PACE PCP Incentive Program by removing one element and adding three new diabetes-based elements. Diabetes continues to be one of the medical conditions that leads to a great deal of morbidity and mortality in the PACE population. By revising the QI measures as proposed, we would increase the potential QI incentive from the $10 PMPM allocated level in 2018-19 to $12.50 PMPM in 2019-20. This would bring it more in line with CalOptima's other lines of business. Staff also proposes to maintain the same distribution methodology. Please note that the implementation of the incentive plan is subject to regulatory approvals.

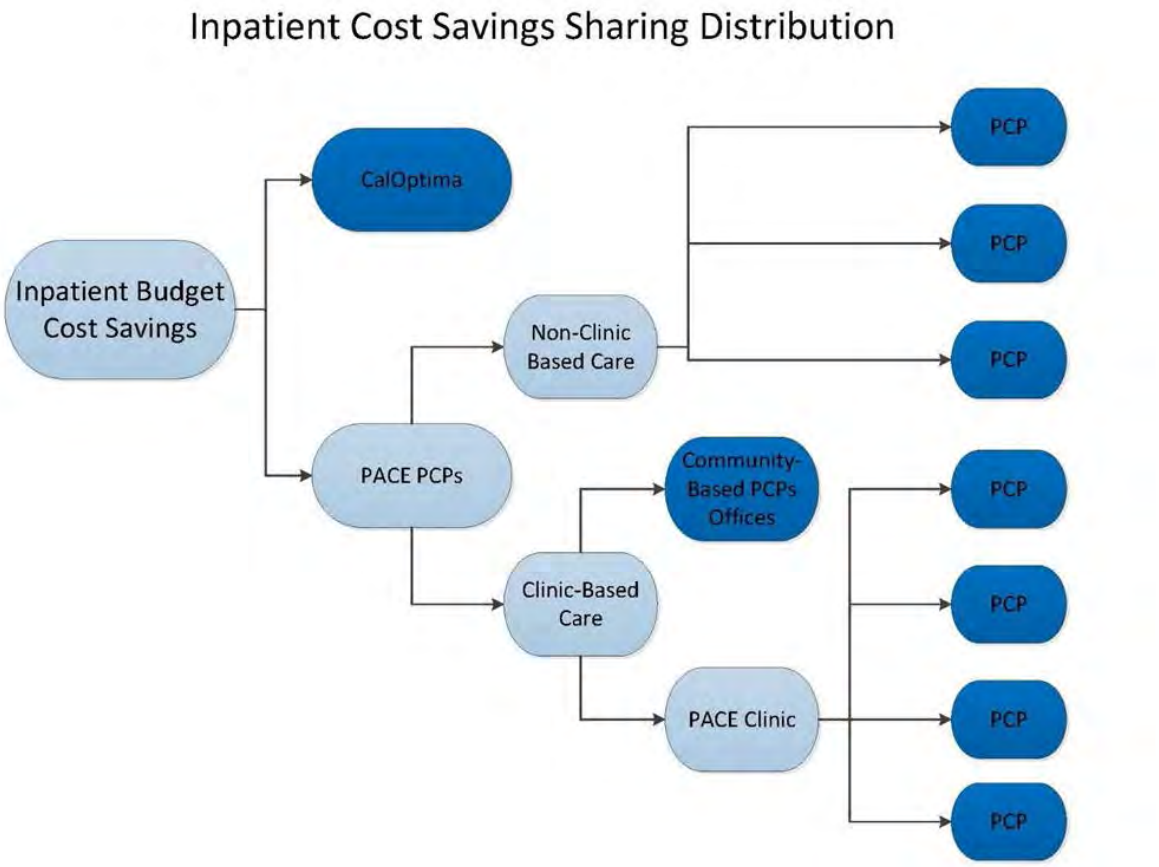
In order to be eligible to receive the incentive payments, PCPs providing the care must also be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

UM Measure (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment C: PACE PCP UM Incentive grid).
  - CalOptima and the PACE PCPs
    - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
    - PCPs will be able to earn from 25% up to a maximum of 40% of the cumulative inpatient cost savings below the first 5% as outlined in Attachment C, the PACE UM Incentive grid.
    - For comparison, the One Care and One Care Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.

- Clinic-based care and non-clinic based care.
  - Those incentives earned by the PACE PCPs will be apportioned to those PCPs providing clinic-based and those providing non-clinic based care.
  - Clinic-based care
- Includes all the primary care taking place in an outpatient setting such as the clinic at the PACE center, the office of PACE community-based PCP or in the home of a participant who has selected PACE at Home.
- The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the PACE center clinic PCPs and the community-based PACE PCPs based on the number of assigned participant member months.
- The UM cost savings incentive apportioned to the PACE PCPs at the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- Staff recognizes the importance of this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
  - Non-clinic-based care
- Includes all the care occurring outside of the outpatient settings listed above. This includes evaluations and care delivered in the inpatient setting, nursing facilities and emergency rooms.
- Any earned UM incentives allocated to the non-clinic-based care will be apportioned based upon the volume of services provided for the above non-clinic-based services as determined by the amount of paid claims for these services.
- The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
  - The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on CalPACE and NPA benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed and updated and approved annually by the Board.

Back to Agenda


Inpatient Cost Savings Sharing Distribution
Inpatient Budget Cost Savings
CalOptima
PACE PCPs
Non-Clinic Based Care
Community-Based PCPs Offices
Clinic-Based Care
PACE Clinic
PCP
PCP
PCP
PCP
PCP
PCP
PCP

Quality Improvement Measures

- The number of QI measures will increase from five to seven
  - Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepressants or Antipsychotics will be removed.
  - Three Comprehensive Diabetes Care (CDC) elements will be added.
    - Diabetics with a blood pressure <140/90.
    - Diabetics with a completed Annual Eye Exam.
    - Diabetics with Nephropathy monitoring.
  - Participant Satisfaction with Medical Care, Overall Participant Satisfaction, Functional Status Assessment Completion and Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus Tricyclic Antidepressants or Antipsychotics will remain.
- The potential QI incentives will increase from $10 PMPM to $12.50 PMPM and is detailed in Attachment D: PACE PCP QI Incentive Grid.
- The QI incentive will be apportioned between the PACE PCPs.
  - The QI incentive will be apportioned to the PACE clinic PCPs and the community-based PACE PCP based on the number of assigned participant member months.
  - The QI incentive apportioned to the PACE PCPs at the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI measures, metrics and goals will be reviewed and updated annually.

As proposed, all the current PACE PCP contracts amendments would be ratified to reflect these changes in the PACE PCP Incentive program. Additionally, this program shall be included in all future PACE PCP contracts. Staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract will also be included, as necessary

Fiscal Impact

The recommended action to revise the PACE PCP Incentive Program is a budgeted item under the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. Based on the projected PACE enrollment and the budgeted QI incentive at $12.50 PMPM, the estimated annual cost is approximately $57,500 for FY 2019-20.

The UM incentive will not result in additional costs beyond the amounts included in the CalOptima FY 2019-20 Operating Budget. CalOptima staff will make incentive distributions to participating providers only if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends slight revisions in the PACE PCP incentive program for FY 2019-2020 to better align incentives and ensure that PACE participants cost effectively receive necessary care.

Concurrence
Gary Crockett, Chief Counsel
Attachments

1. Contracted Entities Covered by this Recommended Action
2. Board Action dated September 7, 2017, Specific to the CalOptima PACE program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
3. Board Action dated June 7, 2018, Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts.
4. 2019-2020 PACE PCP Utilization Management Incentive Grid
5. 2019-2020 PACE PCP Quality Improvement Incentive Grid

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

Back to Agenda

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Back to Agenda

Fiscal Impact

It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation

As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

10/28/11 — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

39. Consider Authorizing Revision and Expansion of the Program of All Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Specific to the CalOptima PACE Program, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
2. Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
3. Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima's program is the first PACE program offered to Orange County residents

At its September 7, 2017 meeting, the Board authorized the CEO to amend the physician services contract with UCI to include the UCI PACE PCP Incentive Program, as well as contracts with non-UCI PCPs as necessary to provide appropriate primary care coverage for the ongoing operation of PACE. At that meeting, the Board also authorized staff to submit the PACE community-based physician waiver which allows members to continue to see their current PCPs while also participating in the PACE program. This waiver was approved by CMS in March 2018.

PCPs have traditionally provided both clinic and non-clinic based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE center clinic. Non-clinic based PCP services are those provided outside of an outpatient clinic such as in an emergency room (ER), nursing facility, hospital, or the participant's home. Although it is less common to find community PCPs who provide both clinic and non-clinic based care, it is common within PACE organizations.

The UCI PACE PCP Incentive Program currently includes both Quality Improvement (QI) and Utilization Management (UM) elements. The program has led to significant improvements in all three of the QI elements including overall PACE satisfaction, satisfaction with medical care and reduced coding errors. In 2017, CalOptima PACE program participant satisfaction with medical care and overall satisfaction improved from the previous year and were higher than both the CalPACE and

National PACE averages. The current incentive program allocates $3 per member per month (PMPM) to the three QI incentive elements. As a comparison, management's recommended budget for CalOptima's Community Care Network (CCN) allocates $20 PMPM in FY2018-19.

Unlike the QI incentive elements, the UM inpatient cost savings sharing element has not reached the goal set, with inpatient utilization actually increases year over year. Some of this increase is attributed to the severe flu season this winter. However, even without that event, CalOptima's targeted goals would not have been met. After careful analysis, staff has identified a number of opportunities related to the current program. First, only the UCI PACE PCPs are currently able to participate in the incentive program. Second, the UCI PACE PCPs are only involved in clinic-based care. They are not involved in non-clinic based care such as ER, inpatient (IP) and skilled nursing facility(SNF) care. Third, due to the frailty and age of many of CalOptima's pace participants, they are often admitted unnecessarily as the ER physicians and hospitalists are not familiar with the participants or the resources available in the PACE program.

To better incentivize PCPs serving CalOptima PACE members to address these issues, non-UCI PACE PCPs were recently added as an option for CalOptima PACE members, and the role of the PACE PCP has been expanded to include non-clinic based care (including IP, SNF, ER, and Home Visits) in line with a number of other PACE programs. It is anticipated that these PCPs will provide enhanced, real-time evaluations in the evenings, weekends and on holidays which will include home visits, nursing home evaluations and emergency room evaluations.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Staff is proposing to revise the UCI PACE PCP Incentive Program (now the PACE PCP Incentive Program) as the PACE PCPs are essential in appropriately assessing a participant's condition as well as avoiding unnecessary ER visits and inpatient admissions. Staff believes that the updated PACE PCP Incentive Program will support quality care, reduce inpatient utilization and promote appropriate use of healthcare resources. The program will continue to have both UM and QI elements. Please note that the implementation of the incentive plan is subject to regulatory approvals.

Staff would like to extend the program to include all current and future PACE PCPs including community-based physicians. PACE will need additional PCPs to provide both clinic-based and non-clinic based care as the program grows and expands into south county. Staff also proposes to increase the number of QI elements and the funds allocated to these elements to bring them more in line with CalOptima's other lines of business. Staff also proposes to revise the distribution of the UM inpatient cost savings sharing element to support the inpatient avoidance strategies. PCPs must be specifically contracted to participate in the PACE PCP Incentive Program. In order to be eligible to receive the incentive payments, PCPs must be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

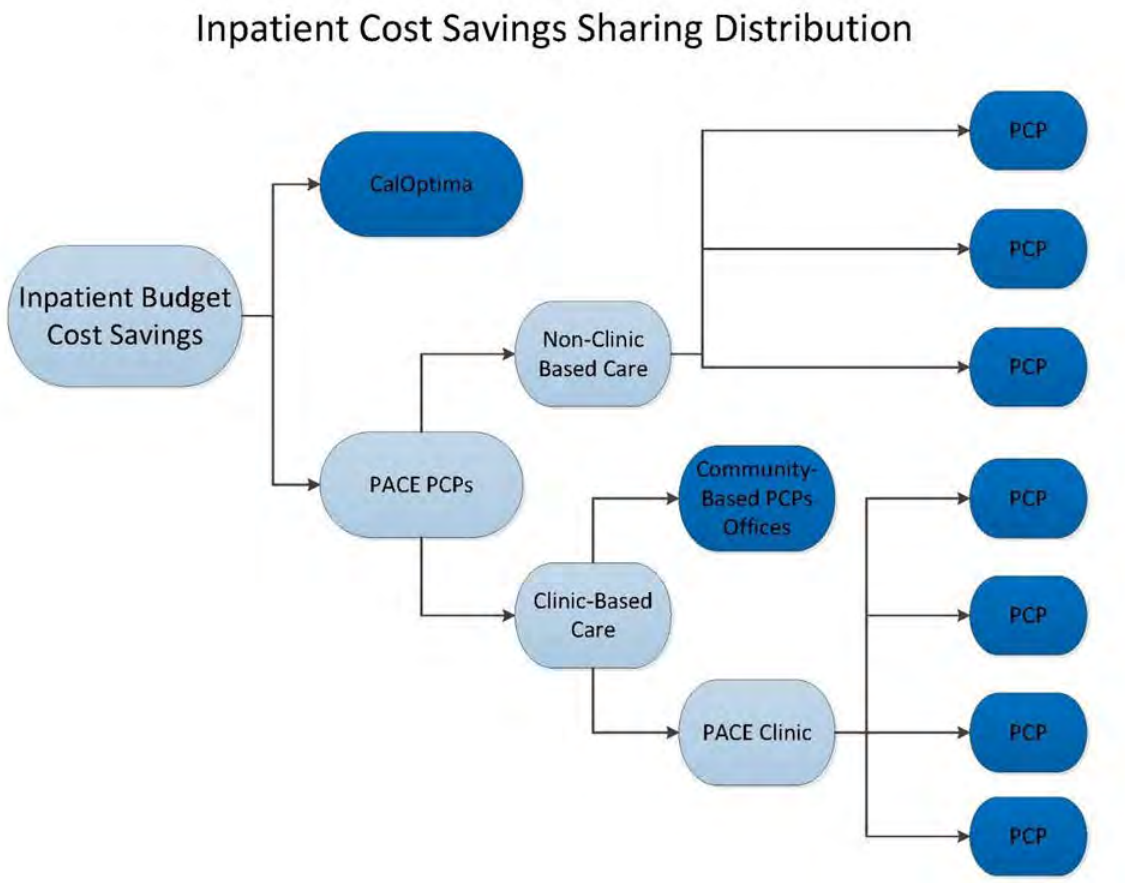
UM Element (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment A: PACE UM Incentive grid).
  - CalOptima and the PACE PCPs
    - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
    - PCPs will be able to earn up to 40% of the cumulative inpatient cost savings below the first 5% up to the percentages outlined in Attachment A, the PACE UM Incentive grid.
    - For comparison, the One Care and One Care Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.
  - Clinic-based care and non-clinic based care.
    - Those incentives earned by the PCPs will be apportioned to those PCPs providing clinic-based and those providing non-clinic based care.
    - Clinic-based care
      - Includes all the primary care taking place in an outpatient clinic such as the clinic at the PACE center or in the office of PACE community-based PCP.
      - Staff recognizes the importance of this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
    - Non-clinic based care
      - Includes all of the care occurring outside of an outpatient clinic. This includes evaluations and care delivered in IP, SNF, and ER locations. It also includes evaluations and care which occurs in the participant's home.
      - Any funds allocated to the non-clinic based care will be apportioned based upon the volume of services provided for the above non-clinic based services.
      - The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
  - PACE center clinic and community-based physician offices.
    - The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
  - PACE center clinic PCPs .

  - The UM cost savings incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on CalPACE and NPA benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed and updated and approved annually by the Board.
- In the future, staff will consider developing a draft policy that would incorporate all of the PACE PCP Incentive Programs activities. Prior to implementation, the draft policy would be brought to the Board for approval.

<u>Incentive Program Transition</u>

- The current PACE PCP Incentive Program began on January 1, 2018 and will end on June 30 2018.
- The current PACE PCP Incentive Program performance will be measured and paid according to the timeline in Attachment D: PACE PCP Incentive January to June 2018 Measurement and Payment Timelines.
- The revised PACE PCP Incentive Program will start on July 1, 2018.



Quality Improvement Elements

- The number of QI elements will increase from three to five.
    - Completion of the physician participant assessments within the regulatory required timeline will be added as a QI element and coding errors will be removed.
    - The participant satisfaction QI elements will be enhanced. Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with medical care and overall satisfaction with the PACE program.
    - Two potentially harmful Drug/Disease Interactions in the Elderly (DDE) elements will be added.
- The potential QI incentives will increase from $3 per member per month (PMPM) to $10 PMPM and are detailed in Attachment B: PACE PCP QI Incentive Grid.
- The QI inpatient cost savings will be apportioned between the PACE PCPs (reference Attachment B: PACE QI Incentive grid).
    - PACE center clinic and community-based physician offices.
        - The QI incentive will be apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
    - PACE center clinic PCPs.
        - The QI incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI elements, metrics and goals will be reviewed and updated annually.
- The QI element rates and incentive for the community-based PCPs will be calculated based on the number of member months of those participants assigned to them.

As proposed, the contract with UCI would be amended to reflect these changes in the PACE PCP Incentive program and to include the program in all current and future PACE PCP contracts. In addition,, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract will also be included, as necessary

Fiscal Impact

The recommended action to modify the PACE PCP Incentive Program is a budgeted item under the proposed CalOptima Fiscal Year (FY) 2018-19 Operating Budget, with no additional fiscal impact. Specifically, the QI incentive is budgeted at $10.00 PMPM. Based on the projected PACE enrollment, the estimated annual cost for the QI incentive is approximately $37,000 for FY 2018-19. The UM incentive will not incur additional costs beyond the approved budgeted inpatient expense for FY 2018-19. Distributions to participating providers will only occur if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends revising the PACE PCP incentive program to better align incentives and ensure that PACE participants cost effectively receive necessary care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Proposed PACE PCP Incentive Program Revisions
2. Board Action dated September 7, 2017, Specific to the CalOptima PACE program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
3. PACE PCP Quality Improvement Incentive Grid
4. PACE PCP Utilization Management Incentive Grid
5. PACE PCP Incentive Program January to June 2018 Measurement and Payment Timelines.

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Proposed PACE PCP Incentive Program Revisions

Board of Directors Meeting

June 7, 2018

Miles Masatsugu, M.D.

Medical Director

Back to Agenda

Overview of the PACE Program

- To be eligible for PACE, a person must be:
  - 55 years or older
  - Residing in the PACE service area
  - Certified to need nursing facility level care
  - Able to live safely in community

- PACE serves the frailest seniors
  - Average age is older than 80 years
  - Multiple chronic medical conditions
  - High level of functional dependencies (need help bathing, walking, toileting, etc.)

Back to Agenda

PACE UCI PCP Incentive Background

- University of California, Irvine (UCI) had been providing all of the PCP clinic-based care at PACE since the program began in October 2013.
- Staff started working on a contract update with UCI in December 2016.
- At that time, PACE did not have a pay-for-value or an inpatient cost savings sharing program.
- Inpatient care is one of the highest costs for PACE.
- Most of the elements and goals had been established by June, 2017.

Board Actions

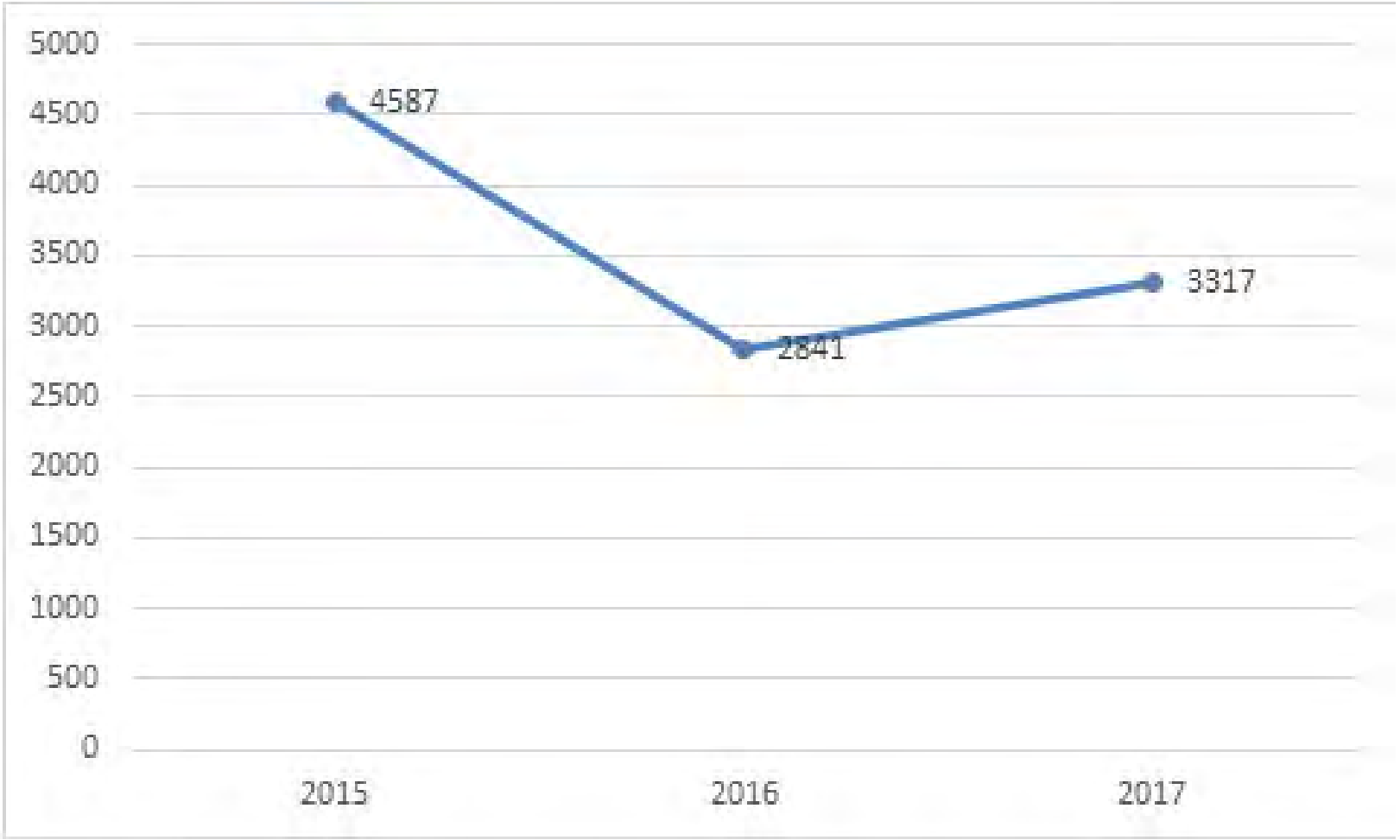
- September 7, 2017: Board authorized four actions via two COBARS
  - UCI PACE PCP incentive program with two components
    - Pay-for-value Quality Improvement (QI) component
      - Overall participant satisfaction
      - Participation satisfaction with medical care
      - Coding error rate
    - A savings sharing Utilization Management (UM) component
      - Based on actual inpatient costs
  - Fellows and residents rotations at PACE
  - Contract with non-UCI PCPs
  - Application for the PACE community-based physician waiver (approved in March, 2018)

Preliminary QI Results: 2017 Annual Participant Satisfaction Survey

Domain	2016 CalOptima PACE	2017 CalOptima PACE	2017 CalPACE Average	2017 National Average
Transportation	98%	**98%**	93%	95.5%
Center Aids	92%	**96%**	93%	91.7%
Home Care	92%	**93%**	87%	87.8%
Medical Care	86%	**92%**	88%	89.5%
Health Care Specialist	85%	**92%**	87%	87.4%
Social Worker	96%	**95%**	94%	95.5%
Meals	71%	**63%**	71%	73.1%
Rehabilitation Therapy and Exercise	98%	**97%**	95%	93.2%
Recreational Therapy	82%	**86%**	84%	82.7%
Other Indicators	92%	**94%**	89%	89.4%
Overall Satisfaction	89%	**90%**	88%	88.4%

Back to Agenda

Preliminary Utilization Results: Hospital Bed Days (Goal: 2,100 Bed Days/1,000 Participants/Year)



Back to Agenda

Challenges/Opportunities

- Small number of QI elements
- Funding of the QI component is small compared with CalOptima's other comparable lines of business
- Only UC Irvine PACE PCPs can participate in the incentive program
- UCI PCPs are not directly involved in inpatient and nursing home care
- The frail population and unfamiliarity with PACE leads to unnecessary hospitalizations.

Back to Agenda

Steps Taken

- September 2017: Board approves 4 actions related to PACE
- October 2017: UCI PACE PCP contract amended
- October 2017: PACE contracts with House Call Medical Associates (HCMA) for PCP services
- November 2017: HCMA assumes most inpatient and Skilled Nursing Facility (SNF) care
- January 2018: UCI PACE PCP incentive begins for remainder of fiscal year (ends 6/30/18)
- May 2018: Presented to CalOptima Board of Directors Quality Assurance Committee

Proposed Modifications to PACE PCP Incentive Program

- Allow all PACE PCPs to participate in the PACE incentive program, including community-based physicians
- Increase the number of QI elements
- Increase QI incentive from $3 PMPM to $10 PMPM.
- Change distribution of UM component (savings sharing) to support inpatient avoidance strategies
  - After-hours telephonic coordination of care
  - After-hours home visit evaluations
  - Admission directly to SNFs for appropriate cases
  - ER evaluations with observation stays

Back to Agenda

Proposed QI Incentive Elements

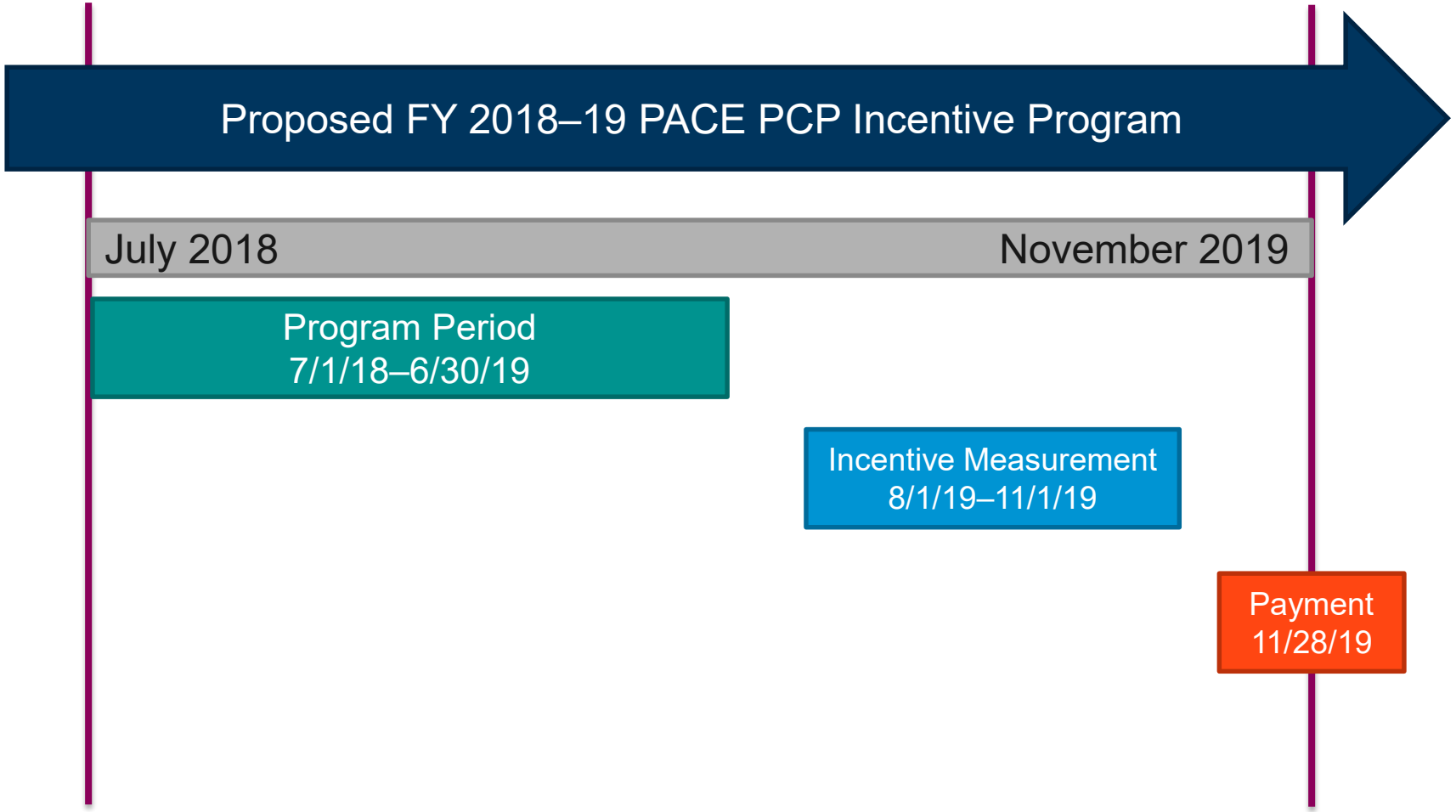
Elements	Current	Proposed
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	✓	✓
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	✓	✓
Coding Errors	✓	
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus tricyclic antidepressants or antipsychotics		✓
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus tricyclic antidepressant or anticholinergic agents		✓
Functional Status Assessment		✓
Total Potential QI Incentive	**$3 PMPM**	**$10 PMPM**

Proposed UM Incentive (Savings Sharing)

	Budget	Sharing by Tier Level		Cumulative Total Savings		PCP Role (Distribution by Tier)	
	100%	CalOptima	PCP	CalOptima	PCP	Non-clinic based (IP, ER, SNF, Home Visits)	Clinic-based
Tier 1	95%–100%	100%	0%	100%	$0	N/A	N/A
Tier 2	90%–95%	50%	50%	75%	25%	75%	25%
Tier 3	85%–90%	50%	50%	67%	33%	80%	20%
Tier 4	80%–85%	50%	50%	63%	38%	85%	15%
Tier 5 (Incentive Ends)	75%–80%	50%	50%	60%	40%	90%	10%

Back to Agenda

Proposed Timeline



Back to Agenda

Recommendation

- Specific to the CalOptima PACE Program, consider authorizing the Chief Executive Officer (CEO), with the assistance of Legal Counsel to:
  - Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
  - Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
  - Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contacts, including those of community-based physicians serving CalOptima PACE members.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

Back to Agenda

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Back to Agenda

Fiscal Impact

It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation

As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

10/28/11 — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda

2018-2019 CalOptima PACE PCP Incentive Program Grid

QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY	August	TruChart Analytics and Pharmacy Utliization Report. 2016 HEDIS Quality Compas 90th percentile is <37.50%.	>/=37.50%	$0 PMPM	January
					<37.50%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$10	January

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda
Back to Agenda

2018-2019 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM; CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PCP care including real-time evaluations in the evenings and weeksends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care. The structure of this program avoids any risk to the PCP.	FY 2019	Audited FY Performance	PCP receives % of the actual inpatient cost savings calculated from the audited FY financial.	Tier	Performance (% below Budget)	Maximum % Savings from Inpatient Budget	% of UM Savings to Cal Optima by Tier	% of UM Savings to PCPs by Tier	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Clinic-Based Services	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of UM Savigs to Cal Optima	Cumulative % of UM Savings to PACE PCP's UM Incentive	Nov-19
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**38%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center

Back to Agenda
Back to Agenda

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	Jan 1, 2018 to June 30th, 2018	Oct-18	The CalOptima Coding Department will audit 100% of the charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	Nov-18
					75-89%	$0.5 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	Jan 1, 2018 to June 30th, 2018	Audited FY Performance September 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $20 PMPM or $31,020***	Nov-18
					Incentive ends at BD / K / Y equivalent of 2,000		

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda

2019-2020 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM: CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PACE PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PACE PCP care including real-time evaluations in the evenings and weekends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care.	FY 2019-2020	Audited FY Performance	PACE PCPs receives percentage of the actual inpatient cost savings calculated from the audited FY financials.	Tier	Performance (% below Budget)	Total % Savings from Inpatient Budget	% of UM Cost Savings to CalOptima by Tier	% of UM Cost Savings to PACE PCPs by Tier	% of PACE PCP UM Cost Savings to PACE PCPs performing Clinic-Based Services	% of PACE PCP UM Cost Savings to PACE PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of Inpatient UM Cost Savings to CalOptima	Cumulative % of Inpatient UM Savings to PACE PCPs	January
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**38%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the UM Incentive based on the member months of the members assigned to them.

PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.

Individual PACE PCP Clinic-Based Incentives will be calculated based on the number of hours worked at the PACE center

Back to Agenda
Back to Agenda

2019-2020 PACE PCP QI Incentive Grid

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
QI: Annual PACE Par icipant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	FY 2019-2020	October (2019 Survey resuls equals 25% of score and 2020 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfac ion Report: Par icipant Sa isfaction with Medical Care, Summary Score*	<89%	$0 PMPM	January
					>/= 89%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Annual PACE Par icipant Satisfaction Survey: Overall PACE Patient Satisfaction	Par icipants sa isfaction of medical care is directly measured. However, PCPs are important members of he IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	FY 2019-2020	October (2019 Survey resuls equals 25% of score and 2020 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 88%	$0 PMPM	January
					>/= 88%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Comprehensive Diabetes Care	PACE participants with diabetes will be monitored by he PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	FY 2019-2020	August	>80.12% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	>80.12%	$1.50 PMPM	January
				> 83.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2017 HEDIS 90th percen ile)	>83.54%	$1.50 PMPM	January
				>98.38% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	>98.38%	$1.50 PMPM	January
QI: Potentially Harmful Drug/Disease Interactions in he Elderly (DDE): Dementia + tricyclic an idepressant or anticholinergic agents	PACE par icipants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as he PACE pharmacist to develop strategies for improvement.	FY 2019-2020	August	TruChart Analytics and Pharmacy Utliiza ion Report. 2017 HEDIS Quality Compas (75th percentile is 40.61% and 90th percentile is <36.13%).	>40.61%	$0 PMPM	January
					36.13% to 40.61%	$1 PMPM	
					<36.13%	$2 PMPM	
QI: Func ional Status Assessment	At a minimum, all par icipants need a complete Func ional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY 2019-2020	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$12.50	January

PACE Community PCP's will be eligible for the QI Incentive based on he member months of the members assigned to hem.

PACE PCP Incentives will be based on he member months of all member's not assinged to PACE Community PCP's.

Individual PACE PCP Incentives will be calculated based on the number of hours worked at he PACE center

*The summary score is a weighted average of the quality indicators within the "Participant Sa isfaction with Medical Care".

** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service and Clinic Provider Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

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 negotiate rates for certain fee-for-service (FFS) and PACE clinic provider contracts, within budget and rate guidelines and regulatory requirements.

Rev. 8/1/19

Background

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 325 members via the CalOptima PACE center and five operating alternative care settings.

CalOptima has implemented several different contracting models for its lines of business. In a June 5, 2017 COBAR, the Board authorized guidelines for certain fee-for-service contracts with the rationale that CalOptima must be responsive and adaptive to opportunities to secure services based on best pricing and to secure access to providers where such access may be limited. While the goal was, and still remains, to contract adequate numbers of providers within standard fee schedules, it is necessary to have contracting flexibility in certain situations.

Discussion

CalOptima PACE utilizes providers for primary care and specialist services rendered in the PACE center. In September 7, 2017, the Board authorized a maximum hourly rate of $200 for PACE physicians and $130 for non-physician primary care services for center-based services. Staff recommends increasing the maximum allowable rate to up to $300 per hour for providers to ensure competitive rates to continue to contract with needed PACE providers and to allow PACE to utilize the hourly rate payment model to contract with physician specialists. In addition to primary care, behavioral health and an on-site clinical medical director, CalOptima PACE will contract utilizing up to the maximum allowable rate for on-site specialist services at the PACE center including but not limited to endocrinology, rheumatology, pain management, neurology, dermatology, psychiatry, speech therapy and other ancillary services. .
Hourly rates also give PACE the mechanism to reimburse specialists for attending PACE Interdisciplinary Team (IDT) meetings which is vital to the PACE Model of Care, improving quality and coordination.

Back to Agenda

All the physicians who are approaching or at the $200 maximum allowable rate are PCPs. Currently, PACE has been unable to contract with specialists at an hourly rate, as most physician specialists are reimbursed in the $225 to $300 range. This range varies and the actual rates within the allowable range will be set based on the provider's training, specialty and experience. In addition to over five years of direct experience with the demands of operating a PACE clinic, staff recommendation is based on consultation from a provider staffing group specializing in the Southern California market. The group asserts that provider services in 2019, including primary care, clinic medical director, behavioral health, LCSWs and other specialists, range from an hourly rate of $110 to $300. To meet the demands of the market, staff recommend an increase in the maximum allowable rate at this time to maintain and expand medically necessary provider contracts for primary care, specialty and ancillary services provided in the PACE clinic, within the rate ranges listed in the following table.

PROVIDER TYPE	Min. Hourly Rate	Max. Hourly Rate
Primary Care Providers – MD, DO, NP, PA	$140.00	$250.00
Ancillary Providers, Speech Therapy and Licensed Clinical Social Workers	$90.00	$150.00
Dermatology, Endocrinology, Neurology, Pain Medicine, Psychiatry, Rheumatology, and other physician specialists as required.	$150.00	$300.00
Medical Director	$150.00	$300.00

CalOptima PACE requires a network of community based, credentialed, quality providers to support PACE participants' medical needs. CalOptima PACE will contract with providers using appropriate fee schedules, with payment based on the product line and current product line rates, but there will be periodic needs to deviate from these rates to maintain adequate and necessary access and availability. To this end, Contracting may negotiate rates up to 150% of the Medicare fee schedule for unique and hard to access services rendered to PACE members. Any rate in excess of 150% of the Medicare fee schedule requires additional approval from the Board.

Fiscal Impact

The recommended action to negotiate rates for certain FFS and PACE provider contracts is budget neutral. Funding for the estimated increase to medical costs is within the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

CalOptima PACE must be responsive and adaptive to opportunities to secure medically necessary services for PACE participants, based on the Board-approved budget and best pricing, to secure access where such access may be limited.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Board Action dated June 5, 2007, Authorize CEO to Negotiate Rates for Certain FFS Contracts
2. Board Action dated September 7, 2017, Authorize an Amendment to Physician Services Contract for PACE

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 5, 2007
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. B. Authorize the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service Contracts for Health Care Services

Contact
Gregory Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the CalOptima Chief Executive Officer (CEO) or his designee, to negotiate rates for certain fee-for-service (FFS) contracts within budget and rate guidelines and regulatory requirements.

Background
CalOptima has implemented several different contracting models for health care services for its lines of business. The CalOptima Direct (COD) network includes fee-for-service hospital contracts as well as some limited ancillary services contracts (e.g., wheelchairs). The CalOptima OneCare program includes physician shared risk contracts and other contracted hospitals and ancillary providers. At present the delivery system for the Medi-Cal and Healthy Families programs is primarily through capitated health networks. CalOptima needs to be able to negotiate best pricing for physicians, hospitals, ancillary and other services as well as secure access to services. In order to do so, CalOptima seeks authority to enter into negotiated fee-for-service contracts.

Discussion
CalOptima is building a contracted provider network to support the medical needs of all of our members in each of our product lines that is both budget based and medically appropriate. The building of this network is required to have a full scope, qualified provider panel for all of our members and to be able to effectively manage the health care needs for our diverse population including the very young, the very old, and the medically fragile and vulnerable.

CalOptima requires a network of credentialed, quality providers to support our members' medical needs. CalOptima needs to contract with providers using appropriate fee schedules and will base the payment on the product line and current product line rates, but there will be periodic needs to deviate from these rates for issues of access and availability. The fee-for-service agreements will create a provider network both within Orange County and outside of the County, as needed, to support the covered services.

Back to Agenda

The following guidelines will apply to negotiated fee-for-service contracts:

- When appropriate to access best pricing or access to services, CalOptima may enter into negotiated fee-for service contracts for identified items and services.
- CalOptima will continue to use standard medical service agreements based on product lines and provider types, with assistance of legal counsel, but may negotiate reimbursement terms.
- Negotiated fee-for-service contracts will not be sought for services to members where CalOptima has subcapitated financial risk for the items and/or services to a provider (e.g., Medi-Cal PHC contracts, Medi-Cal and Medicare shared risk contracts), but CalOptima will encourage contracted parties to extend the same terms, rates and conditions to its subcapitated entities.
- Rates will be negotiated within the guidelines below. Any rate in excess of 150% of the fee schedule will require approval from the CEO or designee.

Rate Summary:

Situation	Payment Rate
Routine services including ancillary services	Contract with rates at or below the fee schedule
Difficult to access services meeting predetermined access criteria	Contract with the minimally mutually agreeable rates < 150% of the fee schedule
Rare, one time situations where provider is unwilling to contract at available rates	One time Letter of Agreement for a specified service for a specific patient

Fiscal Impact
The recommended action to negotiate rates for fee-for-service contracts for certain health care services will use approved contract boilerplate agreements and budget based payment schedules. These costs have been included in budget projections for 2008.

Rationale for Recommendation
CalOptima must be responsive and adaptive to opportunities to secure ancillary items and services based on best pricing and to secure access to providers where such access may be limited. While the goal is to contract as many providers as possible within the standard fee schedules, it is necessary to have the contracting flexibility in these situations.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Att chments
None

Richard Chamberlain — **Authorized Signature**

5/31/07 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

Back to Agenda

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Back to Agenda

Fiscal Impact

It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation

As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

10/28/11 — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

Contact
Silver Ho, Executive Director, Compliance (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action
Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the California Department of Health Care Services and CalOptima related to rate changes.

Background
As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion
DHCS has informed Plans that it submitted amendments to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to Full Dual Eligible beneficiaries for Calendar Year (CY) 2015, 2016, 2017 and 2018. Additionally, DHCS has informed Plans that it has submitted amendments to CMS for approval that will incorporate revised SFY 2017-18 rates including hospital directed payment requirements, revised Hospital Quality Assurance Fee (HQAF) for January through June 2017, revised SFY 2017-18 Coordinated Care Initiative (CCI) Non-Full Dual rates and rate changes related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) and Hyde (Abortion) Proposition 56 rates, Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments for the period of July 2018 to June 2019 to managed care plan (MCP) contracts.

Rate Changes

DHCS' proposed amendment(s) seeks to incorporate rates related to:

- Rate changes related to Full Dual Eligible beneficiaries for Calendar Year (CY) 2015, 2016, 2017 and 2018
- Revised SFY 2017-18 rates including hospital directed payment requirements

- Revised Hospital Quality Assurance Fee (HQAF) for January through June 2017

- Revised SFY 2017-18 CCI Non-Full Dual Rates

- Base Medi-Cal Classic, ACA Optional Expansion (OE) and Hyde (Abortion) Proposition 56 rates for the period of July 2018 to June 2019, with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments.

Full–Dual Rates for Calendar Year (CY) 2015, CY 2016, CY 2017 and CY 2018

CY 2015 Full Dual Rates

The Full Dual rates for January 1, 2015 through December 31, 2015 were first sent to CalOptima as draft rates in May 2016. DHCS sent CalOptima final rates in March 2017. The reasons for the rate changes are due to the following:

- Base data logic revisions
- For CY 2015 and State Fiscal Year (SFY) 2015–16 rate development, base data was used from CY 2012 and CY 2013.
    - CY 2013 data was used to adjust CY 2012 to better reflect the distribution of services across Home and Community Based Services (HCBS) High and Low.
- Program change adjustments including:
    - LTC rate changes
    - In-Home Supportive Services (IHSS) wage changes
    - Hospice rate updates
    - IHSS utilization reduction
    - IHSS overtime, effective February 1, 2016

CY 2016 Full Dual Rates

The Full Dual rates for January 1, 2016 through December 31, 2016 were first sent to CalOptima as draft rates in December 2016. DHCS sent CalOptima final rates in June 2017. The CY 2016 rates were developed through a rate update approach leveraging the same CY 2012 and CY 2013 base data used in the CY 2015 rate development. The reasons for the rate changes are due to the following:

- Updated trend assumptions
- More recent information relating to programmatic changes, including the following:
    - IHSS wage changes
    - Long–Term Care (LTC) daily rate changes
    - IHSS overtime and travel time
- CY 2016 mix projections based on historical data including recasted membership figures through 2015.

Back to Agenda

CalOptima received updated exhibits containing the increment–level breakdown of the CCI CY 2016 Full Dual rates in March 2018. The increment–level breakdown identified the base portion of CalOptima's rate as well as the portions associated with the MCO tax, Community–Based Adult Services (CBAS), IHSS, and Multipurpose Senior Services Program (MSSP). These updated rate exhibits were submitted to CMS on January 19, 2018 and reflect CalOptima's final recast member mix for Phases I and II. On average, CalOptima's actual member mix was less acute than the projected member mix for the Cal MediConnect (CMC) population and more acute than the projected member mix for the larger non–CMC population.

CY 2017 Full Dual Rates

The Full Dual rates for January 1, 2017 through December 31, 2017 were sent to CalOptima in March 2019. These final dual rates contain the following updates:

- CMC rates for CY 2017 are not subject to the MCO tax; in addition, the rate ranges are prior to the application of the appropriate savings and quality withhold percentages for CY 2017.
- County–specific capitation rate calculation sheets (CRCS) are included by Category of Aid (COA) for the Cal MediConnect Eligible and Cal MediConnect ineligible populations.
- Blended non–CMC rate ranges display rates which incorporate the impact of the MCO tax.
- For CMC, the displayed rate and rate increments reflect the application of the appropriate CY 2017 savings percentage, but not of the 3% quality withhold.

CY 2018 Full Dual Rates

The Full Dual rates for January 1, 2018 through December 31, 2018 were sent to CalOptima in May 2019. These final dual rates contain the following updates:

- Plan–specific rate summaries by COA, for the Cal MediConnect (CMC) Eligible and CMC Ineligible populations.
- CRCS by COA, for the CMC Eligible and Ineligible populations.
- Plan–specific rate summaries that shows the final, blended CY 2018 non–CMC (i.e. MLTSS) Full Dual rate range based on the Phase 3 prospective member mix.
- Blended non–CMC rate ranges which displays rates that incorporate the impact of the MCO Tax.
- Increment–level breakdown of the final, blended CMC and non–CMC (i.e. MLTSS) Full Dual rates.
- For CMC, the displayed rate and rate increments reflect the application of the appropriate CY 2018 savings percentage, but not of the 3% quality withhold.

Package 69: Revised SFY 2017–18 Rates and Hospital Directed Payments (Includes HIPF for July–December 2017)

The base Medi-Cal Classic and ACA OE capitation rates for July 1, 2017 through June 30, 2018 were first sent to CalOptima as draft rates in July 2017. DHCS sent CalOptima updated draft rates in April

2018. DHCS then sent CalOptima revised SFY 2017–18 rates in March 2019 to incorporate the following:

- Final rate ranges prior to pooled directed payments for SFY 2017–18 with the MCO tax which includes a rate build-up with Proposition 56 Physicians and HQAF pass-through add-ons;
- Estimated per-member-per-month (PMPM) amounts for the hospital directed payment program;
- Final rate ranges prior to pooled directed payments for SFY 2017–18 with the MCO tax for the ACA OE Category of Aid (COA) including a rate build-up with Proposition 56 Physicians and HQAF pass-through add-ons;
- Rate summary displaying the rate build-up inclusive of hospital directed payments based upon estimated PMPM amounts for the ACA OE COA.
- Rate summary displaying Plan–specific increments, excluding pooled hospital directed payments, along with estimated payment timing for each increment.

Coordinated Care Initiative (CCI) Non–Full Dual Rate Ranges

CalOptima received State Fiscal Year (SFY) 2017–18 CCI non-full dual rates in March 2018. Authority to execute the contract amendment related to the 2017–18 CCI Non–Full Dual rate ranges received in March 2018 was granted to the Chair during the June 2018 meeting of the CalOptima Board of Directors. CalOptima received updated exhibits related to the SFY 2017–18 CCI Non–Full Dual rate ranges in May 2018. The overall rate methodology and structure of the exhibits remain unchanged; however, there were changes to the HCBS High and HCBS Low rate ranges.

Package 76: Revised January –June 2017 HQAF Rates (Includes HIPF)

In March 2019, CalOptima received rate exhibits for January 2017 through June 2017 to reflect the final rates and rate detail for HQAF. SB 239 imposed a QAF from January 1, 2014 to December 31, 2016 and authorizes the framework for the existing HQAF built into CalOptima's rates which have been approved numerous times by the CalOptima Board of Directors, including most recently in June 2017. Assembly Bill (AB) 1607 extended the HQAF program to January 1, 2018, creating a one-year extension of the program. Proposition 52 permanently extended the HQAF. Highlights regarding this rate exhibit are as follows:

- Final rate ranges for Medi-Cal Classic and ACA OE for the January through June 2017 time period, with and without the MCO tax inclusive of HQAF.
- Rate impact of HQAF adjustments at the lower and upper bound.
- Rate summary displaying final Plan–specific increments along with estimated payment timing for each increment.
- Managed Long–Term Support Services (MLTSS) Medi-Cal only and Partial Dual rates containing county capitation rates prior to the addition of the MCO Tax and lower and upper bound impacts of adding HQAF to the January 2017 through June 2017 time period. These impacts are at the county level to coincide with the structure for rate development.

Package XX: 2018–2019 Rates

Base Classic Medi–Cal and ACA Optional Expansion Rates

Noteworthy items for the updated SFY 2018–19 rates include, but are not limited to:

- Proposition 56 Physician Payments
- MCO Tax
- Applicable Pass-Through Payments (e.g. HQAF)
- Updated program changes such as Ground Emergency Medical Transportation (GEMT), Pediatric Palliative Care, Diabetes Prevention Program and Long–Term Care/Intermediate Care Facility for the Developmentally Disabled (LTC/ICF–DD) rate increase
- Minor update to the administrative load on capitation rates and supplemental payments
- Hyde with Proposition 56 payments

The base Medi–Cal Classic and ACA OE capitation rates for July 2018 through June 2019 were first sent to CalOptima as draft rates in April 2018. DHCS sent CalOptima updated draft rates in June 2018 and final rates in March 2019. Highlights regarding these final rates are as follows:

- Rates display the updated final Plan–specific rate ranges (including add–ons).
- Plan–specific Cost and Reimbursement Comparison Schedule (CRCS) sheets which include a detailed build-up of the Plan–specific classic rates by Category of Aid (COA) and Category of Service (COS).
- Plan–specific CRCS sheets which includes base data with trend and program changes introduced as well as a final demographic adjustment.
- Plan–specific base sheets which outlines the base data for the final rates.
- Program changes chart which shows each program change that was applied in the rates and its lower bound PMPM impact on the rates.

Behavioral Health Treatment (BHT) Payments

BHT supplemental payment rates for the period of July 1, 2018 through June 30, 2019 were sent to CalOptima in July 2018. These final BHT rates contain the following updates:

- Rates include both Autism Spectrum Disorder (ASD) and transitioning non–ASD members (with the non–ASD transition effective July 1, 2018.
- Rate development for the ASD portion of the SFY 2018–19 rates was nearly identical in methodology to the SFY 2017–18 rates, with the main change being the use of 24 months of base data experience (CY 2016 and CY 2017) reported by CalOptima.
- The SFY 2017–18 BHT rats used only 10 months of base data experience (Jan–Oct 2016). The extended base period of the 2018–19 provided a greater level of credibility to the data which may have resulted in a larger influence of CalOptima's data in the final rates.
- Lower costs on a Per User Per Month (PUPM) basis relative to the ASD population driven by lower levels of utilization.

- The final SFY 2018–19 supplemental payment rate is a blend of the ASD and non–ASD populations. It is calculated a utilizer month–weighted average of the respective ASD and non–ASD PUPMs, based on projected utilizer months. The ASD utilizer month projections were developed using CalOptima's reported utilizer month counts and the non–ASD utilizer month projections were developed using DHCS' detailed non–ASD transition plan.
- Lower bound trends for SFY 2018–19 are 1.75% for utilization and 3.25% for unit cost.

Hepatitis–C Payments

Hepatitis–C supplemental payment rates for the period of July 1, 2018 through June 30, 2019 were first sent to CalOptima as draft rates in April 2018. The rate exhibits contained detailed rate development for the non–340B Hepatitis C and 340B Hepatitis C supplemental payment. Rates for Hepatitis–C did not change from the original draft versions of the rates provided in April 2018. In March 2019, CalOptima received the final rate range detail exhibit for Hepatitis C.

Abortion (Hyde) Payments

Abortion (Hyde) payments for the period of July 1, 2018 through June 30, 2019 were first sent to CalOptima as draft rates in April 2018. The rate exhibits contained a detailed build-up of the abortion rate development for the Child, Adult, and ACA OE COA groups. In March 2019, CalOptima received final rate range summaries and CRCS detail tabs for the Hyde rates.

Rates for Hepatitis–C and Abortion (Hyde) did not change from the original draft versions of the rates provided in April 2018.

Non–Medical Transportation (NMT) Payments

Non–Medical Transportation (NMT) PMPM rate increments for the period of July 1, 2018 through June 30, 2019 were first sent to CalOptima as draft rates in April 2018. DHCS sent CalOptima updated draft rates in June 2018. Both the Classic Medi-Cal and ACA Optional Expansion category of aid (COA) groups are included in these PMPM impacts. Effective July 1, 2017, NMT became a managed care covered service for transportation to medically necessary services included in MCP contracts. Effective October 1, 2017, NMT became a managed care covered service for all Medi-Cal covered services, including those not covered under the MCP contract, including, but not limited to, specialty mental health, substance use disorder, dental, and any benefit covered through Medi-Cal Fee-for-Service (FFS).

Proposition 56 Directed Payments

DHCS sent CalOptima exhibits reflecting CalOptima's SFY 2018–19 Proposition 56–Physicians PMPM add–on amounts in December 2018. Highlights regarding these amounts include the following:

- The SFY 2018–19 estimates were developed using a rate methodology consistent with SFY 2017–18 estimates. CY 2015 and CY 2016 health plan reported supplemental data request (SDR) experience was utilized along with CY 2015 and CY 2016 encounters.

- The underlying dollar add–ons for each CPT code have increased to reflect the enhanced payments for SFY 2018–19 rating period. This includes add–ons for Evaluation and Management (E&M) and preventive codes whereas SFY 2017–18 only included enhanced payments for E&M codes.
- Consistent with SFY 2017–18 PMPM add–ons:
    - Adjustments to the final amounts include offsets for Part B members.
    - FQHC/RHC/CBRC/IHS utilization is not included in the final add–on amount as these providers are exempt from Proposition 56.
    - The exhibits contain the projected SFY 2018–19 member months by Category of Aid (COA) along with the anticipated number of Proposition 56 impacted services; this is the same enrollment projection that was utilized in the risk adjustment calculation. Therefore, final revenue and projected visit figures will vary based on actual enrollment figures.
    - The exhibits include the combined E&M and preventive code utilization per 1,000 members, the unit cost and the resulting adjustment PMPM add-on amounts.
    - The final PMPM add-on amounts include administrative load and underwriting gain (UG). The administrative load is 3.4% and the UG is 2%.

For SFY 2018–19, DHCS incorporated 10 additional CPT codes that qualify for the Proposition 56 physician payments. The amount of the Proposition 56 directed payments varies by CPT code as outlined below:

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval.	$35.00
90792	Psychiatric Diagnostic Eval. with Medical Services	$35.00
90863	Pharmacologic Management	$5.00
99381	Initial Preventive Evaluation and Management, new patient; infant	$77.00
99382	Initial preventive evaluation and management, new patient; early childhood	$80.00

99383	Initial preventive and evaluation and management, new patient; late childhood	$77.00
99384	Initial preventive evaluation and management; new patient, adolescent	$83.00
99385	Initial preventive evaluation and management, new patient; adult	$30.00
99391	Periodic preventive evaluation and management, established patient; infant	$75.00
99392	Periodic preventive evaluation and management, established patient; early childhood	$79.00
99393	Periodic preventive evaluation and management, established patient; late childhood	$72.00
99394	Periodic preventive evaluation and management, established patient; adolescent	$72.00
99395	Periodic preventive evaluation and management, established patient; adult	$27.00

All applicable Evaluation & Management (E&M) services outlined above are eligible for this enhanced Proposition 56 funding except for services incurred by members with Medicare Part B coverage (Full or Partial Duals), and services provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHP) and Cost–Based Reimbursement Clinics (CBRCs). On a quarterly basis, CalOptima will continue to report data to DHCS on all Proposition 56 directed payments made pursuant to DHCS APLs, either directly by CalOptima, or by CalOptima's delegated entities and subcontractors.

Additionally, CalOptima received Hyde (Abortion) rate ranges, Hyde (Abortion) Proposition 56 add-ons and Intermediate Care Facility–Developmentally Disabled (ICF–DD) Proposition 56 rate increases in March 2019.

Hospital Directed Payments

CalOptima received estimated PMPM amounts for the hospital directed payments program for SFY 2018–19 in April 2019. These rate exhibits included rate summaries for Medi-Cal Classic and ACA OE rates which display the final Plan–specific rate ranges (including add-ons) prior to the estimated pooled hospital directed payments and rate summaries displaying the rate build-up of pooled hospital directed payments based upon estimated PMPM amounts.

Coordinated Care Initiative (CCI) Non–Full Dual Rate Ranges

CalOptima received SFY 2018–19 CCI non-full dual draft rates in December 2018. The rate exhibits include county–specific CRCS for Home and Community–Based Services (HCBS) High and Low add–ons and a Plan–specific rate summary for HCBS High and Low add–ons. The rate ranges reflect the removal of In–Home Supportive Services (IHSS) as a managed care benefit effective January 1, 2018, but also recognize the Plan's continuing IHSS care management responsibilities.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

CY 2015, 2016, 2017 and 2018 Full Dual Eligible Rates

There is no additional fiscal impact to CalOptima. Given the long delay in CalOptima's receipt of these rate adjustments, Staff has included the updated rates into the applicable annual financial statements for Fiscal Year (FY) 2014-15, FY 2015-16, FY 2016-17, FY 2017-18, and FY 2018-19.

Revised SFY 2017-18 Rates and Hospital Directed Payment Program

The revised capitation rates for July 1, 2017, through June 30, 2018, that included updates for the hospital directed payment program is projected to be revenue neutral to CalOptima. Staff previously incorporated the rate adjustments into the CalOptima FY 2017-18 Medi-Cal Operating Budget.

Revised HQAF for January – June 2017

The revised capitation rates for January 1, 2017, through June 30, 2017, that included updates for the HQAF, results in an average per member per month (PMPM) increase of $4.68. By statute, CalOptima will pass through to participating hospitals the full amount of supplemental hospital funds it receives from DHCS.

Revised SFY 2018-19 Rates

Base Medi-Cal Classic and Medi-Cal Expansion rates for July 1, 2018, through June 30, 2019

Compared to SFY 2017-18 rates, the revised capitation rates for the July 1, 2018, through June 30, 2019, period are 2.8% or $5.48 PMPM higher for Medi-Cal Classic, and 5.6% or $23.76 PMPM higher for Medi-Cal Expansion. However, because rate increases were anticipated and included in the CalOptima FY 2018-19 Medi-Cal Operating Budget, Staff projects the net fiscal impact to CalOptima will not be significant for FY 2018-19.

BHT, Hepatitis C, Abortion (Hyde), NMT, MLTSS Payments

The revised capitation rates for July 1, 2018, through June 30, 2019, that includes updates for BHT and Hepatitis C supplemental payments, Abortion (Hyde) payments, NMT payments, MLTSS payments, and CCI Non-Full Dual rates are projected to be revenue neutral to CalOptima. Staff has incorporated the rate adjustments in the CalOptima FY 2019-20 Medi-Cal Operating Budget.

Back to Agenda

Proposition 56 Directed Payments
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 2018-19. 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 that the net fiscal impact will be budget neutral.

Rationale for Recommendation
DHCS develops capitation rates according to base data reported by CalOptima through the Rate Development Template (RDT) process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreements with DHCS

s/s Michael Schrader *7/24/19*
Authorized Signature **Date**

APPENDIX TO AGENDA ITEM

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

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

Back to Agenda
Back to Agenda

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

Back to Agenda

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019

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

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

Back to Agenda

A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing and Directing the Execution of an Amendment to the Primary Agreement with the California Department of Health Care Services Related to the Addition of Covered Aid Codes

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement between the California Department of Health Care Services and CalOptima related to the addition of covered aid codes.

Background

As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Aid Code Additions

New Aid Code– 8U

Effective January 1, 2019, DHCS began to enroll newly eligible members into Medi-Cal managed care plans (MCPs), including CalOptima, using aid code 8U. Aid code 8U provides Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no Share–of–Cost (SOC) in the month after the infant's birth. Aid code 8U mirrors the full–scope aid code P9 with respect to payment and eligibility criteria. Aid code P9 is currently a covered aid code under CalOptima's Primary Agreement with the DHCS. Aid code 8U is considered an "Adult & Family/Optional Targeted Low–Income Child (Under 19)" aid code for payment purposes.

New Aid Code–R1

Effective November 1, 2018, DHCS began to enroll newly eligible members into Medi-Cal MCPs, including CalOptima, using aid code R1. Aid code R1 provides Medi-Cal benefits for non–citizen trafficking and crime victims. Aid code R1 mirrors the full–scope aid code 30 with respect to payment and eligibility criteria. Aid code 30 is currently a covered aid code under CalOptima's Primary

Agreement with the DHCS. Aid code R1 is considered an "Adult & Family/Optional Targeted Low–Income Child (Under 19 and 19 & Older)" aid code for payment purposes.

New Aid Code–5L

Effective January 1, 2018, DHCS began to enroll newly eligible foster/youth members up to age 21 into Medi-Cal MCPs, including CalOptima, using aid code 5L. Aid code 5L is used to identify cases when a child/youth is placed with an emergency caregiver on an emergency or compelling reason basis who has a pending Resource Family Approval (RFA) application. Aid code 5L mirrors the full–scope aid code 5K with respect to payment and eligibility criteria. Aid code 5K is currently a covered aid code under CalOptima's Primary Agreement with the DHCS. Aid code 5L is considered an "Adult & Family/Optional Targeted Low–Income Child (Under 19 and 19 & Older)" aid code for payment purposes.

New Aid Code–L6

Effective February 1, 2019, DHCS began to enroll newly eligible members into MCPs, including CalOptima, using aid code L6. Aid code L6 provides Medi-Cal benefits to disabled/blind Adult Expansion adults, from age 19 up to age 65 who are not enrolled in Medicare and whose Modified Adjusted Gross Income (MAGI) is at or below 128 percent of the Federal Poverty Level (FPL), and are citizens or lawfully present. Aid code L6 is considered an "Adult Expansion" aid code for payment purposes.

DHCS has informed CalOptima that it intends to include language authorizing these aid codes into a forthcoming contract amendment for CalOptima but has not specified timing or additional content of that contract amendment. In order to be prepared to promptly execute such an amendment, Staff is requesting that the Board authorize and direct its Chairman to execute an amendment that contains the addition of the aforementioned aid codes. Staff will return to the Board for authority to execute any additional language contained within the amendment.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to add covered aid codes is budget neutral. Members included under the new aid codes were part of previously established aid categories. The proposed capitation rates are expected to fully fund anticipated costs for these populations.

Rationale for Recommendation

The added aid codes will ensure that CalOptima is authorized to provide services for and receive capitation payments for populations deemed eligible by the state of California.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

APPENDIX TO AGENDA ITEM

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

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

Back to Agenda
Back to Agenda

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

Back to Agenda

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019

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

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

Back to Agenda

A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Authorizing Approval of Revised Policy GG.1517, Transgender Services

Contact
Donald Sharps, MD, Medical Director, Behavioral Health Integration (714) 246-8400
Tracy Hitzeman, RN, CCM, Executive Director, Clinical Operations (714) 246-8400
David Ramirez, MD, Chief Medical Officer (714) 246-8400

Recommended Action
Authorize approval of revised Policy GG. 1517, Transgender Services

Background
CalOptima's policy GG. 1517, Transgender Services initially took effect on November 1, 2013 based on Department of Health Care Services (DHCS) All Plan Letter (APL) 13-011, and was most recently updated on August 1, 2017. The currently proposed revision for GG. 1517 was reviewed and approved by CalOptima's Policy Review Committee in December 2018. It was subsequently discussed and accepted by CalOptima's Quality Improvement Committee on April 9, 2019. This proposed revision reflects the work of CalOptima's Integrated Transgender Care workgroup beginning in January 2017 after APL 16-013 was released.

APL16-013 (which is more detailed than/supersedes APL 13-011), The Affordable Care Act (ACA) and federal regulations prohibit Managed Care Plans (MCPs) from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a transgender beneficiary based on the fact that a beneficiary's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.

GG. 1517 follows the requirements of APL 16-013:

1) MCPs are required to provide beneficiaries who have been diagnosed with gender dysphoria *(F64.1)* with all Medi-Cal covered services that are provided to non-transgender beneficiaries, so long as the services are medically necessary, OR meet the definition of reconstructive surgery.
2) Reconstructive surgery which is "surgery performed to correct or repair abnormal structures of the body... to create a normal appearance to the extent possible" (Health and Safety Code § 1367.63, subd. (c)(1)(B)). In the case of transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.
3) MCPs are not required to cover cosmetic surgery, which is "performed to alter or reshape normal structures of the body in order to improve appearance."
4) The determination of whether the requested service is medically necessary and/or constitutes reconstructive surgery will be made by the MCP.
5) MCPs' UM processes must make the same determinations for medically necessary services and/or reconstructive surgery that are otherwise available to non-transgender beneficiaries on a case-by-case basis applying non-discriminatory limitations, exclusions, and utilization management criteria.

Back to Agenda

Discussion

This Transgender Services Policy supports the needs of members diagnosed with Gender Dysphoria and the provider community to provide appropriate care. The policy was further revised after CalOptima's Integrated Transgender Care workgroup met with LA Care's Transgender Care Management Program, UCI's Gender Diversity Program, LGBT Center of OC, Kaiser's Transgender services, Children Hospital of Los Angeles' Center for Transyouth Health and Development, and Children's Hospital of Orange County. These programs provide transgender services based on the most current *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, published by the World Professional Association for Transgender Health (WPATH). The *Standards of Care* includes a complete discussion of the clinical determinations that physicians must make and the criteria they must follow as they treat patients who may benefit from transgender services.

WPATH describes Gender Dysphoria treatment options to include the following:

1) Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
2) Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.
3) Hormone therapy to feminize or masculinize the body;
4) Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, and body contouring);

Fiscal Impact

The recommended action to authorize approval of revised CalOptima Policy GG. 1517: Transgender Services may increase CalOptima's claims expense. Given the lack of experience data for Gender Dysphoria treatments, the estimated fiscal impact is unknown at this time. However, Staff has included costs trends in the Fiscal Year 2019-20 Operating Budget that are expected to cover anticipated medical and administrative expenses for covered transgender services in the current fiscal year.

Rationale for Recommendation

CalOptima's mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. This Policy and Procedure guides CalOptima utilization decisions to support the needs of our members and work closely with the provider community to provide members with access to covered services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy GG.1517, Transgender Services

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

Policy #: GG.1517
Title: **Transgender Services**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 11/01/2013
~~Last Review Date:~~ ~~08/01/17~~08/01/2019
~~Last~~ Revised Date: ~~08/01/17~~08/01/2019

I. PURPOSE

This policy ~~ensures~~describes how CalOptima~~, its~~ and Health Networks~~, and Third Party Administrators (TPA) are aware of, and implement,~~ ensure the provision of covered Transgender Services ~~that are available~~ to Medi-Cal ~~Members~~Members.

II. POLICY

~~A. Treatment for Gender Dysphoria is a covered Medi-Cal benefit when Medical Necessity has been demonstrated.~~

A. ~~CalOptima shall ensure that the criteria for Medical Necessity of Transgender Services shall be based on the most current~~ CalOptima or a Health Network shall provide Medically Necessary Covered Services to all Medi-Cal Members, including transgender Members. CalOptima or a Health Network shall also provide reconstructive surgery to all Medi-Cal Members, including transgender Members.

B. The determination of whether a Covered Service requested by a transgender Member is medically appropriate must be made by a Qualified and Licensed Mental Health Professional and the treating surgeon, in collaboration with the Member's primary care provider.

C. CalOptima or a Health Network shall make the determination of whether the requested service is Medically Necessary and/or constitutes Reconstructive Surgery. Medical Necessity and/or Reconstructive Surgery determinations must be made on a case-by-case basis.

D. CalOptima or a Health Network will not discriminate on the basis of gender, including gender identity or gender expression.

E. CalOptima or a Health Network shall use nationally-recognized medical/clinical guidelines in reviewing requested Covered Services from transgender Members and shall apply those standards consistently across the population, such as:

1. MCG Guidelines;

2. "Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People~~"~~," published by the World Professional Association for Transgender Health (WPATH~~)~~); and ~~in accordance~~

Back to Agenda

~~B.~~3. "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," published by Center of Excellence for Transgender Health with ~~Title 22,~~University of California ~~Code of Regulations, Section 51303.~~, San Francisco.

F. CalOptima ~~and its~~or a Health ~~Networks~~Network shall ~~consider~~not limit a service or the ~~requirement~~frequency of services available to a transgender Member, and must provide ~~awareness~~all Medically Necessary services and ~~implementation of Transgender Services~~/or Reconstructive Surgery that are otherwise available to ~~Medi-Cal~~non-transgender Members, in a timely manner or as soon as the Member's health condition requires.

~~C.~~ For purposes of this policy, "Reconstructive Surgery" shall have the same meaning as described ~~by the Department of Health Care Services (DHCS) in item 21 of the Medi-Cal Provider Updates for March 2013 regarding Gender Dysphoria, when they review Prior Authorization requests related to Transgender Services.~~

~~D.~~G. ~~CalOptima shall provide Reconstructive Surgery to all Medi-Cal Members, including transgender Members, as defined by~~in Health and Safety Code~~, Section~~ section 1367.63(c)(1~~)(~~(B~~). For transgender Members,~~): "surgery performed to correct or repair abnormal structures of the body…to create a normal appearance ~~shall~~to the extent possible." In the case of transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the Member identifies~~.~~.

~~E.~~ CalOptima ~~shall~~ or a Health Network is not required to cover Cosmetic Surgery~~, as defined by Health and Safety Code, Section 1367.63(d).~~

~~F. In order to determine if~~. No request should be denied solely on the ~~requested~~ basis that the service ~~is covered under Medi-Cal, CalOptima and its Health Networks shall determine the~~ or procedures is considered cosmetic. A particular service or procedure may be Medically Necessary for a specific case, and may be found to be cosmetic in another case, based on the supporting medical documentation. Therefore, Medical ~~Necessity of each claim on a case-by-case basis, pursuant to the 2001 Writ of Mandate regarding Transgender Services issued by the California Superior Court.~~

1. ~~CalOptima shall apply non-discriminatory limitations and exclusions, conduct Medical Necessity and~~necessity and/or Reconstructive Surgery determinations~~, and/or apply appropriate utilization management criteria that are non-discriminatory.~~ must be made on a case-by-case basis.

~~G. Gender reassignment surgery is covered when an individual meets the following requirements:~~

~~1. Is eighteen (18) years of age or older;~~

~~2. Has the capacity for fully informed consent; and~~

~~3. Meets WPATH criteria for the surgery.~~

2. ~~Covered benefits for gender reassignment~~A particular service or procedure may be Medically Necessary for a specific case, and may be found to be cosmetic in another case, based on the supporting medical documentation.

H. Reconstructive surgery include, the following:

1. Mastectomy;

2. Orchiectomy;

3. Hysterectomy;

4. Salpingo-oophorectomy;

5. Ovariectomy; and

6. Genital surgery, including, but not limited, to:

a. Placement of testicular prostheses, when indicated.

7.3. Augmentation mammoplasty forto confer male to or female (MtF) individuals is a covered benefit only when an appropriate trial of hormone therapy has not resulted in breast enlargement.characteristics does not involve Cosmetic Surgery to improve appearance.

8. Behavioral health services including, psychotherapy.

I.H. A Member shall be entitled to appeals and grievance procedures as prescribed by DHCSin state and federal law and in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services and HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. CalOptima shall ensure that all Transgender Services for Medi-Cal Members are communicated to, and provided by, CalOptima's Health Networks, TPAs, and subcontractors, as described by the Department of Health Care Services (DHCS).

B.A. CalOptima, its Health Networks, and TPAsCalOptima physicians providing surgical or hormonal Transgender Services shall submit Prior Authorization requests for Transgender Services, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

B. CalOptima shall review a written report from a Qualified and Licensed Mental Health Professional confirming the diagnosis of Gender Dysphoria and an opinion that the requested procedure is medically appropriate for alleviating the severe symptoms of Gender Dysphoria and once received with an Authorization Request from treating physician, CalOptima will begin the process of Medical Necessity determination for the requested Transgender Services, including surgery or hormonal therapy.

C. Prior to CalOptima or a Health Network's determination for Transgender Services, including surgery or hormonal therapy an individual must have:

1. A written report from a Qualified and Licensed mental health professional, which:

a. Confirms diagnosis of Gender Dysphoria (F64.1);

b. Utilizes the collaboration with the treating physician and the beneficiary's primary care provider;

c. Provides an opinion that the requested procedure is medically appropriate for alleviating the severe symptoms of Gender Dysphoria, and that other less invasive options would not or have not alleviated the severe symptoms; and

d. Describes the assessment and treatment of any co-existing mental health concerns. Such concerns should be addressed as part of the overall treatment plan.

D. Prior Authorization requirements

1. Hormone Therapy

a. Feminizing/masculinizing Hormone Therapy may be requested by the treating provider to induce feminizing or masculinizing changes, and the criteria for this off-label use of hormones as follows:

i. A Member must have diagnosis of Gender Dysphoria; and

ii. A Member must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and if under eighteen (18) years of age, the parents or legal guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

iii. If significant medical or mental health concerns are present, they must be reasonably well controlled.

b. Puberty suppressing hormones for adolescents may be requested to suppress estrogen or testosterone production and consequently delay the physical changes of puberty, or alternative treatment options may be requested to decrease the effects of androgens or suppress menses, and the criteria for this off-label use of hormones is:

i. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or Gender Dysphoria (whether suppressed or expressed), and

ii. Gender Dysphoria emerged or worsened with the onset of puberty; and

iii. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment; and

iv. The adolescent has given informed consent and, the parents or legal guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

2. Sex Reassignment surgery

a. CalOptima shall primarily utilize MCG for guidelines to make Medical Necessity determinations and Health Networks will utilize evidence-based standardized criteria that has been approved by the Audit & Oversight Department in accordance with CalOptima Policy GG.1619: Delegation Oversight.

b. For all sex reassignment surgery:

i. A Member must have diagnosis of Gender Dysphoria; and

ii. A Member must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and if under eighteen (18) years of age, the parents or legal guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process and

iii. If significant medical or mental health concerns are present, they must be reasonably well controlled; and

iv. Only the necessary Reconstructive Surgery is involved that does not involve Cosmetic Surgery to improve appearance; and

v. A Member must have lived for twelve (12) continuous months in a gender role that is congruent with their gender identity.

E. CalOptima or a Health Network may apply non-discriminatory limitations and exclusions, conduct Medical Necessity and Reconstructive Surgery determinations, and/or apply appropriate utilization management criteria that are non-discriminatory.

~~1.~~F. If a request for Transgender Services is denied on the basis that the services are not Medically Necessary, not considered Reconstructive Surgery, or that the services do not meet ~~CalOptima's~~CalOptima or a Health Network's utilization management criteria, the decision shall be subject to review in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services and HH.1108: State Hearing Process and Procedures.

~~C. Prior Authorization requests shall include the following:~~

~~1. Hormone Therapy in which:~~

~~i. A Member must have diagnosis of Gender Dysphoria; and~~

~~ii. A Member, or Authorized Representative, must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and~~

~~2. Breast/Chest surgery such as:~~

~~a.~~A. ~~Mastectomy and creation of a male chest in Female to Male (FtM) Members in which:~~

~~i. A Member must have diagnosis of Gender Dysphoria; and~~

~~ii. A Member, or Authorized Representative, must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and~~

~~b.~~a. ~~Breast Augmentation (Implants/Lipofiling) in MtF Members in which:~~

~~i. A Member must have diagnosis of Gender Dysphoria;~~

~~ii. A Member, or Authorized Representative, must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and~~

~~iii. A Member must have undergone a twelve (12) month course of feminizing hormone therapy prior to breast augmentation surgery; and~~

~~3. Genital Surgery such as a:~~

~~a. Hysterectomy and Salpingo-Oophorectomy in FtM Members and Orchiectomy in MtF Members in which:~~

~~i. A Member must have diagnosis of Gender Dysphoria;~~

~~ii. A Member or Authorized Representative must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and~~

~~iii. A Member must have undergone a twelve (12) month course of feminizing hormone therapy prior to breast augmentation surgery; and~~

~~b. Metoidoplasty or Phalloplasty in FtM Members and Vaginoplasty in MtF Members in which:~~

~~i. A Member must have diagnosis of Gender Dysphoria;~~

~~ii. A Member or Authorized Representative must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and~~

~~iii. A Member must have had twelve (12) continuous months of living in a gender role that is congruent with their gender identity.~~

~~D. CalOptima shall not limit a service or the frequency of services available to a transgender Member and shall provide all Medically Necessary services and/or Reconstructive Surgery, in a timely manner, or as soon as the Member's health condition requires.~~

~~E.~~G. CalOptima's Health Networks, TPAs, and subcontractors, shall comply with the standards outlined in this policy. CalOptima's Office of Compliance may issue Corrective Action Plan(s) and/or Sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, if a Health Network, TPA, and/or subcontractor fails to adhere to this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People, Version 7: World Professional Association for Transgender Health
C. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," published by Center of Excellence for Transgender Health with University of California, San Francisco
~~A.~~D. California Superior Court Case No. 00CS00954, Doe v. Bonta, January 29, 2001
~~B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal~~
~~C.~~E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers

~~D.~~F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
H. CalOptima Policy GG.1619: Delegation Oversight
I. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~E.~~J. CalOptima Policy HH.2002Δ: Sanctions
~~F.~~K. CalOptima ~~Policy~~Policies HH.2005Δ: Corrective Action Plan
~~G.~~L. Department of Health Care Services All Plan Letter (APL) 16-013 (supersedes 13-011): Ensuring Access to Medi-Cal Services for Transgender Beneficiaries
M. Health and Safety Code Section (§)1365.5
~~H.~~N. Health and Safety Code, §1367.63(c)(1)(B)
~~I.~~O. Health and Safety Code, §1367.63(d)
P. Title 22, California Code of Regulations, §51300
~~J.A. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7: World Professional Association for Transgender Health~~
~~K.~~Q. Title 22, California Code of Regulations, §51303
R. Title 42, Code of Federal Regulations, §156.125(b)
S. MCG Behavioral Healthcare 22nd Edition, General Surgery or Procedure GRG SG-GS
T. MCG Behavioral Healthcare 22nd Edition, Urologic Surgery or Procedure GRG SG-US
U. MCG Behavioral Healthcare 22nd Edition, Gynecologic Surgery or Procedure GRG SG-OBS
V. MCG Behavioral Healthcare 22nd Edition, Gonadotropin-Releasing Hormone (GnRH) Agonists ACG: A-0304

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	11/01/2013	GG.1517	Transgender Services	Medi-Cal
Revised	11/01/2015	GG.1517	Transgender Services	Medi-Cal
Revised	10/01/2016	GG.1517	Transgender Services	Medi-Cal
Revised	08/01/2017	GG.1517	Transgender Services	Medi-Cal
Revised	08/01/2019	GG.1517	Transgender Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by a Member's Authorized Representative.
Cosmetic Surgery	Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Gender Dysphoria	A person's strong, persistent feelings of identification with the opposite gender and discomfort with one's own assigned sex.
Health Network	Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Hormone Therapy	For the purposes of this policy, refers to a form of hormone replacement therapy administered for the purposes of synchronizing an individual's secondary gender characteristics with their gender identity. Hormone therapy is used in the treatment of gender dysphoria.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Qualified and Licensed Mental Health Professional	A Qualified and Licensed Mental Health Professional is a licensed Psychiatrist or Psychologist that shares the ethical and legal responsibility for that decision with the physician who provides the service and has specific knowledge related to Gender Dysphoria.

Term	Definition
Reconstructive Surgery	Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1. To improve function; and 2. To create a normal appearance, to the extent possible.
Standards of Care	A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.
Transgender	A person whose gender does not correspond to that person's biological sex assigned at birth.
Transgender Services	The treatment of the gender identify disorder which may include, but is not limited to, psychotherapy, continuous hormonal therapy, laboratory testing to monitor hormone therapy, and gender reassignment surgery that is not cosmetic in nature.
World Professional Association for Transgender Health (WPATH)	A professional organization devoted to the understanding and treatment of gender identity disorders.

Policy #:	GG.1517
Title:	**Transgender Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/2013
Revised Date:	08/01/2019

I. PURPOSE

This policy describes how CalOptima and Health Networks ensure the provision of covered Transgender Services to Medi-Cal Members.

II. POLICY

A. CalOptima or a Health Network shall provide Medically Necessary Covered Services to all Medi-Cal Members, including transgender Members. CalOptima or a Health Network shall also provide reconstructive surgery to all Medi-Cal Members, including transgender Members.

B. The determination of whether a Covered Service requested by a transgender Member is medically appropriate must be made by a Qualified and Licensed Mental Health Professional and the treating surgeon, in collaboration with the Member's primary care provider.

C. CalOptima or a Health Network shall make the determination of whether the requested service is Medically Necessary and/or constitutes Reconstructive Surgery. Medical Necessity and/or Reconstructive Surgery determinations must be made on a case-by-case basis.

D. CalOptima or a Health Network will not discriminate on the basis of gender, including gender identity or gender expression.

E. CalOptima or a Health Network shall use nationally-recognized medical/clinical guidelines in reviewing requested Covered Services from transgender Members and shall apply those standards consistently across the population, such as:

1. MCG Guidelines;

2. "Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health (WPATH); and

3. "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," published by Center of Excellence for Transgender Health with University of California, San Francisco.

F. CalOptima or a Health Network shall not limit a service or the frequency of services available to a transgender Member, and must provide all Medically Necessary services and/or Reconstructive Surgery that are otherwise available to non-transgender Members, in a timely manner or as soon as the Member's health condition requires.

Back to Agenda

G. For purposes of this policy, "Reconstructive Surgery" shall have the same meaning as described in Health and Safety Code section 1367.63(c)(1(B): "surgery performed to correct or repair abnormal structures of the body…to create a normal appearance to the extent possible." In the case of transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the Member identifies.

1. CalOptima or a Health Network is not required to cover Cosmetic Surgery. No request should be denied solely on the basis that the service or procedures is considered cosmetic. A particular service or procedure may be Medically Necessary for a specific case, and may be found to be cosmetic in another case, based on the supporting medical documentation. Therefore, Medical necessity and/or Reconstructive Surgery determinations must be made on a case-by-case basis.

2. A particular service or procedure may be Medically Necessary for a specific case, and may be found to be cosmetic in another case, based on the supporting medical documentation.

3. Reconstructive surgery to confer male or female characteristics does not involve Cosmetic Surgery to improve appearance.

H. A Member shall be entitled to appeals and grievance procedures as prescribed in state and federal law and in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services and HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. CalOptima physicians providing surgical or hormonal Transgender Services shall submit Prior Authorization requests for Transgender Services, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

B. CalOptima shall review a written report from a Qualified and Licensed Mental Health Professional confirming the diagnosis of Gender Dysphoria and an opinion that the requested procedure is medically appropriate for alleviating the severe symptoms of Gender Dysphoria and once received with an Authorization Request from treating physician, CalOptima will begin the process of Medical Necessity determination for the requested Transgender Services, including surgery or hormonal therapy.

C. Prior to CalOptima or a Health Network's determination for Transgender Services, including surgery or hormonal therapy an individual must have:

1. A written report from a Qualified and Licensed mental health professional, which:

   a. Confirms diagnosis of Gender Dysphoria (F64.1);

   b. Utilizes the collaboration with the treating physician and the beneficiary's primary care provider;

   c. Provides an opinion that the requested procedure is medically appropriate for alleviating the severe symptoms of Gender Dysphoria, and that other less invasive options would not or have not alleviated the severe symptoms; and

d. Describes the assessment and treatment of any co-existing mental health concerns. Such concerns should be addressed as part of the overall treatment plan.

D. Prior Authorization requirements

1. Hormone Therapy

a. Feminizing/masculinizing Hormone Therapy may be requested by the treating provider to induce feminizing or masculinizing changes, and the criteria for this off-label use of hormones as follows:

i. A Member must have diagnosis of Gender Dysphoria; and

ii. A Member must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and if under eighteen (18) years of age, the parents or legal guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

iii. If significant medical or mental health concerns are present, they must be reasonably well controlled.

b. Puberty suppressing hormones for adolescents may be requested to suppress estrogen or testosterone production and consequently delay the physical changes of puberty, or alternative treatment options may be requested to decrease the effects of androgens or suppress menses, and the criteria for this off-label use of hormones is:

i. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or Gender Dysphoria (whether suppressed or expressed), and

ii. Gender Dysphoria emerged or worsened with the onset of puberty; and

iii. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment; and

iv. The adolescent has given informed consent and, the parents or legal guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

2. Sex Reassignment surgery

a. CalOptima shall primarily utilize MCG for guidelines to make Medical Necessity determinations and Health Networks will utilize evidence-based standardized criteria that has been approved by the Audit & Oversight Department in accordance with CalOptima Policy GG.1619: Delegation Oversight.

b. For all sex reassignment surgery:

i. A Member must have diagnosis of Gender Dysphoria; and

ii. A Member must have the capacity to make a fully informed decision and to be able to give consent for treatment(s); and if under eighteen (18) years of age, the parents or

legal guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process and

iii. If significant medical or mental health concerns are present, they must be reasonably well controlled; and

iv. Only the necessary Reconstructive Surgery is involved that does not involve Cosmetic Surgery to improve appearance; and

v. A Member must have lived for twelve (12) continuous months in a gender role that is congruent with their gender identity.

E. CalOptima or a Health Network may apply non-discriminatory limitations and exclusions, conduct Medical Necessity and Reconstructive Surgery determinations, and/or apply appropriate utilization management criteria that are non-discriminatory.

F. If a request for Transgender Services is denied on the basis that the services are not Medically Necessary, not considered Reconstructive Surgery, or that the services do not meet CalOptima or a Health Network's utilization management criteria, the decision shall be subject to review in accordance with CalOptima Policies GG.1510: Appeals Process for Decisions Regarding Care and Services and HH.1108: State Hearing Process and Procedures.

G. CalOptima's Health Networks, TPAs, and subcontractors, shall comply with the standards outlined in this policy. CalOptima's Office of Compliance may issue Corrective Action Plan(s) and/or Sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, if a Health Network, TPA, and/or subcontractor fails to adhere to this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People, Version 7: World Professional Association for Transgender Health
C. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," published by Center of Excellence for Transgender Health with University of California, San Francisco
D. California Superior Court Case No. 00CS00954, Doe v. Bonta, January 29, 2001
E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
H. CalOptima Policy GG.1619: Delegation Oversight
I. CalOptima Policy HH.1108: State Hearing Process and Procedures
J. CalOptima Policy HH.2002Δ: Sanctions
K. CalOptima Policies HH.2005Δ: Corrective Action Plan
L. Department of Health Care Services All Plan Letter (APL) 16-013 (supersedes 13-011): Ensuring Access to Medi-Cal Services for Transgender Beneficiaries
M. Health and Safety Code Section (§)1365.5
N. Health and Safety Code, §1367.63(c)(1)(B)
O. Health and Safety Code, §1367.63(d)

P. Title 22, California Code of Regulations, §51300
Q. Title 22, California Code of Regulations, §51303
R. Title 42, Code of Federal Regulations, §156.125(b)
S. MCG Behavioral Healthcare 22nd Edition, General Surgery or Procedure GRG SG-GS
T. MCG Behavioral Healthcare 22nd Edition, Urologic Surgery or Procedure GRG SG-US
U. MCG Behavioral Healthcare 22nd Edition, Gynecologic Surgery or Procedure GRG SG-OBS
V. MCG Behavioral Healthcare 22nd Edition, Gonadotropin-Releasing Hormone (GnRH) Agonists ACG: A-0304

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2013	GG.1517	Transgender Services	Medi-Cal
Revised	11/01/2015	GG.1517	Transgender Services	Medi-Cal
Revised	10/01/2016	GG.1517	Transgender Services	Medi-Cal
Revised	08/01/2017	GG.1517	Transgender Services	Medi-Cal
Revised	08/01/2019	GG.1517	Transgender Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by a Member's Authorized Representative.
Cosmetic Surgery	Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Gender Dysphoria	A person's strong, persistent feelings of identification with the opposite gender and discomfort with one's own assigned sex.
Health Network	Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Hormone Therapy	For the purposes of this policy, refers to a form of hormone replacement therapy administered for the purposes of synchronizing an individual's secondary gender characteristics with their gender identity. Hormone therapy is used in the treatment of gender dysphoria.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Qualified and Licensed Mental Health Professional	A Qualified and Licensed Mental Health Professional is a licensed Psychiatrist or Psychologist that shares the ethical and legal responsibility for that decision with the physician who provides the service and has specific knowledge related to Gender Dysphoria.
Reconstructive Surgery	Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1. To improve function; and 2. To create a normal appearance, to the extent possible.

Term	Definition
Standards of Care	A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.
Transgender	A person whose gender does not correspond to that person's biological sex assigned at birth.
Transgender Services	The treatment of the gender identify disorder which may include, but is not limited to, psychotherapy, continuous hormonal therapy, laboratory testing to monitor hormone therapy, and gender reassignment surgery that is not cosmetic in nature.
World Professional Association for Transgender Health (WPATH)	A professional organization devoted to the understanding and treatment of gender identity disorders.

1

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Authorizing Amendment to the Vision Service Plan HMO Services Contract

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Vision Service Plan (VSP) HMO Services Contract to increase the administrative capitation rates for Medi-Cal members effective August 1, 2019.

Background
VSP has been CalOptima's vision services provider since January 1, 2007. The current contract, which was the result of a formal, CalOptima Board of Directors authorized and CalOptima staff issued Request for Proposal (RFP) for vision services, has been in effect since July 1, 2016. An RFP was issued on September 3, 2015, for a new vision contract effective July 1, 2016, containing Medi-Cal, OneCare, OneCare Connect and PACE terms and conditions. Only one response was received, and VSP was awarded the new contract for both CalOptima's Medi-Cal and Medicare programs.

The initial contract term was three years, expiring on June 30, 2019, but allowing for two additional one-year terms at CalOptima's discretion. To date, CalOptima has applied one of the two extensions permitted, carrying its contract term with VSP through June 30, 2020. There have been no capitation payment rate increases to VSP since the inception of the July 1, 2016 contract for any CalOptima programs.

The VSP contract financial terms include a Per Member Per Month capitation rate for the administration of vision services. VSP's contract terms closely align with a CalOptima Health Network model as they are delegated for credentialing, claims payment and management of the benefit including reporting and audit functions.

Since July 1, 2016 CalOptima has added additional administrative requirements for VSP's compliance that were not included in the 2015 RFP. These include increased audit and oversight expectations, reporting, and an additional, annual eye exam for diabetic members.

Discussion
VSP is currently reimbursed an administrative capitation that does not account for the increase in administrative requirements for audits and oversight, reporting, and additional functions related to the annual eye exam for diabetic members. Staff recommends amending the VSP HMO services contract to ensure the administrative capitation rate is commensurate with administrative responsibilities.

Fiscal Impact

Back to Agenda

The net fiscal impact to revise capitation rates for the VSP Contract for Medi-Cal members effective August 1, 2019, through June 30, 2020, is estimated at $420,000. Staff anticipates the forecasted expense trend included in the Board-approved Fiscal Year 2019-20 Medi-Cal Operating Budget is sufficient to cover the anticipated costs related to the recommended action.

Rationale for Recommendation

Maintaining the current contract best meets the goal of continuing to ensure that CalOptima members receive quality vision services in a cost-effective manner. This increase falls within the CalOptima budget, and the additional administrative expectations support increasing the VSP administrative capitation rate.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities covered by this recommended Board Action
2. Board Action dated February 7, 2019, Consider Authorizing Amendment of the HMO Service Contract with Vision Service Plan (VSP) to Modify the Covered Benefits for Medi-Cal Members Diagnosed with Diabetes.
3. Board Action dated September 3, 2015, Authorize Request for Proposal Process for Vision Service Vendor(s) Effective July 1, 2016 for Medi-Cal, OneCare, OneCare Connect, and PACE Programs.

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

7/24/19 — **Date**

Back to Agenda

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 8

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Vision Service Plan (VSP)	3333 Quality Drive	Rancho Cordova	CA	92602

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken ~~January 17~~ February 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Betsy Ha, Executive Director, Quality Analytics, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to the HMO Service Contract with VSP to add one routine eye exam every 12 months for Medi-Cal members diagnosed with diabetes, as an additional covered benefit.

Background

CalOptima has contracted with VSP for the provision of vision services since October 1, 1998. New contracts with VSP were executed in 2009 and 2016 through Board-approved competitive procurement processes, most recently, a Request for Proposal (RFP) held in 2015. The current contract covers Medi-Cal, OneCare, OneCare Connect, and PACE members and is effective through June 30, 2019, with two additional one-year extension options, each exercisable at CalOptima's discretion.

The current VSP contract covers one routine eye exam during any 24-month period for CalOptima Medi-Cal members.

Annual eye exams for diabetic Medi-Cal members are covered by the member's health network.

Discussion

Staff proposes an amendment to expand VSP's contract to permit an annual eye exam for Medi-Cal members diagnosed with diabetes to improve access to care and reduce member confusion. Considering a quality improvement incentive initiative to increase the rate of diabetic eye exams in our Medi-Cal population, the barriers of the current benefit structure for eye exams was highlighted. Currently Medi-Cal members may receive an eye exam from a VSP provider every 24 months as defined in the Medi-Cal benefit guidelines. A diabetic member may have a medical necessity to have an eye exam performed annually. The current benefit structure stipulates that an eye exam will be covered by VSP every 24 months, requiring a diabetic member to obtain an eye exam through their health network the alternate year. The proposed amendment would allow a diabetic Medi-Cal member to obtain an annual eye exam from either VSP or their health network.

CalOptima encounter data show that of 55,949 Medi-Cal members with diabetes, only 18 percent (9,796) have utilized VSP services, and only 2 percent (1,213) utilized both VSP and health network eye care services. This indicator of underutilization strongly points to specific barriers.

Back to Agenda

CalOptima proposes that this amendment will help to: 1) eliminate member confusion regarding their eye care benefit; 2) improve member access to care by removing benefit restrictions, and; 3) directly improve the Comprehensive Diabetes Care Eye Exam measure rates by increasing eye exam utilization. This amendment does not change existing capitation arrangements, as members can currently obtain an annual eye exam through their health network. Instead, the amendment intends to impact access to care by providing equal access to both VSP or a health network eye care provider for the annual eye exam.

The proposed amendment aligns with the Department of Health Care Services Medi-Cal and American Diabetes Association approved clinical guidelines and National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)® requirements.

Other Medi-Cal managed care plans, such as L.A. Care, have added annual diabetic eye exams to their vision service benefit packages and have seen improved access and utilization.

Fiscal Impact

The recommended action to execute an amendment to the HMO Service Contract with VSP to add one routine eye exam every 12 months for Medi-Cal members diagnosed with diabetes, as an additional covered benefit, is forecasted to cost $280,000 per year. The CalOptima Fiscal Year (FY) ~~2017-18~~ 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, included funding for vision services expenses. The additional benefit is unbudgeted, but Staff anticipates the net fiscal impact will be budget neutral as the medical expense budget is projected to be sufficient to cover the increased cost.

Rationale for Recommendation

The Centers for Disease Control and Prevention (CDC) reports that diabetes impacts over 30.3 million Americans. People with diabetes are at an increased risk of serious health complications, including premature death, vision loss, heart disease, stroke, kidney failure, and amputation of toes, feet, or legs. With the correct treatment and recommended lifestyle changes, people with diabetes can prevent or delay the onset of complications. Regular checkups that include annual eye exams by eye care professionals is evidenced-based treatment and can decrease the risk of progressive vision loss and/or life altering vision impairment.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Vision Service Plan	3333 Quality Drive	Rancho Cordova	CA	95670

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. G. Authorize Request for Proposal Process for Vision Service Vendor(s) Effective July 1, 2016 for Medi-Cal, OneCare, OneCare Connect, and PACE Programs

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

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to issue a Request for Proposal (RFP) for Vision Service vendor(s) and contract with the selected vendor effective July 1, 2016 through June 30, 2019, with two one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion
Vision services are a required benefit for Medi-Cal, OneCare Connect (OCC), OneCare (OC) and PACE members. CalOptima has been contracted with VSP since 2009 for services to OneCare and Medi-Cal members as a result of an RFP process conducted in 2008. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OC provider network and use it as the foundation for the Duals Delivery system. Based on this authority, the existing OC contracts were amended to also apply to OCC. The current vision services vendor contract expires on June 30, 2016, based on the previous contract extensions.

As indicated, VSP has been the sole vision provider contracted with CalOptima since 2009 as a result of an RFP released in 2008. In accordance with vendor management best practices, staff recommends completing a new RFP process which will be effective July 1, 2016.

Fiscal Impact
The recommended action is budget neutral.

Rationale for Recommendation
CalOptima staff recommends authorizing issuance of an RFP and selection of a vendor(s) effective July 1, 2016 to ensure that members continue to have access to vision services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

8/28/2015 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Ratifying Early Payment of the Prepayment for Services to be Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds

Contact

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

Recommended Action

Ratify the early payment of the prepayment for services to the Orange County Health Care Agency, in an amount of $11.4 million in Intergovernmental Transfer (IGT) 5 funds and authorize the Chief Executive Officer take such other steps, if any, as necessary to effectuate such prepayment.

Background/Discussion

The Be Well OC Wellness Hub (Hub) is being developed in partnership with the County of Orange and numerous local entities, hospital systems, non-profit organizations, faith-based organizations, and other community stakeholders, now formally known as Be Well OC. In addition, a non-profit entity, Mind OC, has been established to develop financial resources in support of the Hub.

On December 6, 2018 and May 2, 2019, the CalOptima Board took action to authorize payment of up to $11.4 million in IGT 5 funds as prepayment toward enhanced services to be provided to CalOptima Medi-Cal members at the Hub; once the Hub is operational, services are to commence and continue to be provided to CalOptima members at no additional cost to CalOptima or its members for the greater of five (5) years or until the prepayment funding amount is exhausted.

In accordance with the Board's actions, prepayment for enhanced services for CalOptima Medi-Cal members was contingent upon:

- Receipt of written attestation that Mind OC has obtained the balance of funds required to complete development of the Hub, and that CalOptima's prepayment for services funding will be no more than $11.4 million or one-third of the costs of development of the Hub, whichever is less.
- The parties' agreement for specific services, oversight and CalOptima Medi-Cal member access to the agreed upon services as part of a contract between CalOptima and the County of Orange (and Mind OC, if appropriate).
- Contract approval and execution prior to disbursement of funds.

With the exception of the receipt of the full amount expected to be required to complete Hub development, all other contingencies have been met. The County of Orange has provided an attestation that Mind OC has received a total of $38 million of the budgeted $40 million, with the final $2 million committed by and to be received from the Kaiser Permanente Southern California Community Foundation:

Agency	Amount	Status
County of Orange Contribution	$16.6 Million	Received by MIND OC 07/03/2019
Hoag Memorial Hospital Presbyterian:	$ 4.0 Million	Received by MIND OC 05/29/2019
Kaiser Permanente Southern California Community Foundation Through OneOC (Kaiser)	$ 2.0 Million	Received by MIND OC 06/292019 **$ 2.0 Million Pending payment**
St. Jude Hospital Grant dated 2/28/19	$ 1.0 Million	Received by MIND OC 04/02/2019
St. Jude Hospital Grant dated 3/1/19	$ 2.0 Million	Received by MIND OC 05/10/2019
St. Jude Hospital Grant dated 4/22/19	$ 1.0 Million	Received by MIND OC 05/16/2019
CalOptima prepayment for services	$11.4 Million	Received by County 07/12/2019
TOTAL RECEIVED	**$38.0 Million**	

CalOptima's prepayment of $11.4 million for services for Medi-Cal members is provided subject to the obligation to provide CalOptima Medi-Cal members with services once the Hub is up and running. The County has advised that the final $2 million payment from Kaiser is expected to be received within the next several months based on the terms of Kaiser's Be Well grant agreement.

On July 12, 2019, CalOptima paid to the County of Orange the $11.4 million, representing prepayment for services based on Mind OC having satisfied the contingencies except actual receipt of the final $2 million pledged by Kaiser. This early payment of the prepayment for services was made to ensure that services are available to CalOptima members at the earliest possible date. Staff now seeks ratification of the prepayment and authority to take other steps, if any, as necessary (e.g., possible modification of the agreement between CalOptima and County to reflect actual payment timing).

Fiscal Impact

The recommended action to ratify the early payment of the prepayment for services of $11.4 million in IGT 5 funds to the County of Orange Health Care Agency has no fiscal impact on the CalOptima Operating Budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of its vision of working Better. Together., CalOptima, as the community health plan for Orange County, is committed to working with community stakeholders to address the unique health care needs of Medi-Cal members. Ratifying early payment of the prepayment for services for CalOptima Medi-Cal members ahead of receipt of the final $2 million payment by Kaiser will help to ensure that services are available to CalOptima members at the Hub at the earliest possible date.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds
2. Board Action dated May 2, 2019, Consider Authorizing a Contract for Prepayment of Services Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds in an Amount of $11.4 Million
3. Mind OC Project Forecast dated May 13, 2019
4. County of Orange Health Care Agency Attestation dated July 3, 2019

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Cheryl Meronk, Director, Strategic Development (714) 246-8400

Recommended Action

1. Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area;
2. Authorize the CEO, with the assistance of Legal Counsel, to enter into a contract with the County of Orange Health Care Agency, or a three-way agreement with the Orange County Health Care Agency and Mind OC, including indemnification, defense and hold harmless provisions by the County of Orange and also by Mind OC (if three-way agreement), in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services provided to CalOptima Medi-Cal members at the Be Well Wellness Hub to commence once the Hub is operational.

Background

IGTs must meet state and federal requirements and must be approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Funding agreements provide that provider recipients will use their share of IGT-funded capitation rate increases for the provision of health care services to CalOptima Medi-Cal members. Similarly, where CalOptima retains portions of IGT-funded capitation increases, such funds are designated for health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in remaining IGT 5 funds. The funding categories included in DHCS-approved IGT 5 included:

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health; and
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver Initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

Discussion

Be Well OC Regional Wellness Hub

The County of Orange and numerous other local public agencies, hospital systems, non-profit organizations, faith-based organizations and other community stakeholders have been meeting to discuss the mental health care system in Orange County. This group of stakeholders, known as the Orange County Coalition for Behavioral Health (the Coalition), now formally known as Be Well OC, came together to promote, facilitate and support existing mental health services and identify gaps in care that exist across the County. In addition, the Coalition formed a non-profit entity, Mind OC, to develop financial resources to support the goal of creating a high-quality behavioral health system of care.

While CalOptima Medi-Cal members are each assigned a primary care provider and a health network that are responsible for meeting member health care needs, results from the MHNA suggest that as many as 40% of CalOptima members may not know who to call or where to go for mental health services. In addition, Orange County hospital data indicates that more than 50% of Emergency Department (ED) visits for mental health and substance use disorder (SUD) issues involve Medi-Cal members[1]. The costs for these ED visits fall on CalOptima and its delegated health networks. The ED environment is often counter-indicated for the treatment of mental health and SUD. In certain situations, the ED may exacerbate the condition, potentially leading to longer stays and increasing the likelihood of an inpatient admission to a hospital-based psychiatric facility.

The Regional Wellness Hub (Hub), which is currently in its initial stages of development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services, and community-based social support services in a central, easily accessible location that improves access, addresses whole-person care, improves outcomes, and reduce recidivism. The goal is to redirect a meaningful percentage of mental health patients from the ED to the more appropriate care setting of a Regional Wellness Hub. Staff's understanding is that the County of Orange acquired 265 Anita Street in March of 2018 for the amount of $7.8 million and Be Well OC has provided additional financial resources to develop project plans and cost estimations.

Based on these factors, the CalOptima Board of Directors IGT 5 Ad Hoc Committee comprised of Supervisor Do and Director DiLuigi, recommends that CalOptima commit up to $11.4 million for the Be

[1] 2016 Office of Statewide Health Planning and Development (OSHPD)

Well OC Regional Wellness Hub, to be drawn from IGT 5 funds, consistent with DHCS-approved uses, to address the behavioral health needs of CalOptima members that are not carved out of CalOptima's State Contract.

Advance Funding Requirements

Operational details and services to be offered at the Hub have been developed including the go-live date, specific scope of mental health and other services; some other key considerations still need to be finalized. In addition, the volume of CalOptima members who will use the Hub is uncertain at this time and it is unknown how long it will take for services to meet the advance funding amount. As proposed, funds are being provided prior to commencement of services at the Hub, such that the County of Orange and Mind OC may end up using these funds for facility development, construction and/or other start-up costs, subject to the obligation to provide CalOptima Medi-Cal members services once the Hub is up and running. Given the uncertainty of these factors and CalOptima's advance funding, CalOptima will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are returned if the Regional Wellness Hub project does not go forward, does not ultimately deliver mental health services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub by the County of Orange or Mind OC is challenged and/or recovered by any regulatory agency.

The up to $11.4 million advance funding for services to CalOptima Medi-Cal beneficiaries will be based on the following requirements:

- Services prepayment funding is contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less;
- Commencement of development of the Wellness Hub by July 2020 and provision of agreed upon services to CalOptima Medi-Cal members no later than July 2021 based on Be Well's proposed construction schedule plus over an additional year for any potential delay;
- The Wellness Hub is to provide mental health and other related services to CalOptima Medi-Cal members at no additional cost to the members for the greater of five years or until the funding amount is exhausted (services provided to CalOptima Medi-Cal to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed upon methodology). Service areas may include the following:
    - Triage
    - Psychiatric intake and referral
    - Substance use disorder intake and referral
    - Residential treatment services
    - An integrated support center providing community and faith-based services
- Services provided to CalOptima members (and charged to the CalOptima funding amount pursuant to this proposed arrangement) do not include mental health services (e.g., Specialty Mental Health Services) that are carved out of CalOptima's State Contract and are the financial responsibility of the County of Orange Health Care Agency (OCHCA) or Social Services Agency;
- The Wellness Hub must accept all CalOptima Medi-Cal members whose condition is appropriate for the facility; and

- The parties will agree upon specific services as part of a contract (between CalOptima, County of Orange, and Mind OC, as appropriate), ensuring OCHCA will oversee all Wellness Hub operations and services, and ensure CalOptima Medi-Cal members access to the agreed upon services. The contract must be approved by the CalOptima Board prior to funds being disbursed.

The Orange County Board of Supervisors and Be Well OC will finalize operational and program plans in early 2019. The CalOptima Board of Directors will be provided with an update at that time.

Fiscal Impact

The recommended action to approve a contract of up to $11.4 million from IGT 5 to the Orange County Health Care Agency, or the Orange County Health Care Agency and Mind OC in exchange for mental health services for CalOptima Medi-Cal members has no fiscal impact on CalOptima's operations budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Be Well OC Regional Wellness Hub
2. Be Well Orange County 265 Anita St. Proposal

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

Be Well OC Regional Wellness Hub

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Mental Health in Orange County

- CalOptima's Member Health Needs Assessment highlighted Mental Health as a priority need in the community
  - Providers identified mental/behavioral health as one of the most important health problems facing Medi-Cal beneficiaries
  - Lack of knowledge and fear of stigma are key barriers to receiving mental health services
    - Approximately 1 in 4 CalOptima members who needed mental health services did not see a mental health specialist
      - Members did not know who to call or how to ask for help
      - Members did not feel comfortable talking about personal problems

Be Well OC Regional Wellness Hub

- CalOptima is participating in Be Well OC, a collaborative initiative to make improvements to the mental health system of care in Orange County
- Be Well initiative includes creation of Regional Wellness Hubs
- Services available at the Wellness Hubs are expected to include (but may not be limited to):
  - Variety of mental health services
  - Substance Use Disorder treatment programs
  - Integrated support services linking community and social services
- Services available to any OC resident
  - Access based on clinical need

Back to Agenda

Wellness Hub Services May Include:

- Triage
- Psychiatric intake and referral
- Substance use disorder intake and referral
- Residential treatment services
- Integrated support services center
  - Mobile crisis response team
  - Transportation
  - Social and community-based services
  - Faith-based organizations
  - Education, employment and legal services

Back to Agenda

Be Well OC Regional Wellness Hub

- Benefits for CalOptima members
  - Centralized and accessible services
  - Whole person approach to address needs and coordination of care
  - Co-location of community-based social support services
  - Improved health outcomes and reduction in recidivism

- Estimates are that more than 50% of local Emergency Department visits for mental health and substance use disorder issues are CalOptima members

Anita St. Wellness Hub

- OCHCA 2016 Strategic Financial Plan includes a priority to develop an integrated behavioral health services campus
  - 44,600-square-foot building purchased at 265 Anita St. in Orange
- Planning for the facility evolved in parallel with Be Well OC Blueprint
  - 60,000-square-foot new construction planned in partnership with Be Well
- Initial project cost estimate: $34.2 million

Wellness Hub Funding Deliverables

- Up to $11.4 million funding contract for services to CalOptima members conditioned on the following:
  - Funding contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete development of the first Wellness Hub
  - Construction of Wellness Hub to start no later than July 2020
  - Grand opening of Wellness Hub with full range of agreed upon services available to CalOptima members no later than July 2021
  - Wellness Hub must include agreed upon services at no cost to CalOptima or the member
  - Wellness Hub must accept all CalOptima members for first five years of operation until the funding amount is exhausted
    - Services provided to CalOptima Medi-Cal members to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed-upon methodology
  - MindOC to enter into a three-way contract with OCHCA and CalOptima

Back to Agenda

Recommended Actions

- Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved IGT 5 Adult and Children Mental Health priority area;
- Authorize a contract with County and Mind OC (including indemnity provisions) in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services for CalOptima Medi-Cal members at the Be Well Wellness Hub.

Back to Agenda

Be Well

ORANGE COUNTY

265 ANITA ST. PROPOSAL

Back to Agenda

Vision: Be Well Orange County will lead the nation in optimal mental health[1] and wellness for all residents.

Back to Agenda

[1]In the following document, the terms mental health and wellness encompass substance dependence and abuse.

A community in action.

Families across Orange County are suffering in the face of increasing mental health and substance use disorders. For many families, these challenges have become devastating catastrophes. If you are a resident of the Orange County community today, you undoubtedly have your own story – direct or indirect – to underscore this unfortunate reality.

265 Anita in the city of Orange is the first manifestation of Systems Change in Orange County. It is the place where we begin to build a new reality for this community, where together in public-private partnership we boldly impact individual, systemic and societal conditions so that all residents can Be Well.

265 Anita is a best-in-class regional treatment and wellness hub. It is a symbol of the strength and possibilities created when public and private partners strive together.

Orange County needs and deserves more than a new services building. **Let's build a beacon.**

Back to Agenda
Back to Agenda

Executive Summary

Background

265 Anita St.

The Orange County HCA 2016 Strategic Financial Plan identified as a priority the creation of a campus-like setting for co-location of behavioral health services. In order to meet this need, HCA worked in collaboration with Orange County CEO/ Real Estate to purchase 265 Anita St. in the city of Orange. The 2.1 acre property hosts a 44,556 sq. ft. freestanding, two-story, stucco and glass office building with a landscaped, open-air atrium.

The HCA program planning process for the Anita St. building evolved in parallel with the public-private co-creation of the Be Well OC Blueprint (described in further detail in this section). Within that context, an opportunity emerged for a public-private partnership, between HCA and Mind OC (a not-for-profit organization described in further detail in this section), to design and develop a 60,000 sq. ft. building de novo, for the purpose of providing mental health and substance use disorder (SUD) services for all residents of Orange County regardless of payer.

Proposed here is the recommended plan to leverage public-private collaboration and actualize the full potential of 265 Anita St. as the county's first Be Well OC Regional Mental Health and Wellness Hub.

Back to Agenda

Opportunity

In Process

As the first Regional Wellness Hub, 265 Anita will be a trusted beacon for the Orange County community. To optimize this opportunity, HCA can leverage Mind OC's private sector expertise in real estate development and healthcare facility design to benefit from past learning and efficiencies in planning, project management and construction. Three primary advantages to this approach include:

- speed to market
- cost
- quality

With HCA's approval and collaboration, an exploration of this approach is underway. The contents of this proposal are the result of that work to date. The following pages include a target population assessment, program and services descriptions, design and construction options, financing recommendations, and additional operational considerations. Notably, the 265 Anita clinical program proposed here is comprised of multiple services identified to meet specific community needs as reflected in both county and hospital data. The clinical program and operational facility design have been co-created by the clinical leaders of the HCA and Mind OC.

Back to Agenda

Executive Summary

Context

Be Well OC Blueprint

Co-created by a variety of public and private stakeholders across the county, a branded Be Well OC Blueprint clearly articulates the steps needed to actualize the Be Well OC vision. Success starts with acceptance that the mental health sector alone cannot solve this pervasive healthcare challenge. Neither can the public or private sectors sufficiently address the complexities alone. Be Well OC brings together a robust, community-based, cross-sector strategy – public, private, academic, faith and others – to positively impact those challenges that diminish mental health and well-being.

Be Well OC harnesses a best practice model known as Collective Impact, with a clearly defined leadership structure, to advance: education and prevention of mental illness, reduction of stigma, promotion of mental health, early identification of problems, and comprehensive, coordinated treatment. Be Well OC will establish a community-wide, coordinated ecosystem of optimal mental health support and services.

Mind OC

Mind OC is a community-owned, not-for-profit, 501(c)3 created to support the advancement of Be Well OC and the Orange County mental health and wellness ecosystem. The Mind OC governance board is comprised of a cross-sector, multidisciplinary team of Orange County leaders. The team sets goals, develops strategy and deploys plans through focused work streams and specialized project workgroups, managing the cross-functional alignment of these efforts. Accountabilities include oversight and management of work streams and projects, ensuring adequate information, resources and support are provided, and serving as liaison to key stakeholders. Mind OC has three primary areas of focus:

1. Mental health and wellness infrastructure development

2. Value optimization and transparency in mental health and SUD services

3. Be Well OC sustainability and public/private partnerships

Back to Agenda
Back to Agenda

Regional Hubs

As a foundational component of the Blueprint, and essential to effective services coordination, three regional anchoring Wellness Hubs are required to support the Be Well mental health system of care. The Wellness Hubs will include a variety of mental health and SUD treatment programs and are uniquely available to all residents of Orange County, regardless of payer. Access is based on clinical need.

The Wellness Hubs will be intentionally located and designed in synergistic compliment with the Homeless System of Care, and the goals of each respective Service Planning Area (SPA). It is critical to note the three Wellness Hubs are not designed exclusively to serve the OC homeless population. Hubs will have sufficient service and staffing capacity to address a range of mental health and wellness levels of risk and complexity. Each Hub will also integrate support services providing necessary linkage with myriad complimentary community and social services.

Back to Agenda
Back to Agenda

Community Need

OC Emergency Department Volume, 2016 OSHPD

DIAGNOSES	Total OC Market	5 Mile Radius of 265 Anita	% of Total
Alcohol-related disorders	10,645	2,773	26.1%
Substance-related disorders	6,388	1,984	31.1%
Mood disorders	5,695	1,890	33.2%
Suicide and intentional self-inflicted injury	4,498	1,306	29.0%
Schizophrenia and other psychotic disorders	4,067	1,477	36.3%
Delirium dementia and amnestic and other cognitive disorders	960	285	29.7%
Miscellaneous mental health disorders	888	322	36.3%
Attention-deficit conduct and disruptive behavior disorders	484	174	35 9%
Screening and history of mental health and substance abuse codes	252	66	26.4%
Personality disorders	105	41	39.0%
Totals:	**34,024**	**10,336**	**30.4%**

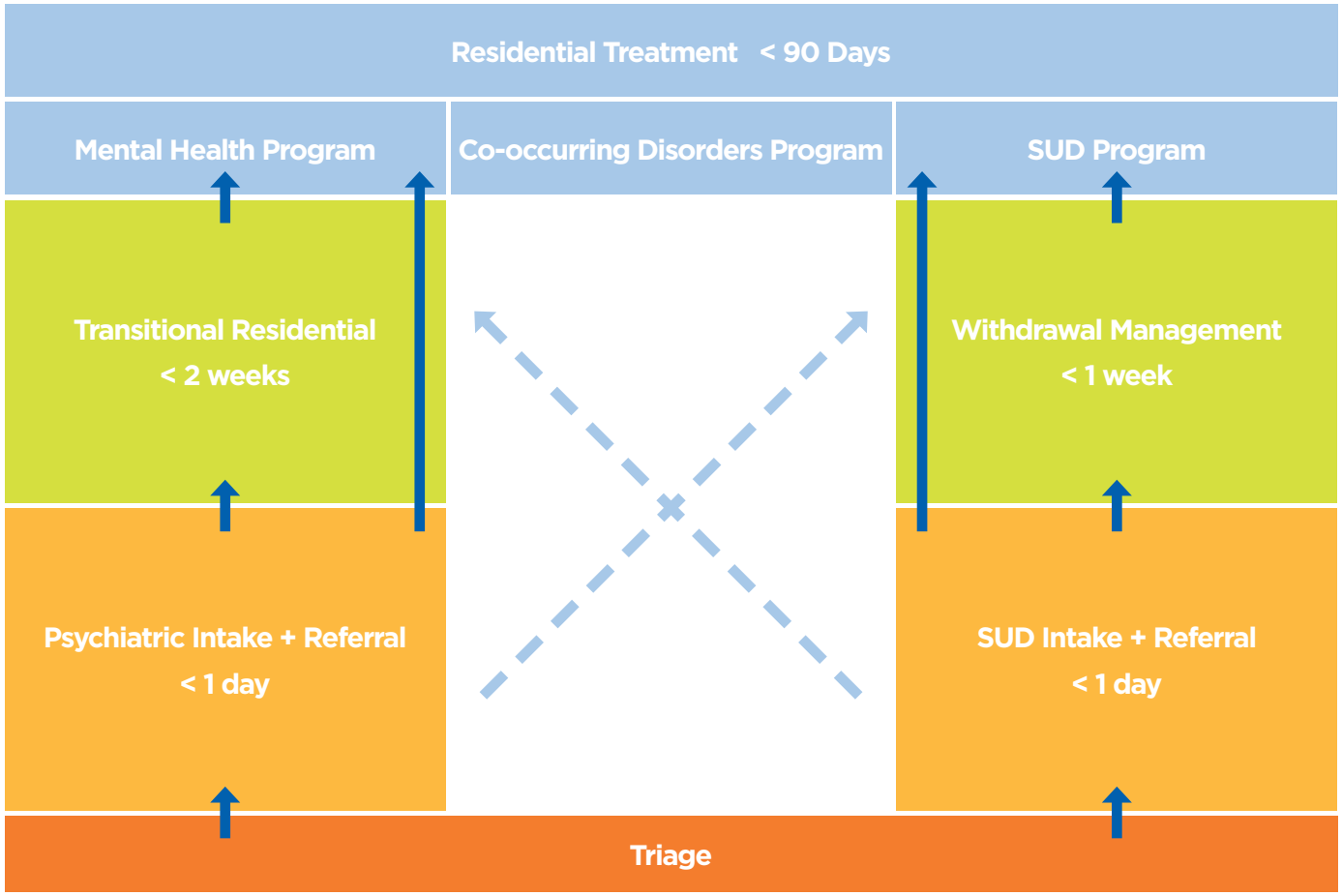
Payer Mix	5 Mile Radius Payer Mix %	Total OC Market	5 Mile Radius of 265 Anita
Medi-Cal	52.9%	15,441	5,463
Commericial	23.0%	10,772	2,379
Self Pay	11.4%	3,823	1,176
Medicare	11.3%	3,464	1,172
Other	1.4%	525	147
Totals:	**100.0%**	**34,024**	**10,336**

Back to Agenda

Back to Agenda

Proposed Program

The sum is greater than the parts. Integration of mental health and substance abuse services in a central, easily accessible location improves access. Coordination in care and operational synergy among services improves experience for patients and providers. Co-locating community-based social support services honors whole-person needs and a whole-systems approach, improves outcomes and reduces recidivism.



Integrated Support Services:

- Mobile Crisis Response Teams
- Transportation
- Social Services Support
- Community Based Organizations
- Faith Based Organizations
- Supportive Employment
- Supportive Education
- Legal Aid Services

*See Appendix for Program Access Projections and Discharge Planning.

Back to Agenda

Proposed Services

There are seven different service elements that make-up the program at this first Be Well Regional Hub. OCHCA will hold the contracts with the various organizations providing the clinical services. The contracted providers will be required to contract with commercial health plans to ensure access to all members of the community regardless of the payer. Revenue from commercial health plans to the service provider will be applied to the cost reimbursement funds they are paid, lowering HCA's cost burden.

Program	Description	Length of Stay
Triage	**Target population:** Adults and adolescents are separated in this receiving area for walk-in/drop-offs to the campus. Screening is completed to determine clinical fit for the onsite programs. If onsite services are not appropriate for the need, a referral and transportation are provided.	**N/A**
Psychiatric Intake + Referral	**Target population:** Walk-in/drop off services for adults and adolescents with acute behavioral health challenges, who are at risk of hospitalization and present on a voluntary or involuntary basis. Services include: basic medical and medication services, psychiatric and psychosocial evaluation, crisis intervention, therapeutic support, education, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Substance Use Disorder (SUD) Intake/Referral	**Target Population:** Walk-in/drop-off services for adults under the influence of drugs and alcohol. Services include: voluntary screening, assessment, physical safety and monitoring, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Withdrawal Management	**Target Population:** Individuals who can safely withdrawal from alcohol and/or other drugs in a safe and supportive community/residential environment. Services include: counseling, withdrawal monitoring and support.	**< 1 week**
Transitional Residential	**Target Population:** Adults in psychiatric decline requiring longer term stabilization to ensure safe transition. Services include: on-going assessment, psychiatric medication management, individual and group intervention, substance abuse education and treatment, and family and significant-other involvement.	**< 2 weeks**
Residential Treatment	**Target Population:** Persons living with Serious Mental Illness and co-occurring SUD. Specialized residential treatment services include: assessment, individual and group counseling, monitoring psychiatric medications, substance abuse education and treatment, and family and significant-other involvement.	**< 90 days**
Integrated Support Center	Through the expansion of the existing footprint of the building, additional services have been identified that function synergistically in support of the above programs. These include: • Mobile Crisis Response Team • Transportation • Social Services • Community Based Organizations • Faith Based Organizations • Supportive Employment • Supportive Education • Legal Aid Services	**N/A**

Back to Agenda

Financing Model

Syndicated Prorata Share

Back to Agenda

Back to Agenda

Back to Agenda
Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing a Contract for Pre-Payment of Services Provided to CalOptima Medi-Cal Members at the Be Well OC Wellness Hub Using Intergovernmental Transfer (IGT) 5 Funds in an Amount Not to Exceed $11.4 Million

Contact

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

Recommended Action

Authorize the CEO, with the assistance of Legal Counsel, to execute a contract with the County of Orange Health Care Agency, including indemnification, defense and hold harmless provisions by the County of Orange, in an amount not to exceed $11.4 million in IGT 5 funds, in exchange for the County of Orange securing Sobering Station and Peer Support services provided to CalOptima Medi-Cal members at the Be Well OC Wellness Hub (Hub) for the greater of five years, or until the funding amount is exhausted, to commence once the Hub is operational.

Background

IGTs are transfers of public funds between governmental entities that meet state and federal requirements and approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). CalOptima utilizes IGT funds towards health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors (Board) authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA were used to identify potential areas of interest for IGT funded initiatives. The areas of interest included community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health.

During the December 6, 2018 CalOptima Board meeting, up to $11.4 million was approved from IGT 5 as prepayment toward enhanced services to be provided to CalOptima Medi-Cal members at the Hub to commence once the Hub is operational and continuing for the greater of five (5) years or until the funding amount is exhausted. The Hub, which is currently in development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services.

The County is expected to establish referral and intake processes, leveraging existing county processes to ensure that the conditions of those individuals who complete the intake process are appropriate for the Hub services. As appropriate, CalOptima staff, health networks and providers would refer members following these processes. Sobering station center services could be referred directly through ambulances and law enforcement.

Back to Agenda

In accordance with CalOptima Board's December 2018 action, prepayment for enhanced services for CalOptima Medi-Cal members is contingent upon:

- Receipt of written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less.
- The parties' agreement for specific services, oversight and CalOptima Medi-Cal member access to the agreed upon services as part of a contract between CalOptima and the County of Orange (and Mind OC, if appropriate).
- Contract approval and execution prior to disbursement of funds.

Discussion

The Hub is being developed in partnership with the County of Orange and numerous local entities, hospital systems, non-profit organizations, faith-based organizations, and other community stakeholders, now formally known as Be Well OC. In addition, a non-profit entity, Mind OC has been established to develop financial resources to support construction of the Hub. Services provided to CalOptima Medi-Cal members at the Hub will be coordinated through the County of Orange. In order to provide the up to $11.4 million prepayment for Hub services, CalOptima staff plans to execute a contract with the County of Orange that will identify the enhanced services to be provided to CalOptima Medi-Cal members (i.e., other than Medi-Cal covered services for which providers can separately bill, and also other than services that the County is separately obligated to provide). The contract will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are to be returned to CalOptima if the Hub project does not go forward, does not ultimately deliver enhanced services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub is challenged and/or recovered by any regulatory agency.

Initially, the intent is for the Hub to provide peer support and sobering station services to CalOptima Medi-Cal Members at no additional cost to those members for the greater of five (5) years or until the funding amount is exhausted. CalOptima staff will return to the Board with further recommendations if additional services are to be added to the contract at a later time. The contract will include prepayment and reconciliation provisions to ensure an accurate accounting of contracted services provided to CalOptima Medi-Cal members. CalOptima staff has worked with the County of Orange to develop appropriate and reasonable pricing for peer support and sobering station services. The following table provides a description of peer support and sobering station services:

Category	County of Orange Provided Wellness Hub Services under this Contract
Peer support services	• Link members to needed behavioral health services • Help members develop capacity and access to resources • Educate members about their mental health condition(s) • Provide informal counseling, support and follow up
Sobering station services	• Community facility, an alternative to jailing and prosecuting intoxicated individuals.

Back to Agenda

	• CalOptima Medi-Cal members can sober up, be assessed regarding their mental health status, and get referred to treatment services as needed.
	• The Sobering station benefits members by providing the resources they need to address health problems. It also benefits the general public by freeing up law enforcement and emergency medical staff and resources so they can provide for the health and safety of the community.
	• Goals:
	  ○ Provide public inebriates with treatment rather than incarceration and prosecution.
	  ○ Eliminate unnecessary paramedic trips and time at hospital emergency departments.
	  ○ Improve public safety by freeing up law enforcement resources.
	  ○ Free up beds in emergency departments of local hospitals.
	  ○ Improve member outcomes, including mortality rates, by offering immediate treatment as well as linkages to treatment services for long-term recovery.
	  ○ Coordinate assistance for recurrent clients of County resources.

Fiscal Impact
The recommended action to approve a contract of up to $11.4 million from existing IGT 5 funding to the Orange County Health Care Agency in exchange for the above-referenced enhanced services for CalOptima Medi-Cal members has no fiscal impact on the CalOptima Operating Budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of its vision of working Better. Together, CalOptima, as the community health plan for Orange County, is committed to working with community stakeholders to address the unique health care needs of Medi-Cal members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds

/s/ Michael Schrader — *4/24/2019*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Cheryl Meronk, Director, Strategic Development (714) 246-8400

Recommended Action

1. Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area;
2. Authorize the CEO, with the assistance of Legal Counsel, to enter into a contract with the County of Orange Health Care Agency, or a three-way agreement with the Orange County Health Care Agency and Mind OC, including indemnification, defense and hold harmless provisions by the County of Orange and also by Mind OC (if three-way agreement), in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services provided to CalOptima Medi-Cal members at the Be Well Wellness Hub to commence once the Hub is operational.

Background

IGTs must meet state and federal requirements and must be approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Funding agreements provide that provider recipients will use their share of IGT-funded capitation rate increases for the provision of health care services to CalOptima Medi-Cal members. Similarly, where CalOptima retains portions of IGT-funded capitation increases, such funds are designated for health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in remaining IGT 5 funds. The funding categories included in DHCS-approved IGT 5 included:

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health; and
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver Initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

Discussion

Be Well OC Regional Wellness Hub

The County of Orange and numerous other local public agencies, hospital systems, non-profit organizations, faith-based organizations and other community stakeholders have been meeting to discuss the mental health care system in Orange County. This group of stakeholders, known as the Orange County Coalition for Behavioral Health (the Coalition), now formally known as Be Well OC, came together to promote, facilitate and support existing mental health services and identify gaps in care that exist across the County. In addition, the Coalition formed a non-profit entity, Mind OC, to develop financial resources to support the goal of creating a high-quality behavioral health system of care.

While CalOptima Medi-Cal members are each assigned a primary care provider and a health network that are responsible for meeting member health care needs, results from the MHNA suggest that as many as 40% of CalOptima members may not know who to call or where to go for mental health services. In addition, Orange County hospital data indicates that more than 50% of Emergency Department (ED) visits for mental health and substance use disorder (SUD) issues involve Medi-Cal members[1]. The costs for these ED visits fall on CalOptima and its delegated health networks. The ED environment is often counter-indicated for the treatment of mental health and SUD. In certain situations, the ED may exacerbate the condition, potentially leading to longer stays and increasing the likelihood of an inpatient admission to a hospital-based psychiatric facility.

The Regional Wellness Hub (Hub), which is currently in its initial stages of development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services, and community-based social support services in a central, easily accessible location that improves access, addresses whole-person care, improves outcomes, and reduce recidivism. The goal is to redirect a meaningful percentage of mental health patients from the ED to the more appropriate care setting of a Regional Wellness Hub. Staff's understanding is that the County of Orange acquired 265 Anita Street in March of 2018 for the amount of $7.8 million and Be Well OC has provided additional financial resources to develop project plans and cost estimations.

Based on these factors, the CalOptima Board of Directors IGT 5 Ad Hoc Committee comprised of Supervisor Do and Director DiLuigi, recommends that CalOptima commit up to $11.4 million for the Be

[1] 2016 Office of Statewide Health Planning and Development (OSHPD)

Well OC Regional Wellness Hub, to be drawn from IGT 5 funds, consistent with DHCS-approved uses, to address the behavioral health needs of CalOptima members that are not carved out of CalOptima's State Contract.

Advance Funding Requirements

Operational details and services to be offered at the Hub have been developed including the go-live date, specific scope of mental health and other services; some other key considerations still need to be finalized. In addition, the volume of CalOptima members who will use the Hub is uncertain at this time and it is unknown how long it will take for services to meet the advance funding amount. As proposed, funds are being provided prior to commencement of services at the Hub, such that the County of Orange and Mind OC may end up using these funds for facility development, construction and/or other start-up costs, subject to the obligation to provide CalOptima Medi-Cal members services once the Hub is up and running. Given the uncertainty of these factors and CalOptima's advance funding, CalOptima will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are returned if the Regional Wellness Hub project does not go forward, does not ultimately deliver mental health services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub by the County of Orange or Mind OC is challenged and/or recovered by any regulatory agency.

The up to $11.4 million advance funding for services to CalOptima Medi-Cal beneficiaries will be based on the following requirements:

- Services prepayment funding is contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less;
- Commencement of development of the Wellness Hub by July 2020 and provision of agreed upon services to CalOptima Medi-Cal members no later than July 2021 based on Be Well's proposed construction schedule plus over an additional year for any potential delay;
- The Wellness Hub is to provide mental health and other related services to CalOptima Medi-Cal members at no additional cost to the members for the greater of five years or until the funding amount is exhausted (services provided to CalOptima Medi-Cal to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed upon methodology). Service areas may include the following:
    - Triage
    - Psychiatric intake and referral
    - Substance use disorder intake and referral
    - Residential treatment services
    - An integrated support center providing community and faith-based services
- Services provided to CalOptima members (and charged to the CalOptima funding amount pursuant to this proposed arrangement) do not include mental health services (e.g., Specialty Mental Health Services) that are carved out of CalOptima's State Contract and are the financial responsibility of the County of Orange Health Care Agency (OCHCA) or Social Services Agency;
- The Wellness Hub must accept all CalOptima Medi-Cal members whose condition is appropriate for the facility; and

- The parties will agree upon specific services as part of a contract (between CalOptima, County of Orange, and Mind OC, as appropriate), ensuring OCHCA will oversee all Wellness Hub operations and services, and ensure CalOptima Medi-Cal members access to the agreed upon services. The contract must be approved by the CalOptima Board prior to funds being disbursed.

The Orange County Board of Supervisors and Be Well OC will finalize operational and program plans in early 2019. The CalOptima Board of Directors will be provided with an update at that time.

Fiscal Impact

The recommended action to approve a contract of up to $11.4 million from IGT 5 to the Orange County Health Care Agency, or the Orange County Health Care Agency and Mind OC in exchange for mental health services for CalOptima Medi-Cal members has no fiscal impact on CalOptima's operations budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Be Well OC Regional Wellness Hub
2. Be Well Orange County 265 Anita St. Proposal

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

Be Well OC Regional Wellness Hub

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Mental Health in Orange County

- CalOptima's Member Health Needs Assessment highlighted Mental Health as a priority need in the community
  - Providers identified mental/behavioral health as one of the most important health problems facing Medi-Cal beneficiaries
  - Lack of knowledge and fear of stigma are key barriers to receiving mental health services
    - Approximately 1 in 4 CalOptima members who needed mental health services did not see a mental health specialist
      - Members did not know who to call or how to ask for help
      - Members did not feel comfortable talking about personal problems

Be Well OC Regional Wellness Hub

- CalOptima is participating in Be Well OC, a collaborative initiative to make improvements to the mental health system of care in Orange County
- Be Well initiative includes creation of Regional Wellness Hubs
- Services available at the Wellness Hubs are expected to include (but may not be limited to):
  - Variety of mental health services
  - Substance Use Disorder treatment programs
  - Integrated support services linking community and social services
- Services available to any OC resident
  - Access based on clinical need

Back to Agenda

Wellness Hub Services May Include:

- Triage
- Psychiatric intake and referral
- Substance use disorder intake and referral
- Residential treatment services
- Integrated support services center
  - Mobile crisis response team
  - Transportation
  - Social and community-based services
  - Faith-based organizations
  - Education, employment and legal services

Back to Agenda

Be Well OC Regional Wellness Hub

- Benefits for CalOptima members
  - Centralized and accessible services
  - Whole person approach to address needs and coordination of care
  - Co-location of community-based social support services
  - Improved health outcomes and reduction in recidivism

- Estimates are that more than 50% of local Emergency Department visits for mental health and substance use disorder issues are CalOptima members

Anita St. Wellness Hub

- OCHCA 2016 Strategic Financial Plan includes a priority to develop an integrated behavioral health services campus
  - 44,600-square-foot building purchased at 265 Anita St. in Orange
- Planning for the facility evolved in parallel with Be Well OC Blueprint
  - 60,000-square-foot new construction planned in partnership with Be Well
- Initial project cost estimate: $34.2 million

Wellness Hub Funding Deliverables

- Up to $11.4 million funding contract for services to CalOptima members conditioned on the following:
  - Funding contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete development of the first Wellness Hub
  - Construction of Wellness Hub to start no later than July 2020
  - Grand opening of Wellness Hub with full range of agreed upon services available to CalOptima members no later than July 2021
  - Wellness Hub must include agreed upon services at no cost to CalOptima or the member
  - Wellness Hub must accept all CalOptima members for first five years of operation until the funding amount is exhausted
    - Services provided to CalOptima Medi-Cal members to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed-upon methodology
  - MindOC to enter into a three-way contract with OCHCA and CalOptima

Back to Agenda

Recommended Actions

- Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved IGT 5 Adult and Children Mental Health priority area;
- Authorize a contract with County and Mind OC (including indemnity provisions) in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services for CalOptima Medi-Cal members at the Be Well Wellness Hub.

Back to Agenda

Be Well

ORANGE COUNTY

265 ANITA ST. PROPOSAL

Back to Agenda

Vision: Be Well Orange County will lead the nation in optimal mental health[1] and wellness for all residents.

Back to Agenda

[1]In the following document, the terms mental health and wellness encompass substance dependence and abuse.

A community in action.

Families across Orange County are suffering in the face of increasing mental health and substance use disorders. For many families, these challenges have become devastating catastrophes. If you are a resident of the Orange County community today, you undoubtedly have your own story – direct or indirect – to underscore this unfortunate reality.

265 Anita in the city of Orange is the first manifestation of Systems Change in Orange County. It is the place where we begin to build a new reality for this community, where together in public-private partnership we boldly impact individual, systemic and societal conditions so that all residents can Be Well.

265 Anita is a best-in-class regional treatment and wellness hub. It is a symbol of the strength and possibilities created when public and private partners strive together.

Orange County needs and deserves more than a new services building. **Let's build a beacon.**

Back to Agenda
Back to Agenda

Executive Summary

Background

265 Anita St.

The Orange County HCA 2016 Strategic Financial Plan identified as a priority the creation of a campus-like setting for co-location of behavioral health services. In order to meet this need, HCA worked in collaboration with Orange County CEO/ Real Estate to purchase 265 Anita St. in the city of Orange. The 2.1 acre property hosts a 44,556 sq. ft. freestanding, two-story, stucco and glass office building with a landscaped, open-air atrium.

The HCA program planning process for the Anita St. building evolved in parallel with the public-private co-creation of the Be Well OC Blueprint (described in further detail in this section). Within that context, an opportunity emerged for a public-private partnership, between HCA and Mind OC (a not-for-profit organization described in further detail in this section), to design and develop a 60,000 sq. ft. building de novo, for the purpose of providing mental health and substance use disorder (SUD) services for all residents of Orange County regardless of payer.

Proposed here is the recommended plan to leverage public-private collaboration and actualize the full potential of 265 Anita St. as the county's first Be Well OC Regional Mental Health and Wellness Hub.

Back to Agenda

Opportunity

In Process

As the first Regional Wellness Hub, 265 Anita will be a trusted beacon for the Orange County community. To optimize this opportunity, HCA can leverage Mind OC's private sector expertise in real estate development and healthcare facility design to benefit from past learning and efficiencies in planning, project management and construction. Three primary advantages to this approach include:

- speed to market
- cost
- quality

With HCA's approval and collaboration, an exploration of this approach is underway. The contents of this proposal are the result of that work to date. The following pages include a target population assessment, program and services descriptions, design and construction options, financing recommendations, and additional operational considerations. Notably, the 265 Anita clinical program proposed here is comprised of multiple services identified to meet specific community needs as reflected in both county and hospital data. The clinical program and operational facility design have been co-created by the clinical leaders of the HCA and Mind OC.

Back to Agenda

Executive Summary

Context

Be Well OC Blueprint

Co-created by a variety of public and private stakeholders across the county, a branded Be Well OC Blueprint clearly articulates the steps needed to actualize the Be Well OC vision. Success starts with acceptance that the mental health sector alone cannot solve this pervasive healthcare challenge. Neither can the public or private sectors sufficiently address the complexities alone. Be Well OC brings together a robust, community-based, cross-sector strategy – public, private, academic, faith and others – to positively impact those challenges that diminish mental health and well-being.

Be Well OC harnesses a best practice model known as Collective Impact, with a clearly defined leadership structure, to advance: education and prevention of mental illness, reduction of stigma, promotion of mental health, early identification of problems, and comprehensive, coordinated treatment. Be Well OC will establish a community-wide, coordinated ecosystem of optimal mental health support and services.

Mind OC

Mind OC is a community-owned, not-for-profit, 501(c)3 created to support the advancement of Be Well OC and the Orange County mental health and wellness ecosystem. The Mind OC governance board is comprised of a cross-sector, multidisciplinary team of Orange County leaders. The team sets goals, develops strategy and deploys plans through focused work streams and specialized project workgroups, managing the cross-functional alignment of these efforts. Accountabilities include oversight and management of work streams and projects, ensuring adequate information, resources and support are provided, and serving as liaison to key stakeholders. Mind OC has three primary areas of focus:

1. Mental health and wellness infrastructure development

2. Value optimization and transparency in mental health and SUD services

3. Be Well OC sustainability and public/private partnerships

Back to Agenda
Back to Agenda

Regional Hubs

As a foundational component of the Blueprint, and essential to effective services coordination, three regional anchoring Wellness Hubs are required to support the Be Well mental health system of care. The Wellness Hubs will include a variety of mental health and SUD treatment programs and are uniquely available to all residents of Orange County, regardless of payer. Access is based on clinical need.

The Wellness Hubs will be intentionally located and designed in synergistic compliment with the Homeless System of Care, and the goals of each respective Service Planning Area (SPA). It is critical to note the three Wellness Hubs are not designed exclusively to serve the OC homeless population. Hubs will have sufficient service and staffing capacity to address a range of mental health and wellness levels of risk and complexity. Each Hub will also integrate support services providing necessary linkage with myriad complimentary community and social services.

Back to Agenda
Back to Agenda

Community Need

OC Emergency Department Volume, 2016 OSHPD

DIAGNOSES	Total OC Market	5 Mile Radius of 265 Anita	% of Total
Alcohol-related disorders	10,645	2,773	26.1%
Substance-related disorders	6,388	1,984	31.1%
Mood disorders	5,695	1,890	33.2%
Suicide and intentional self-inflicted injury	4,498	1,306	29.0%
Schizophrenia and other psychotic disorders	4,067	1,477	36.3%
Delirium dementia and amnestic and other cognitive disorders	960	285	29.7%
Miscellaneous mental health disorders	888	322	36.3%
Attention-deficit conduct and disruptive behavior disorders	484	174	35 9%
Screening and history of mental health and substance abuse codes	252	66	26.4%
Personality disorders	105	41	39.0%
Totals:	**34,024**	**10,336**	**30.4%**

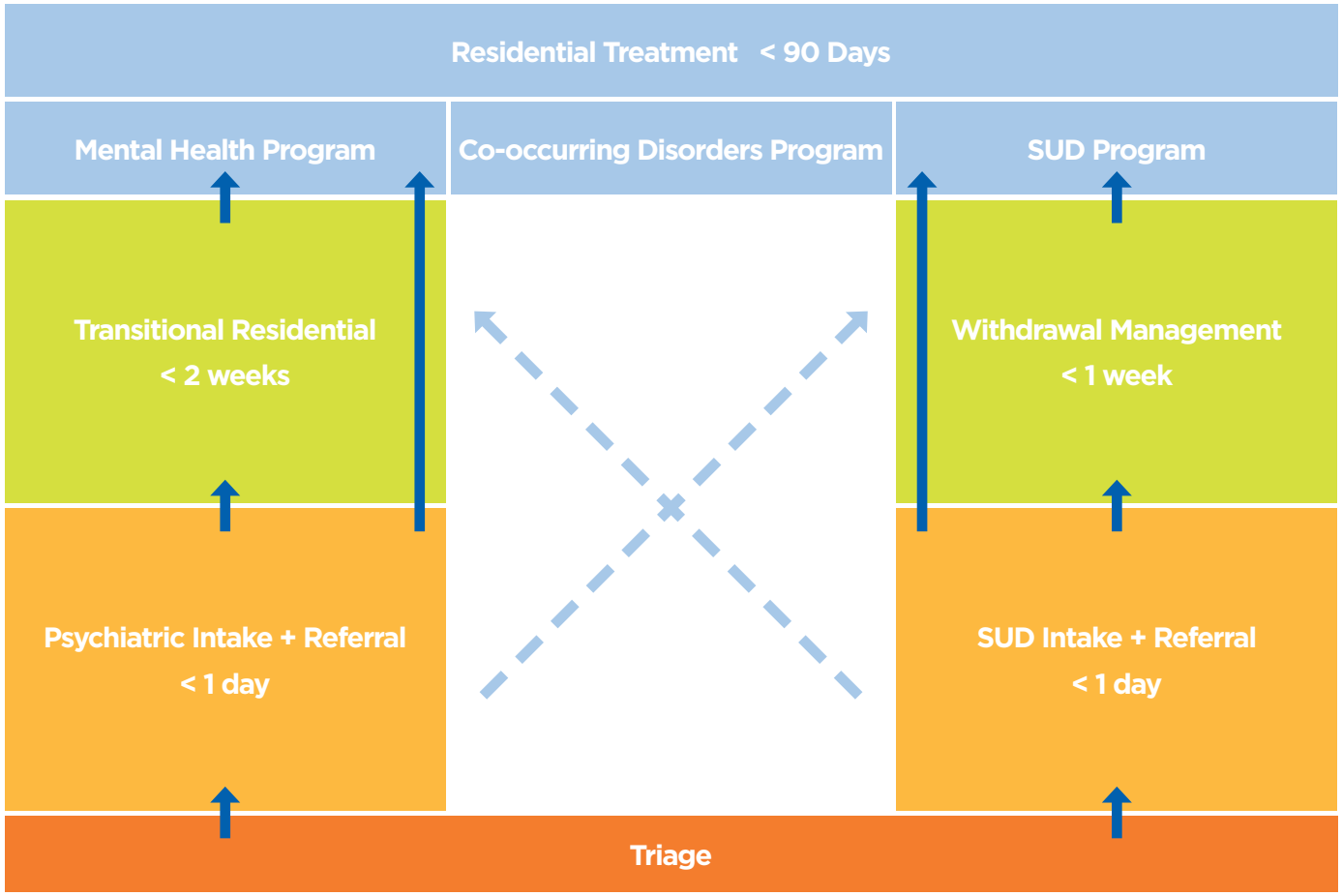
Payer Mix	5 Mile Radius Payer Mix %	Total OC Market	5 Mile Radius of 265 Anita
Medi-Cal	52.9%	15,441	5,463
Commericial	23.0%	10,772	2,379
Self Pay	11.4%	3,823	1,176
Medicare	11.3%	3,464	1,172
Other	1.4%	525	147
Totals:	**100.0%**	**34,024**	**10,336**

Back to Agenda

Back to Agenda

Proposed Program

The sum is greater than the parts. Integration of mental health and substance abuse services in a central, easily accessible location improves access. Coordination in care and operational synergy among services improves experience for patients and providers. Co-locating community-based social support services honors whole-person needs and a whole-systems approach, improves outcomes and reduces recidivism.



Integrated Support Services:

- Mobile Crisis Response Teams
- Transportation
- Social Services Support
- Community Based Organizations
- Faith Based Organizations
- Supportive Employment
- Supportive Education
- Legal Aid Services

*See Appendix for Program Access Projections and Discharge Planning.

Back to Agenda

Proposed Services

There are seven different service elements that make-up the program at this first Be Well Regional Hub. OCHCA will hold the contracts with the various organizations providing the clinical services. The contracted providers will be required to contract with commercial health plans to ensure access to all members of the community regardless of the payer. Revenue from commercial health plans to the service provider will be applied to the cost reimbursement funds they are paid, lowering HCA's cost burden.

Program	Description	Length of Stay
Triage	**Target population:** Adults and adolescents are separated in this receiving area for walk-in/drop-offs to the campus. Screening is completed to determine clinical fit for the onsite programs. If onsite services are not appropriate for the need, a referral and transportation are provided.	**N/A**
Psychiatric Intake + Referral	**Target population:** Walk-in/drop off services for adults and adolescents with acute behavioral health challenges, who are at risk of hospitalization and present on a voluntary or involuntary basis. Services include: basic medical and medication services, psychiatric and psychosocial evaluation, crisis intervention, therapeutic support, education, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Substance Use Disorder (SUD) Intake/Referral	**Target Population:** Walk-in/drop-off services for adults under the influence of drugs and alcohol. Services include: voluntary screening, assessment, physical safety and monitoring, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Withdrawal Management	**Target Population:** Individuals who can safely withdrawal from alcohol and/or other drugs in a safe and supportive community/residential environment. Services include: counseling, withdrawal monitoring and support.	**< 1 week**
Transitional Residential	**Target Population:** Adults in psychiatric decline requiring longer term stabilization to ensure safe transition. Services include: on-going assessment, psychiatric medication management, individual and group intervention, substance abuse education and treatment, and family and significant-other involvement.	**< 2 weeks**
Residential Treatment	**Target Population:** Persons living with Serious Mental Illness and co-occurring SUD. Specialized residential treatment services include: assessment, individual and group counseling, monitoring psychiatric medications, substance abuse education and treatment, and family and significant-other involvement.	**< 90 days**
Integrated Support Center	Through the expansion of the existing footprint of the building, additional services have been identified that function synergistically in support of the above programs. These include: • Mobile Crisis Response Team • Transportation • Social Services • Community Based Organizations • Faith Based Organizations • Supportive Employment • Supportive Education • Legal Aid Services	**N/A**

Back to Agenda

Financing Model

Syndicated Prorata Share

Back to Agenda

Back to Agenda

Back to Agenda
Back to Agenda

Data date: 5/13/2019

Regional Wellness Campus

PROJECT FORECAST

Description	Current Budget
Pre-Construction	$60,000
(1) Feasibility	$60,000
A&E Team	$1,776,825
Reimbursables	$59,625
(2) Consultants	$1,836,450
Construction	$25,710,300
Testing & Inspection	$154,262
(3) Construction	$25,864,562
Furniture & Fixtures	$2,100,000
Equipment	$119,250
Signage	$238,500
Artwork & Plants	$202,725
Information Technology	$954,000
(4) Furniture, Fixtures & Equipment	$3,614,475
CM/Testing/Support	$1,174,331
Permit Fees	$514,206
(5) Construction Management	$1,688,537
Relocation	$0
Storage	$0
(6) Relocation Costs	$0
Construction Contingency	$1,818,923
A&E Contingency	$128,552
FF&E Contingency	$253,013
Project Management Contingency	$118,198
(7) Total Contingency	$2,318,686
Escalation	$617,290
(8) Escalation	$617,290
Project Management ($2M/yr)	$4,000,000
(9) Project Management	$4,000,000
Total	$40,000,000

Back to Agenda

RICHARD SANCHEZ
DIRECTOR

ANNA PETERS
DIRECTOR
ADMINISTRATIVE SERVICES

MARIA PIRONA, MBA
DIVISION MANAGER
CONTRACT SERVICES

405 W. 5th STREET, SUITE 600
SANTA ANA, CA 92701
(714) 834-5809
FAX: (714) 834-4450
mpirona@ochca.com

ADMINISTRATIVE SERVICES
CONTRACT SERVICES

ATTESTATION STATEMENT

July 3, 2019

I, William C. Norsetter, attest the attached documents accurately reflect the financial commitment as required in the BE WELL OC WELLNESS HUB SERVICES CONTRACT BETWEEN THE COUNTY OF ORNAGE AND CALOPTIMA, Paragraph 4.10.2.1 which reads as follows:

> "4.10.2.1 Payment of the Advance Funding Amount is contingent upon receiving of written attestation County that Mind OC has obtained the balance of funds required to complete construction of the Be Well OC Wellness Hub. The Advance Funding Amount will be no greater than 11.4 million dollars or one-third of the costs of development of the Be Well OC Wellness Hub, whichever is less."

Financial commitments are:

County of Orange Contribution;	$16.6 Million	Received by MIND OC 07/03/2019
Hoag Memorial Hospital Presbyterian:	$4.0 Million	Received by MIND OC 05/29/2019
Kaiser Permanente Southern California	$2.0 Million	Received by MIND OC 06/292019
California Community Foundation Through OneOC:	$2.0 Million	Pending payment after 07/01/2019
St. Jude Hospital Grant dated 2/28/19:	$1.0 Million	Received by MIND OC 04/02/2019
St. Jude Hospital Grant dated 3/1/19:	$2.0 Million	Received by MIND OC 05/10/2019
St. Jude Hospital Grant dated 4/22/19:	$1.0 Million	Received by MIND OC 05/16/2019

CalOptima funding of $11.4 million is 28.5% of $40 million (total planned contributions)

CalOptima funding of $11.4 million is 30% of $38 million (total received contributions this date)

Respectfully,

William C. Norsetter, DPA
Administrative Manager II
Contract Services
714 834-4436

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular 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 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 ratify amendments to the 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 as 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 ratify amendments to 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

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 ratify amendments to 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 amendments which include, but are not limited to Government Claims Act specifications, and document and data submissions certification obligations.

This item had been agendized for Board consideration at the June 6, 2019 Regular Board Meeting and June 27th Special Board Meeting, but was continued due to lack of quorum. Staff now requests ratification of amendments to 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 as authorized by the Board.

Fiscal Impact

The recommended action to ratify amendments to 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 ratify amendments to 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 ratify amendments to 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 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/s Michael Schrader — *7/24/19*
Authorized Signature — **Date**

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&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov
Back to Agenda

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

Back to Agenda

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).

Back to Agenda

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.

Back to Agenda

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)

Back to Agenda

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

Back to Agenda

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

Back to Agenda

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

Back to Agenda

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

Back to Agenda

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2020, except those associated with the University of California, Irvine, or St. Joseph Healthcare and its affiliates, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Amend these contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and make applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. The Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS) on a phased-in basis. This transition, referred to as the Whole Child Model (WCM) program, is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016 and DHCS's All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program released on June 28, 2018, which was superseded by APL 18-023 released on December 23, 2018.

On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima. On November 9, DHCS changed the timing of

Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS has determined that more time was needed to ensure effective program preparation and ensure access to a robust number of CCS-paneled providers. Staff is requesting authority to modify the clinic contracts to include definitions and requirements associated with the WCM program.

Additional regulatory requirements are also included in the amendments such as the new Preclusion list requirements. The Preclusion List is a CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Since many of the clinic providers contracted with CalOptima Community Network participate in CalOptima's Medicare programs, the contract is being amended to reflect this new requirement. The contracts are being updated for other regulatory updates such as appointment availability.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts except those associated with the University of California, Irvine, or St. Joseph Health and its affiliates

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima clinic contracts, except for those associated with the University of California, Irvine or St. Joseph Healthcare and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

The fiscal impact of the recommended action to amend contract terms to reflect requirements associated with the Whole-Child Model (WCM) program and reflect other requirements and regulatory changes, as applicable is unknown at this time. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. Management will include projected revenues and expenses associated with the WCM program in the CalOptima FY 2019-20 Operating Budget. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Contracted Entities Covered by this Recommended Board Action

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

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
AltaMed Health Services - Anaheim Lincoln	1814 W Lincoln Ave	Anaheim	CA	92801
AltaMed Health Services - Anaheim Lincoln West	1820 W Lincoln Ave	Anaheim	CA	92801
AltaMed Health Services - East Los Angeles/Whittier	5427 Whittier Blvd	Los Angeles	CA	90022
AltaMed Health Services - Santa Ana Main	1400 N Main St	Santa Ana	CA	92701
AltaMed Medical and Dental Group-Huntington Beach	8041 Newman Ave	Huntington Beach	CA	92647
AltaMed Medical Group Santa Ana Central	1155 W Central Ave Suite 107	Santa Ana	CA	92707
AltaMed Medical Group-Garden Grove	12751 Harbor Blvd	Garden Grove	CA	92840
AltaMed Medical Group-Orange	4010 E Chapman Ave	Orange	CA	92869
AltaMed Medical Group-Santa Ana, Bristol	2720 S Bristol St Suite 110	Santa Ana	CA	92704
Benevolence Industries Inc	805 W La Veta Ave Suite 110	Orange	CA	92868
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Camino Health Center - Lake Forest	22841 Aspan St Suite A	Lake Forest	CA	92630
Center for Inherited Blood Disorders	1010 W La Veta Ave Suite 670	Orange	CA	92868
Central City Community Health Center	12116 Beach Blvd	Stanton	CA	90680
Central City Community Health Center	2237 W Ball Rd	Anaheim	CA	92804
Families Together of Orange County	661 W First St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 190	La Habra	CA	90631
Friends of Family Health - Tustin	13152 Newport Ave Suite B	Tustin	CA	92780
Hurtt Family Health Clinic	1 Hope Dr	Tustin	CA	92782
Hurtt Family Health Clinic - Anaheim	947 S Anaheim Blvd Suite 260	Anaheim	CA	92805
Hurtt Family Health Clinic - Santa Ana	1100B N Tustin Ave Suite A	Santa Ana	CA	92705
KCS Health Center	7212 Orangethorpe Ave Suite 9A	Buena Park	CA	90621

Back to Agenda
Back to Agenda

Name	Address	City	State	Zip
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Health Clinic	12362 Beach Blvd Suite 10	Stanton	CA	90680
Mission City Community Network	1661 W Broadway Suite 11	Anaheim	CA	92802
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Reg Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
Planned Parenthood Anaheim	DBA Melody Women's Health 303 W Lincoln Ave	Anaheim	CA	92805
Planned Parenthood Costa Mesa	DBA Melody Women's Health 601 W 19th St	Costa Mesa	CA	92627
Planned Parenthood Mission Viejo	DBA Melody Women's Health 26137 La Paz Rd	Mission Viejo	CA	92691
Planned Parenthood Orange	DBA Melody Women's Health 700 S Tustin St	Orange	CA	92866
Planned Parenthood Santa Ana	DBA Melody Women's Health 1421 E 17th St	Santa Ana	CA	92705
Planned Parenthood Westminster	DBA Melody Women's Health 14372 Beach Blvd	Westminster	CA	92683
Serve the People Community Health Center	1206 E 17th St Suite 101	Santa Ana	CA	92701
Share Our Selves Community Health Center	1550 Superior Ave	Costa Mesa	CA	92627
Sierra Health Center	501 S Brookhurst Rd	Fullerton	CA	92833
Southland Health Center	9862 Chapman Ave Suite B	Garden Grove	CA	92841
VCC The Gary Center	1000 Vale Terrace	Vista	CA	92084

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

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

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 — *10/24/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

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

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

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

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

Back to Agenda

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.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratifying 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 ratify amendments to the 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 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 revise 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 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. This item had been agendized for Board consideration at the June 6, 2019 Regular Board Meeting and June 27th Special Board Meeting, but was continued due to lack of quorum. Staff now requests ratification of amendments to 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 ratify amended rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action

Fiscal Impact

The recommended action to ratify amendments to 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 ratify amendments to 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 ratify amendments to 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

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/s Michael Schrader — *7/24/19*

Authorized Signature — **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.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov
Back to Agenda

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

Back to Agenda

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).

Back to Agenda

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.

Back to Agenda

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)

Back to Agenda

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

Back to Agenda

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

Back to Agenda

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

Back to Agenda

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

Back to Agenda

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2020, except those associated with Children's Hospital of Orange County, the University of California-Irvine or St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County, the University of California, Irvine, and St. Joseph Health and its Affiliates, through June 30, 2020.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist contracts, except for those associated with Children's Hospital of Orange County, the University of

California, Irvine or St. Joseph Health and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

None

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

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

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 — *10/24/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

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

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

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

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

Back to Agenda

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.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Ratifying Amendments to 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 ratify amendments to the 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 revise 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. This item had been agendized for Board consideration at the June 6, 2019 Regular Board Meeting and June 27th Special Board Meeting, but was continued due to lack of quorum. Staff now requests ratification of amendments to 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 ratify amended rates effective July 1, 2019 to the extent authorized by the Board.

Fiscal Impact

The recommended action to ratify amendments to 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 ratify amendments to 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 ratify amendments to 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

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/s Michael Schrader — *7/24/19*

Authorized Signature — **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.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov
Back to Agenda

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

Back to Agenda

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).

Back to Agenda

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.

Back to Agenda

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)

Back to Agenda

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

Back to Agenda

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

Back to Agenda

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

Back to Agenda

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

Back to Agenda

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2020, except those associated with Children's Hospital of Orange County, the University of California-Irvine or St. Joseph Health and its Affiliates with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County, the University of California, Irvine, and St. Joseph Health and its Affiliates, through June 30, 2020.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management will include expenses associated with the extended contracts in the upcoming proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist contracts, except for those associated with Children's Hospital of Orange County, the University of

California, Irvine or St. Joseph Health and its affiliates, for one year will be a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachment

None

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

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

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 — *10/24/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

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

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

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

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

Back to Agenda

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.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

ALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policy

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400
Brigette Gibb, Executive Director, Human Resources, (714) 246-8400

Recommended Action
Adopt Resolution Approving CalOptima's Updated Human Resources Policy: GA.8058 Salary Schedule and GA.8058 Salary Schedule Attachment A

Background/Discussion
On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists existing Human Resources policy that has been updated and is being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
2.	GA.8058 Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule has been revised in order to reflect recent changes, including the addition of 1 new position and 1 reinstated title. A summary of the changes to the Salary Schedule Attachment A is included for reference.	- Pursuant to CalPERS requirement, 2 CCR §570.5 CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. New Position: Creation of a new Job Title may be due to a regulatory requirement, a change in the scope of a current position or the addition of a new level in a job family.

Back to Agenda

Staffing Adjustments
Staff recommends adding a new title *Activities Coordinator (PACE)* as required by the CMS new PACE Final Rule, and reinstating the position of *Executive Assistant to CEO* as the incumbent vacated the position and position responsibilities have been revised.

Fiscal Impact
There is no additional fiscal impact.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 19-0801, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
   a. GA.8058 Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule

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

7/24/19 — **Date**

RESOLUTION NO. 19-0801

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED HUMAN RESOURCES POLICY

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy GA.8058 Salary Schedule

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this August 1, 2019.

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/_____
Sharon Dwiers, Interim Clerk of the Board

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/2014
Revised Date:	~~02~~08/~~07~~1/20 19

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

Back to Agenda

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 0~~2/07~~8/01/2019)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Back to Agenda

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	Michael Schrader
Effective Date:	05/01/2014
Revised Date:	08/01/2019

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper

Back to Agenda

to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 08/01/2019)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Accountant	K	39	$47,112	$61,360	$75,504	
Accountant Int	L	634	$54,288	$70,512	$86,736	
Accountant Sr	M	68	$62,400	$81,120	$99,840	
Accounting Clerk	I	334	$37,128	$46,384	$55,640	
Activity Coordinator (PACE)	J	TBD	$40,976	$53,352	$65,624	New Position
Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
Actuary	O	357	$82,576	$107,328	$131,976	
Administrative Assistant	H	19	$33,696	$42,224	$50,648	
Analyst	K	562	$47,112	$61,360	$75,504	
Analyst Int	L	563	$54,288	$70,512	$86,736	
Analyst Sr	M	564	$62,400	$81,120	$99,840	
Applications Analyst	K	232	$47,112	$61,360	$75,504	
Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
Associate Director Provider Network	O	647	$82,576	$107,328	$131,976	
Auditor	K	565	$47,112	$61,360	$75,504	
Auditor Sr	L	566	$54,288	$70,512	$86,736	
Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
Biosta istics Manager	N	418	$71,760	$93,184	$114,712	
Board Services Specialist	J	435	$40,976	$53,352	$65,624	
Business Analyst	J	40	$40,976	$53,352	$65,624	
Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
Buyer	J	29	$40,976	$53,352	$65,624	
Buyer Int	K	49	$47,112	$61,360	$75,504	
Buyer Sr	L	67	$54,288	$70,512	$86,736	
Care Manager	M	657	$62,400	$81,120	$99,840	
Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
Certified Coder	K	399	$47,112	$61,360	$75,504	
Certified Coding Specialist	K	639	$47,112	$61,360	$75,504	
Certified Coding Specialist Sr	L	640	$54,288	$70,512	$86,736	
Change Control Administrator	L	499	$54,288	$70,512	$86,736	
Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
** Chief Counsel	T	132	$197,704	$266,968	$336,024	
** Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
** Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
** Chief Informa ion Officer	T	131	$197,704	$266,968	$336,024	
** Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
** Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
Claims - Lead	J	574	$40,976	$53,352	$65,624	
Claims Examiner	H	9	$33,696	$42,224	$50,648	
Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
Clerk of the Board	O	59	$82,576	$107,328	$131,976	
Clinical Auditor	M	567	$62,400	$81,120	$99,840	
Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
Clinical Documenta ion Specialist (RN)	O	641	$82,576	$107,328	$131,976	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Heal h)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	654	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
*	Director Contracting	P	184	$95,264	$128,752	$162,032	
*	Director COREC	Q	369	$114,400	$154,440	$194,480	
*	Director Customer Service	P	118	$95,264	$128,752	$162,032	
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
*	Director Facilities	P	428	$95,264	$128,752	$162,032	
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Services	Q	328	$114,400	$154,440	$194,480	
*	Director Human Resources	Q	322	$114,400	$154,440	$194,480	
*	Director Information Services	R	547	$137,280	$185,328	$233,376	
*	Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
*	Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
*	Director Network Management	P	125	$95,264	$128,752	$162,032	
*	Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
*	Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
*	Director PACE Program	Q	449	$114,400	$154,440	$194,480	
*	Director Population Heal h Management	Q	675	$114,400	$154,440	$194,480	
*	Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
*	Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
*	Director Project Management	Q	447	$114,400	$154,440	$194,480	
*	Director Provider Data Quality	Q	655	$114,400	$154,440	$194,480	
*	Director Provider Services	P	597	$95,264	$128,752	$162,032	
*	Director Public Policy	P	459	$95,264	$128,752	$162,032	
*	Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
*	Director Quality Analy ics	Q	591	$114,400	$154,440	$194,480	
*	Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
*	Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
*	Director Strategic Development	P	121	$95,264	$128,752	$162,032	
*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utiliza ion Management	Q	265	$114,400	$154,440	$194,480	
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Execu ive Adminstra ive Services Manager	M	661	$62,400	$81,120	$99,840	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Assistant to CEO	L	TBD	$54,288	$70,512	$86,736	Reinstated Position
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Execu ive Director Quality & Population Health Management	S	676	$164,736	$222,352	$280,072	
**	Execu ive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
	Facili ies & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facili ies & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
	Facili ies Coordinator	J	438	$40,976	$53,352	$65,624	
	Financial Analyst	L	51	$54,288	$70,512	$86,736	
	Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
	Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
	Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Graphic Designer	M	387	$62,400	$81,120	$99,840	
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Compensation Specialist Sr	N	663	$71,760	$93,184	$114,712	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Educa ion & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
Manager Population Health Management	O	674	$82,576	$107,328	$131,976	
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	653	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	656	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
Manager Strategic Opera ions	N	446	$71,760	$93,184	$114,712	
Manager Systems Development	P	515	$95,264	$128,752	$162,032	
Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
Medical Assistant	H	535	$33,696	$42,224	$50,648	
Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
Medical Case Manager	N	72	$71,760	$93,184	$114,712	
Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	E	485	$25,272	$31,720	$37,960	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	648	$95,264	$128,752	$162,032	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Rela ions Rep	K	205	$47,112	$61,360	$75,504	
	Provider Rela ions Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recrea ional Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Die itian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
*	Sr Director Regulatory Affairs and Compliance	R	658	$137,280	$185,328	$233,376	
	Sr Manager Financial Analysis	P	660	$95,264	$128,752	$162,032	
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
	Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	
	Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
	Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
	Staff Attorney	P	195	$95,264	$128,752	$162,032	
	Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
	Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
	Supervisor Behavioral Health	N	659	$71,760	$93,184	$114,712	
	Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
	Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
	Supervisor Claims	K	219	$47,112	$61,360	$75,504	
	Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
	Supervisor Credentialing	L	671	$54,288	$70,512	$86,736	
	Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
	Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
	Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
	Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
	Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
	Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
	Supervisor Finance	N	419	$71,760	$93,184	$114,712	
	Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
	Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
	Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
	Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
	Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
	Supervisor Nursing Services (PACE)	N	662	$71,760	$93,184	$114,712	
	Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
	Supervisor Payroll	M	517	$62,400	$81,120	$99,840	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised August 1, 2019
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Population Health Management	N	673	$71,760	$93,184	$114,712	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Text in red indicates new changes to the salary schedule proposed for Board approval.

Summary of Changes to Salary Schedule
GA.8058 Attachment A

For August 2019 Board Meeting:

Title	Old Wage Grade	New Job Code/ Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/ Changed
Activity Coordinator	N/A	TBD/J	New position for Program for All-Inclusive Care for the Elderly (PACE) as required by the Centers for Medicare & Medicaid Services (CMS) new PACE Final Rule	N/A	August 2019
Executive Assistant to CEO	N/A	TBD/L	Reinstated job title; Incumbent vacated the position and position responsibilities revised	N//A	August 2019

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

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

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

Back to Agenda

Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP responses and evaluated them based on the following criteria:

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

Discussion

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Back to Agenda

Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

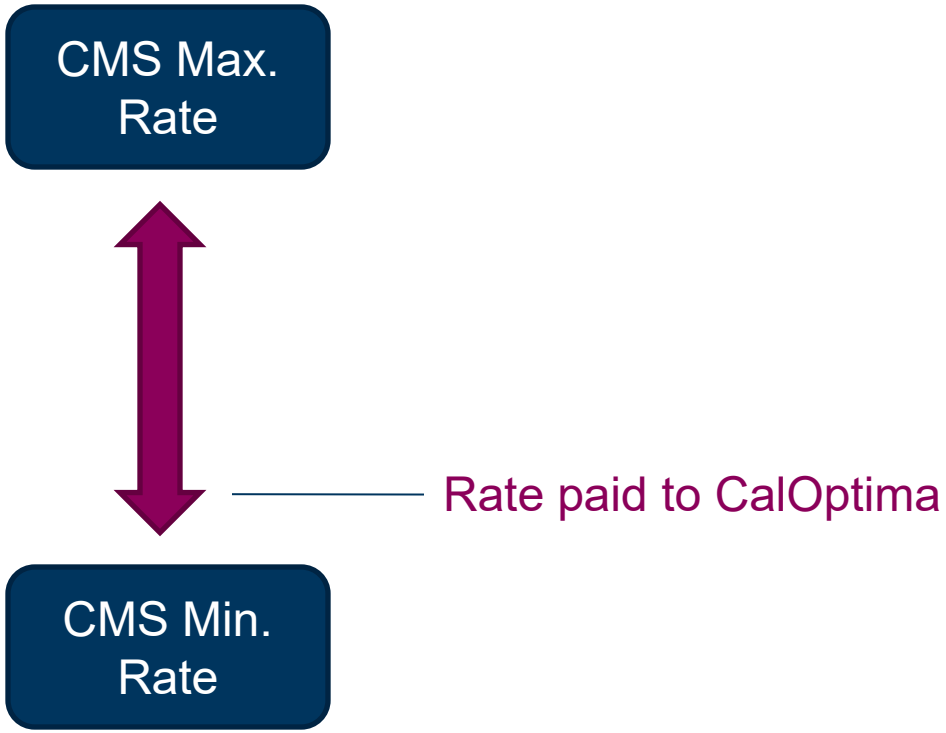
Back to Agenda

Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



Back to Agenda

IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

Back to Agenda

CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

Back to Agenda

IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

As of 5/31/2017

Back to Agenda

IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

As of 5/31/2017

Back to Agenda

IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

As of 5/31/2017

Back to Agenda

IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

As of 5/31/2017

Back to Agenda

IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Back to Agenda

Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Back to Agenda

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Back to Agenda

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

Back to Agenda

Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Back to Agenda

Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

CalOptima's Mission

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

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

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

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

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

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

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

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

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

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

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

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

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

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants to Address Children's Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment

Contact

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

Recommended Actions

1. Approve the expenditure plan for allocation of IGT 6 and 7 funds in the amount of $21.1 million for the Department of Health Care Services (DHCS)-approved and Board-approved priority areas; and
2. Authorize the release of Requests for Proposal (RFPs) for community grants and internal project applications, with staff returning at a future Board meeting with evaluation of proposals and recommendations for award(s) being granted.

Background

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

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

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

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

Staff performed an examination of all the responses and evaluated them based on the following criteria:

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

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

Rev. 9/6/18

Back to Agenda

Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

Rev. 9/6/18

Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

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

8/29/2018 — **Date**

IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

Back to Agenda

IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

Back to Agenda

IGT 6 & 7 Funding

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

Back to Agenda

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Back to Agenda

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

* Multiple awardees may be selected per RFP

Back to Agenda

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

Back to Agenda

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Back to Agenda

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

Back to Agenda

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Back to Agenda

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

*Multiple awardees may be selected per RFP

Back to Agenda

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

Back to Agenda

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

Back to Agenda

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Back to Agenda

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Back to Agenda

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

Back to Agenda

Agenda

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

Back to Agenda

Current System of Care

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

**For Medi-Cal Members*

Back to Agenda

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Back to Agenda

Additional Considerations

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

Back to Agenda

Recommended Actions

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

Back to Agenda

Recommended Actions (Cont.)

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

Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

IGT 6/7 Requests for Proposal (26 RFPs)

1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Allocation of Intergovernmental Transfer 5 Funds

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

Recommended Actions
1. Approve the amended recommended allocations of IGT 5 funds in the total amount of $2.4 million ~~3.4 million~~ for RFP 2., Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics) and RFP 3., Adult Dental Services for community grants; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute grant contracts with the recommended community grantees.
3. The Board directed staff to bring back details of applications submitted for Request for Proposal (RFP) Category 1., Access to Children's Dental Services for a funding amount of $1 Million, including criteria, evaluations, scoring sheets, and qualifications for further review at its September 5, 2019, Board of Directors meeting.

Rev. 8/1/19

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1-7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net.

On December 1, 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) the results of which would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per the approved priority areas. The MHNA data collection activities were completed in November 2017.

Back to Agenda

On February 1, 2018, a summary of MHNA results was shared with the CalOptima Board of Directors. Based on the results of the MHNA, the Board additionally approved the release of eight RFPs for $14.4 million community grants in the following categories:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

In preparation for the release of the RFPs, staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. On June 7, 2018, the CalOptima Board approved release of Requests for Information related to these eight categories; ninety-three responses in July 2018.

On December 6, 2018, the CalOptima Board of Directors approved $11.4 million of IGT 5 funds to the Be Well Wellness Hub in December 2018. At that time, the Board of Directors also approved the release of the three following RFPs in the total amount of $3.4 million ($3 million remaining in IGT 5 and $400,000 reallocated from IGT 2) for community grants.

Request for Proposal	Priority Area	Allocation Amount
1. Access to Children's Dental Services	Strengthening the Safety Net	$1.0 million
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Strengthening the Safety Net	$1.4 million
3. Adult Dental Services	Strengthening the Safety Net	$1.0 million

The three RFPs garnered 20 responses. External subject matter experts and staff performed an examination of all the responses and evaluated them based on the following criteria:

Back to Agenda

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

Discussion

The IGT 5 Ad Hoc committee comprised of Dr. Nikan Khatibi and Dr. Alexander Nguyen met on July 23, 2019 to discuss the results of the 20 RFP responses for Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Adult Dental Services. Following the review of the evaluation committee results, the Ad Hoc committee is recommending the following allocation of $3.4 million for IGT 5 board-approved priority areas through three (3) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Access to Children's Dental Services	Healthy Smiles for Kids of Orange County	$1,000,000
RFP 2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Santa Ana Unified School District	$1,400,000
RFP 3 Adult Dental Services	KCS Health Center (Korean Community Services)	$1,000,000

Fiscal Impact

The recommended action to approve the allocation of $3.4 million from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT 5 Expenditure Plan Allocation
2. CalOptima Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants
3. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
4. CalOptima Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Intergovernmental Transfer (IGT) 5 Funds
5. CalOptima Board Action dated December 6, 2018, Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds.
6. List of responders by RFP category.

/s/ Michael Schrader *7/24/2019*
Authorized Signature **Date**

Back to Agenda

IGT 5 Community Grant Award Consideration

Board of Directors Meeting

August 1 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- CalOptima Board of Directors approved IGT 5 priority areas for community-based funding opportunities
  - Childhood Obesity
  - Mental Health (Adult and Children's)
  - Improving Children's Health
  - Strengthening the Safety Net

IGT 5 Background Summary

Board authorized Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identified categories for community grants

Board authorized Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board authorized the release of 3 RFPs

Back to Agenda

RFP Evaluation Criteria

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Back to Agenda

Site Visits

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

Back to Agenda

RFP Summary

RFP	Total Received	Total Recommended
1. Access to Children's Dental Service ($1.0 million)	5	1
2. Primary Care Services & Social Determinants of Health ($1.4 million)	6	1
3. Access to Adult Dental Service ($1.0 million)	9	1
Total	**20**	**3**

Back to Agenda

1. Access to Children's Dental Service ($1 million)

Organization	Original Request	Recommended Funding Amount
Healthy Smiles for Kids of Orange County	$1,000,000	$1,000,000
Total	**$1,000,000**	**$1,000,000**

Back to Agenda

2. Primary Care Services & Social Determinants of Health ($1.4 million)

Organization	Original Request	Recommended Funding Amount
Santa Ana Unified School District	$1,400,000	$1,400,000
Total Awarded	**$1,400,000**	**$1,400,000**

Back to Agenda

3. Access to Adult Dental Service ($1.0 million)

Organization	Original Request	Recommended Funding Amount
KCS Health Center (Korean Community Services)	$987,600	$1,000,000
Total	**$987,600**	**$1,000,000**

Back to Agenda

Recommended Board Actions

- Approve the recommended allocations of IGT 5 funds in the amount of $3.4 million for community grants; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

CalOptima's Mission

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

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

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

Back to Agenda

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

Back to Agenda

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

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

1/25/2018 — **Date**

Back to Agenda

Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

Back to Agenda

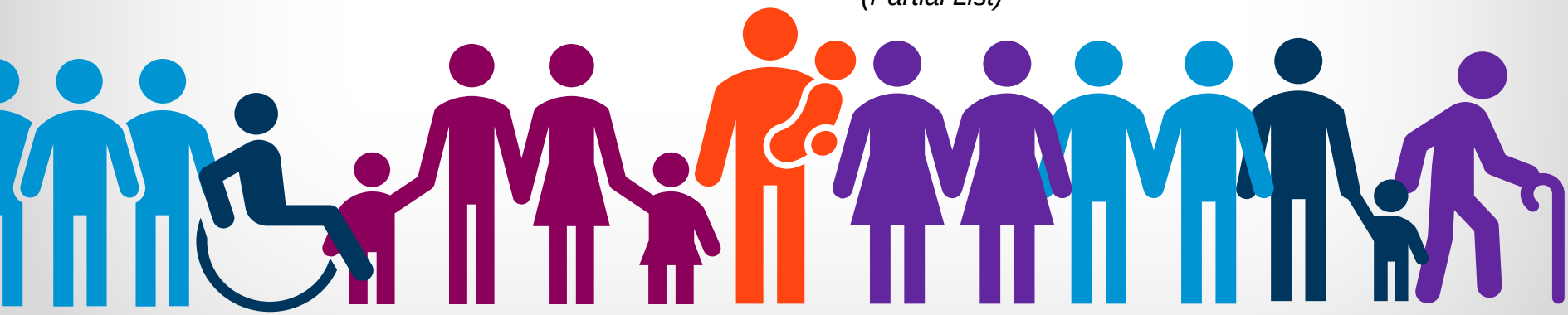
A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County

Back to Agenda

More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

Back to Agenda

CalOptima
A Public Agency
Better. Together.

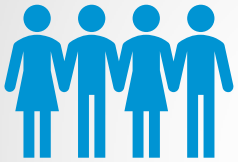
More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

Back to Agenda

More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

Back to Agenda

More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

Back to Agenda

Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

Back to Agenda

Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Back to Agenda

Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

Back to Agenda

Lack of Awareness (Cont.)

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

25%

Don't have or know of a dentist

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Back to Agenda

Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

Back to Agenda

Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

Back to Agenda

CalOptima
A Public Agency
Better. Together.

RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

Back to Agenda

RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

Back to Agenda

RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category
Children's Mental Health

Back to Agenda

RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

Back to Agenda

RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

Back to Agenda

RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category

Supporting the Safety Net

Back to Agenda

RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category

Supporting the Safety Net

Back to Agenda

RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category

Children's Health

Back to Agenda

Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

Back to Agenda

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

CalOptima
A Public Agency
Better. Together.

In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

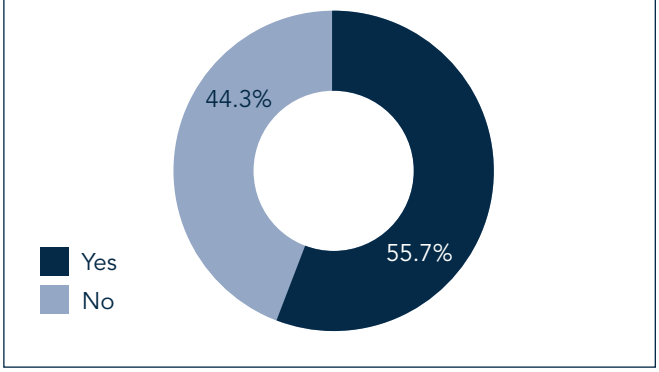
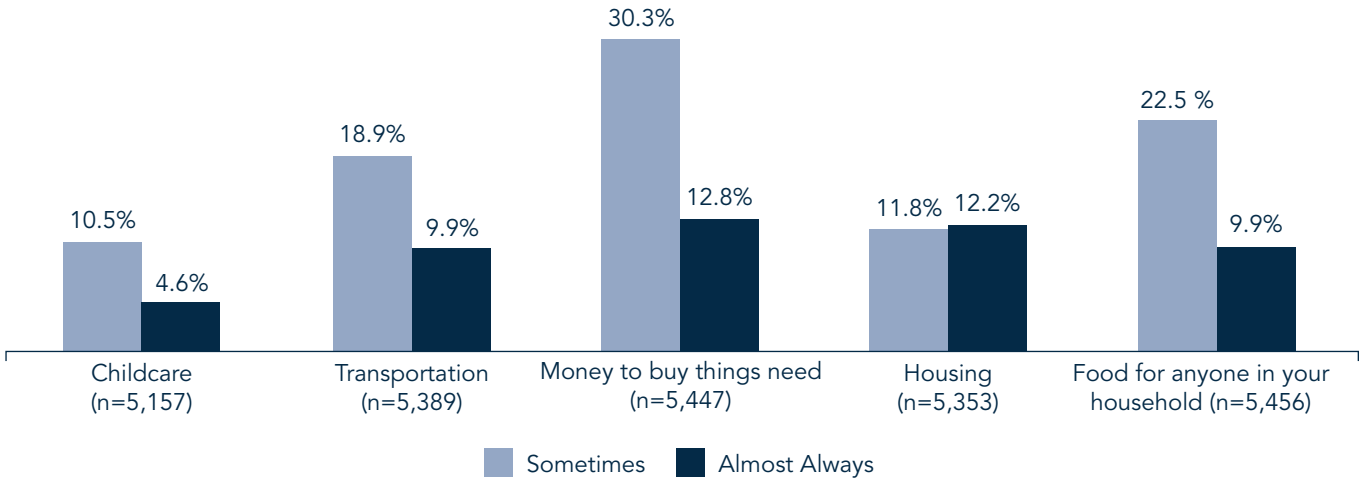
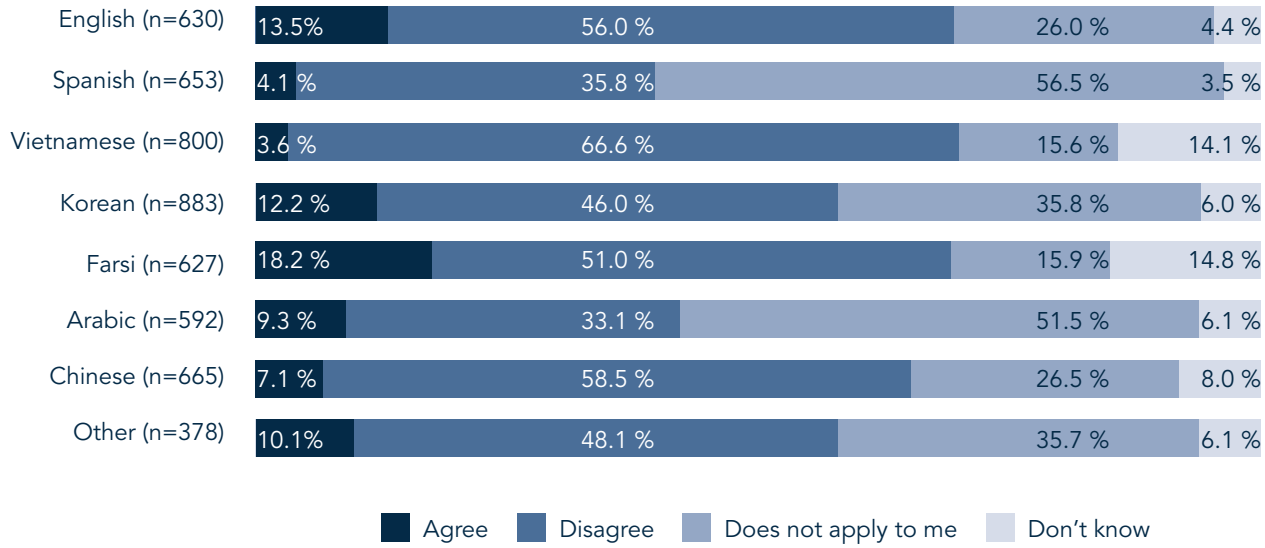


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

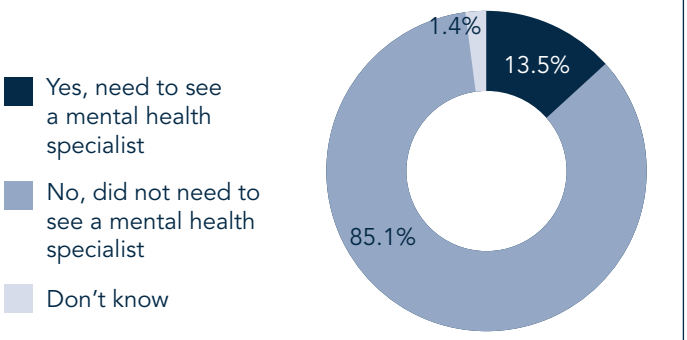
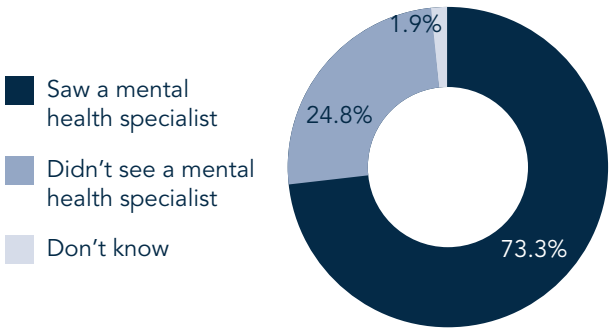
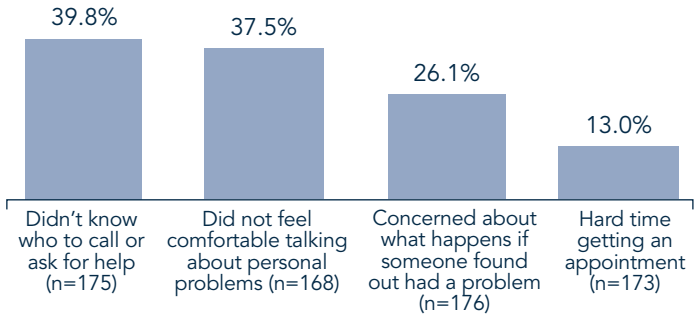


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

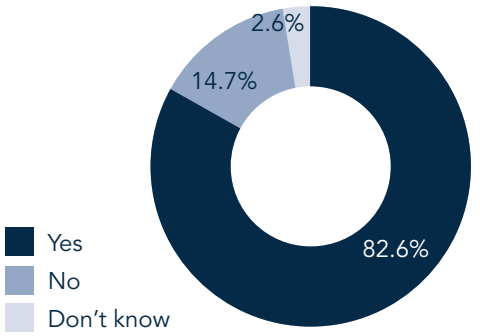
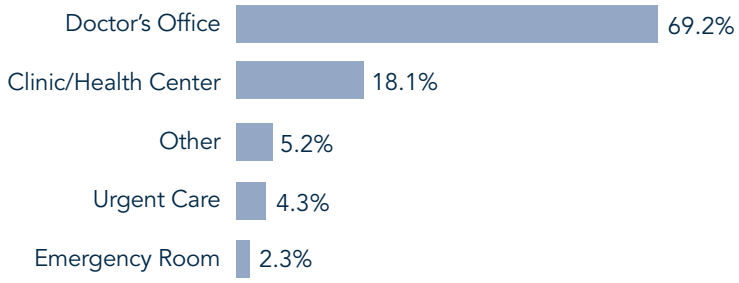


Exhibit 9: Where respondents go to see their doctor (n=5,743)

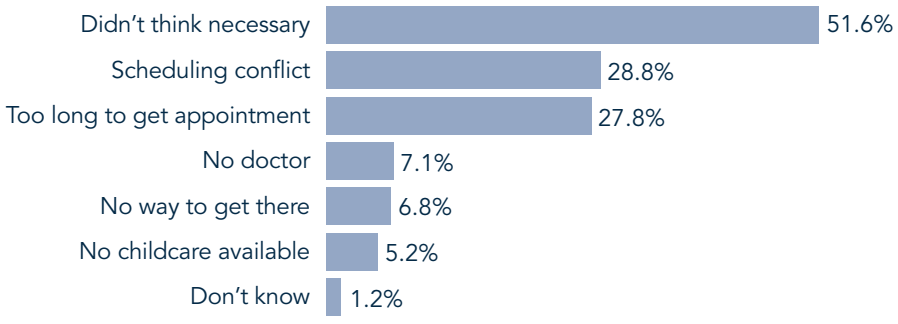


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

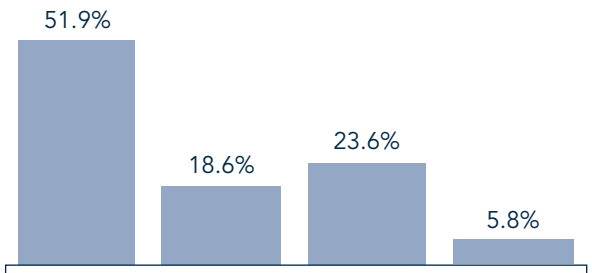
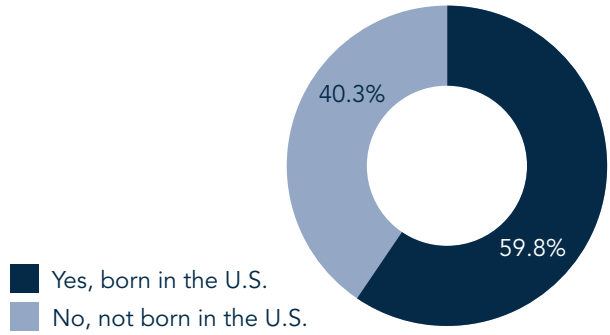


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

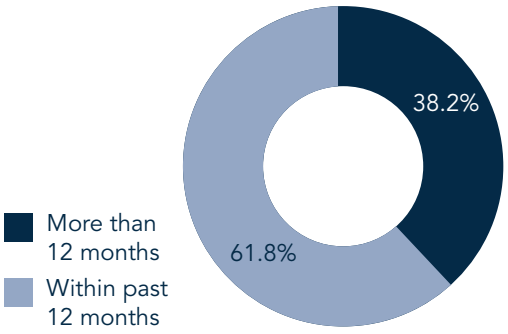
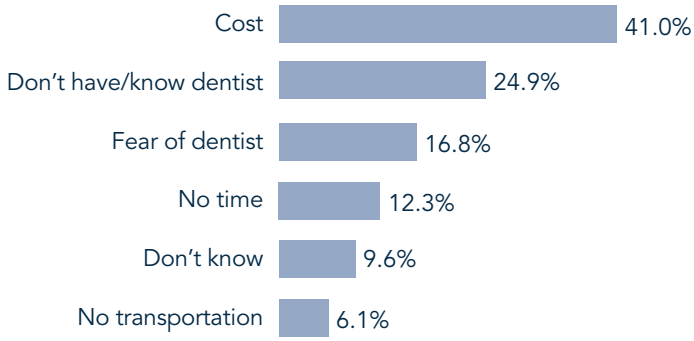


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

DRAFT

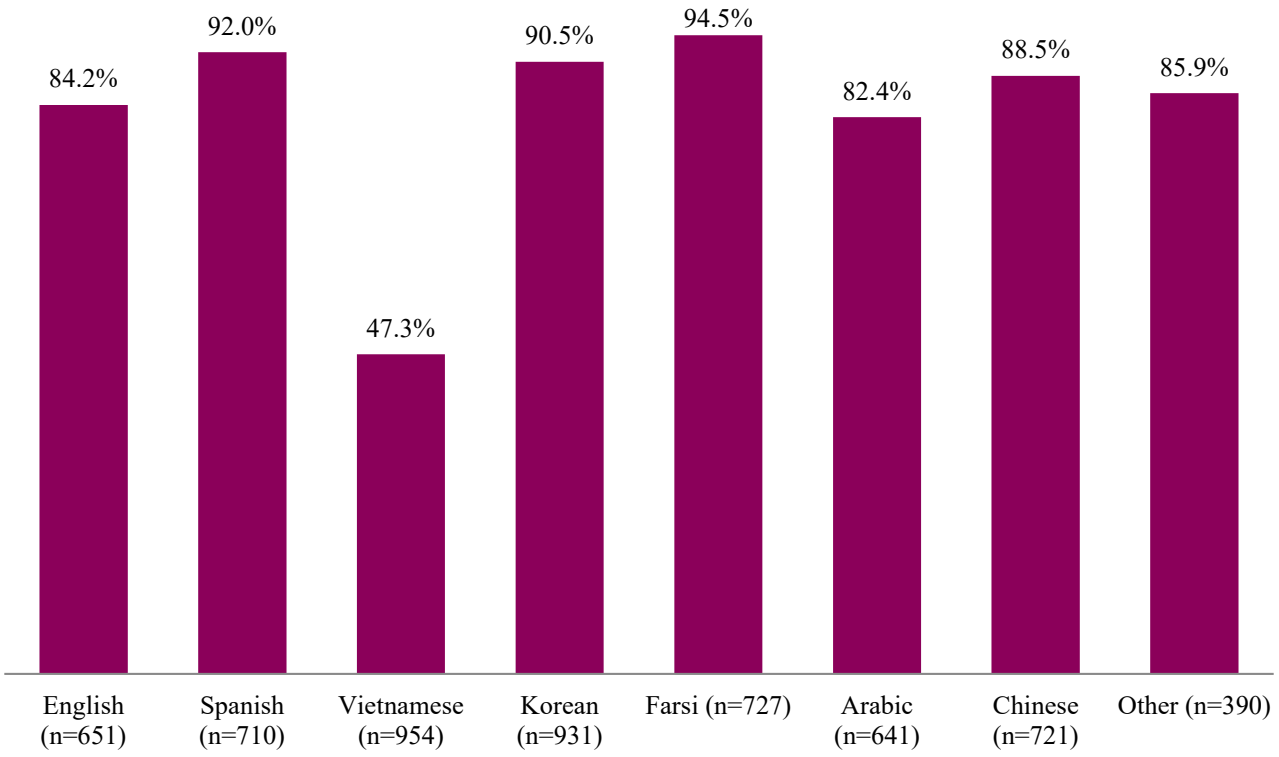
harder+co | community research

CalOptima A Public Agency Better. Together.

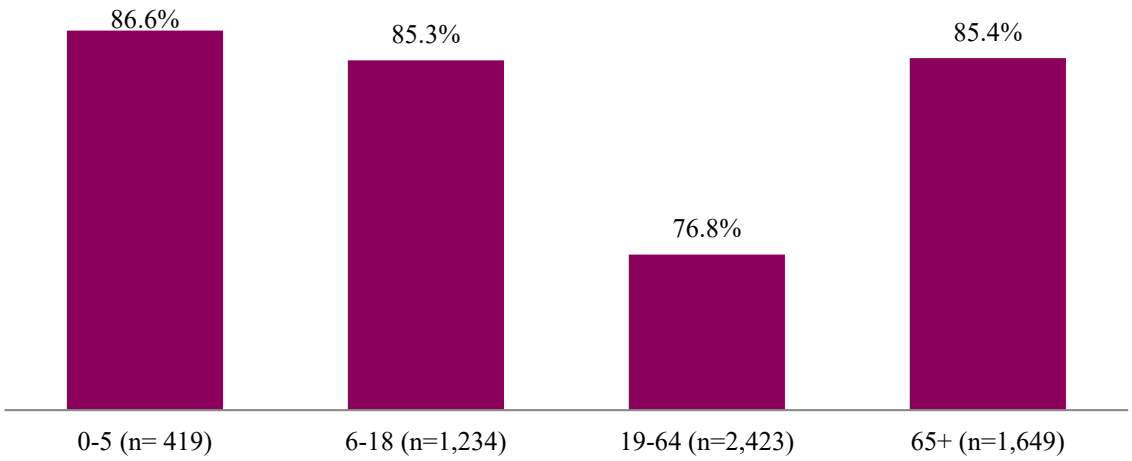
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

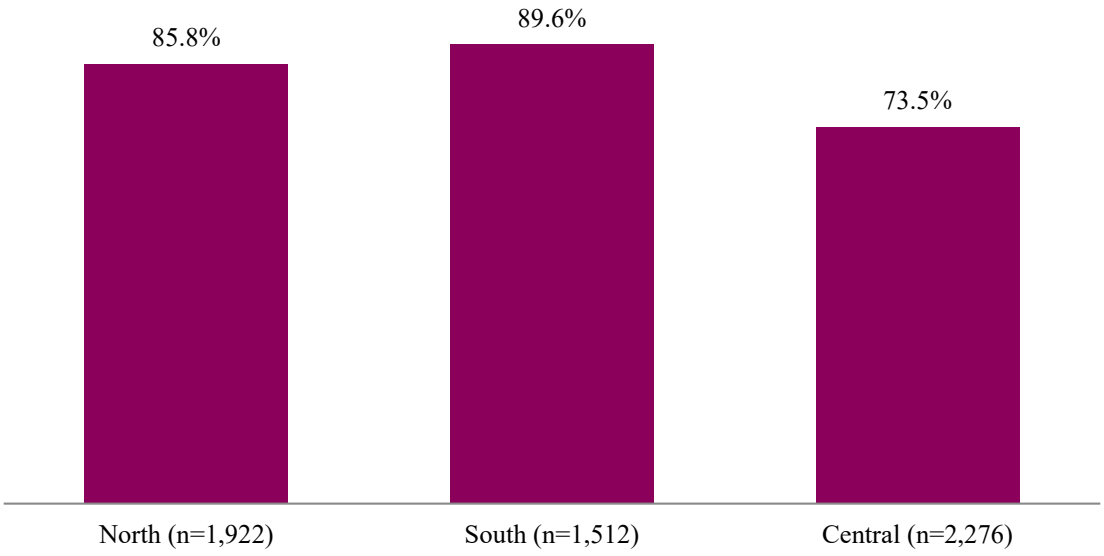


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

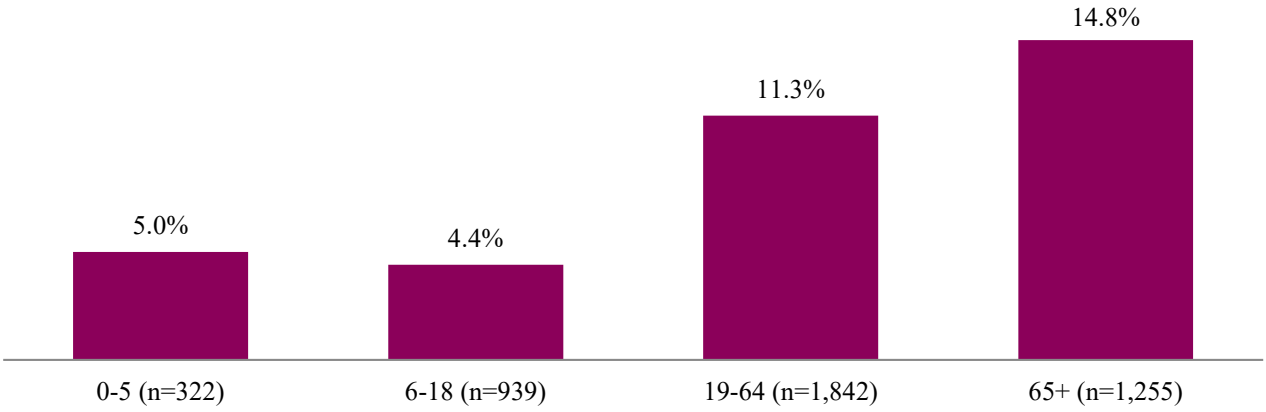
Region:

Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

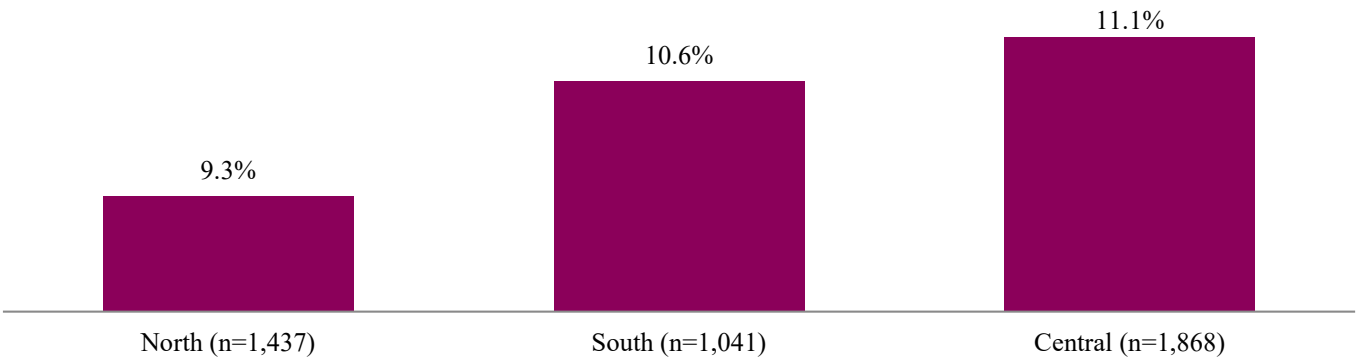
Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

CalOptima language:

Age Category:



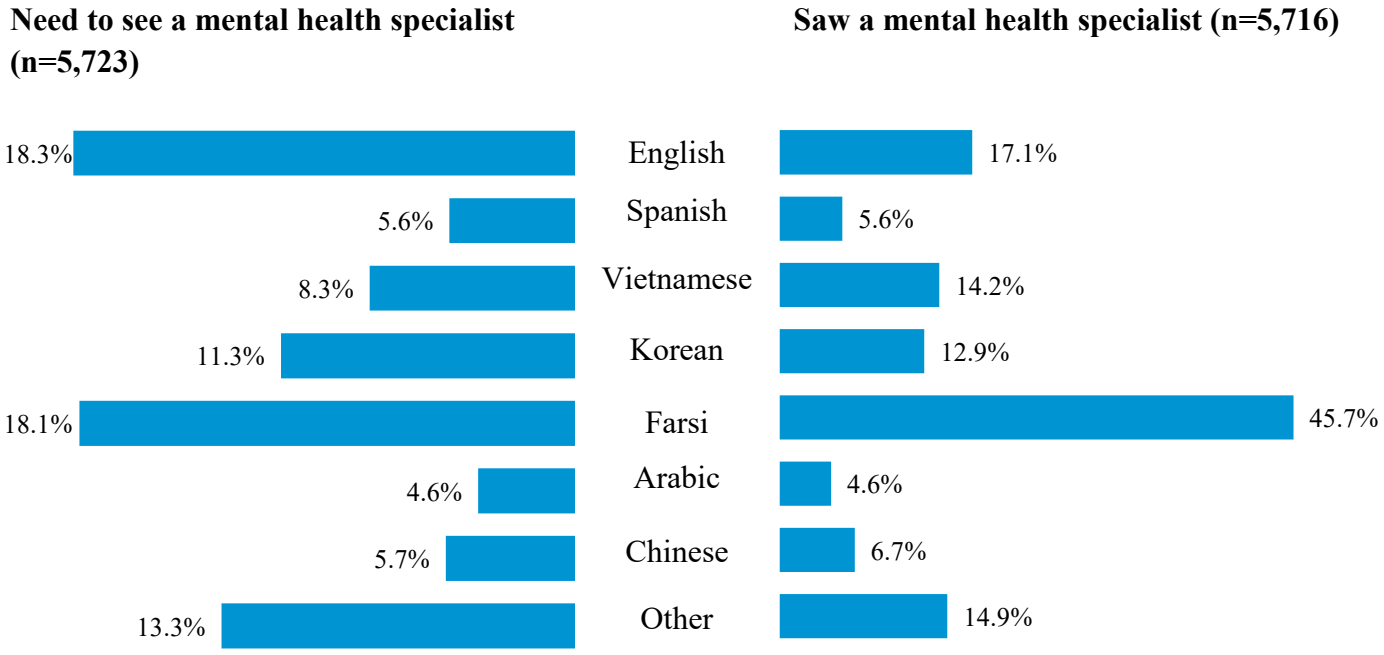
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

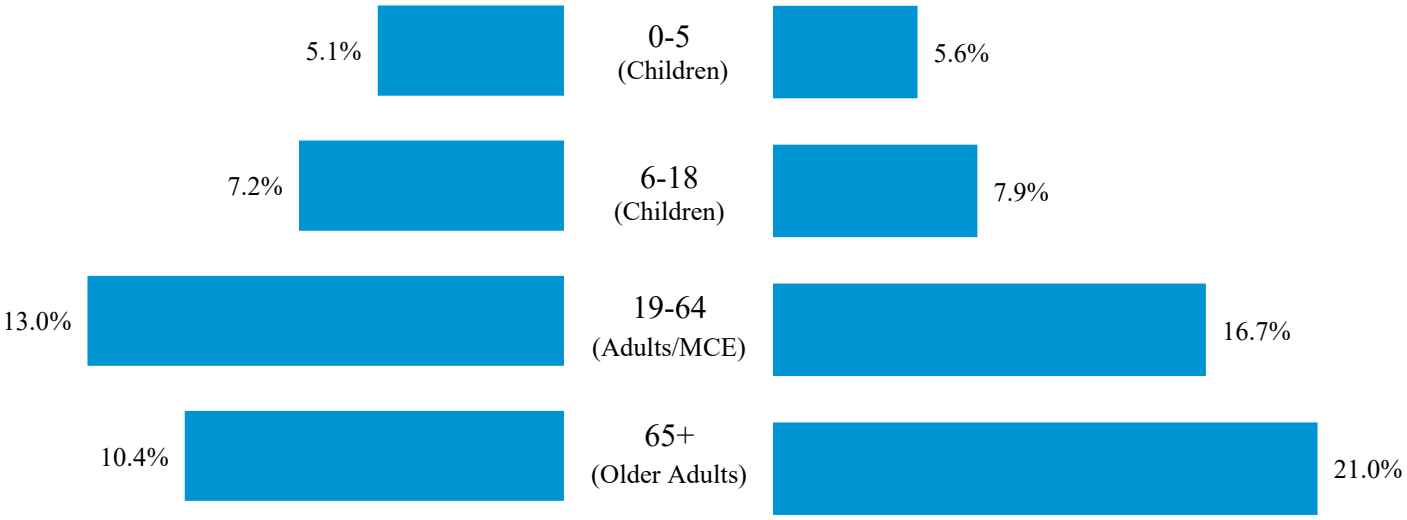


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

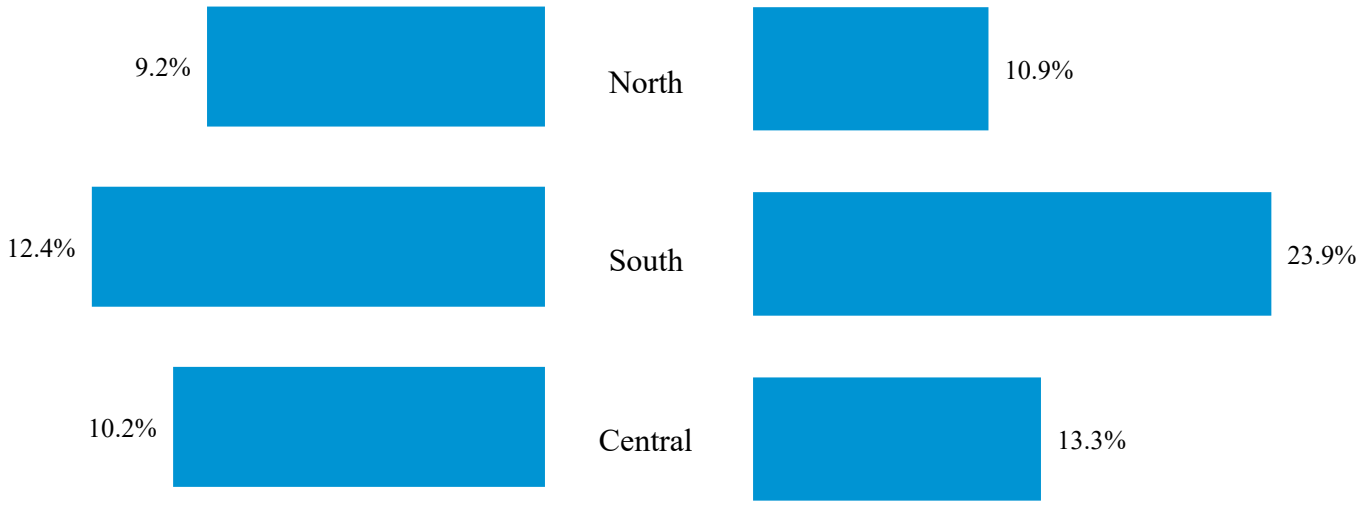
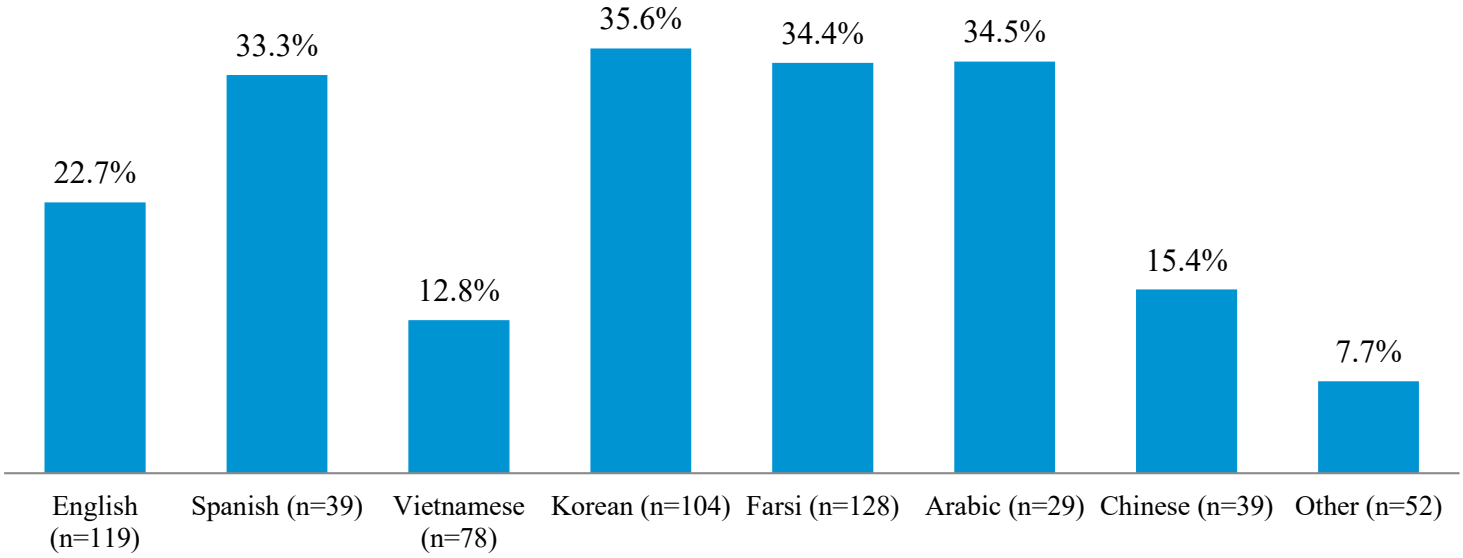
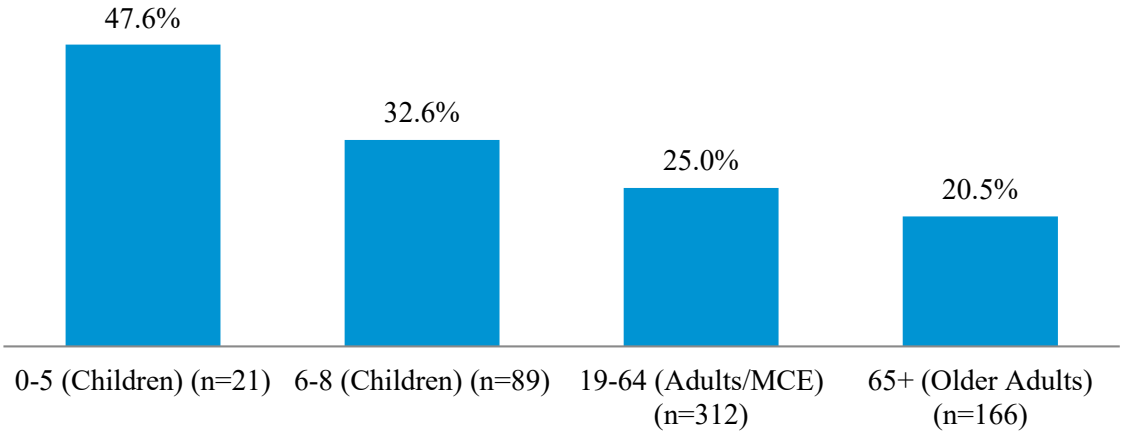


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

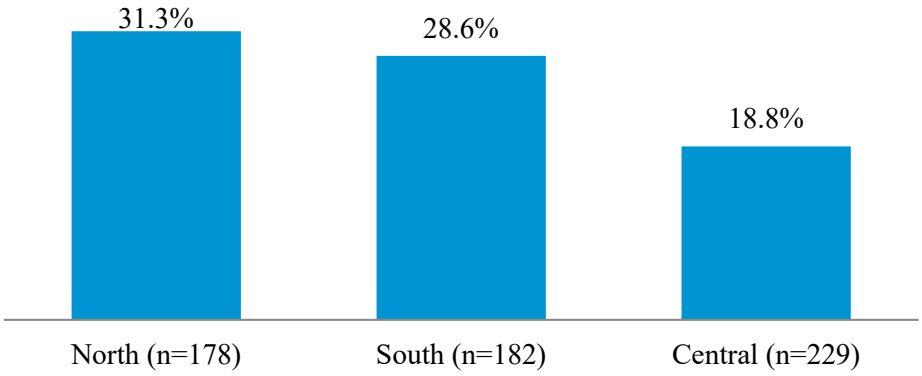
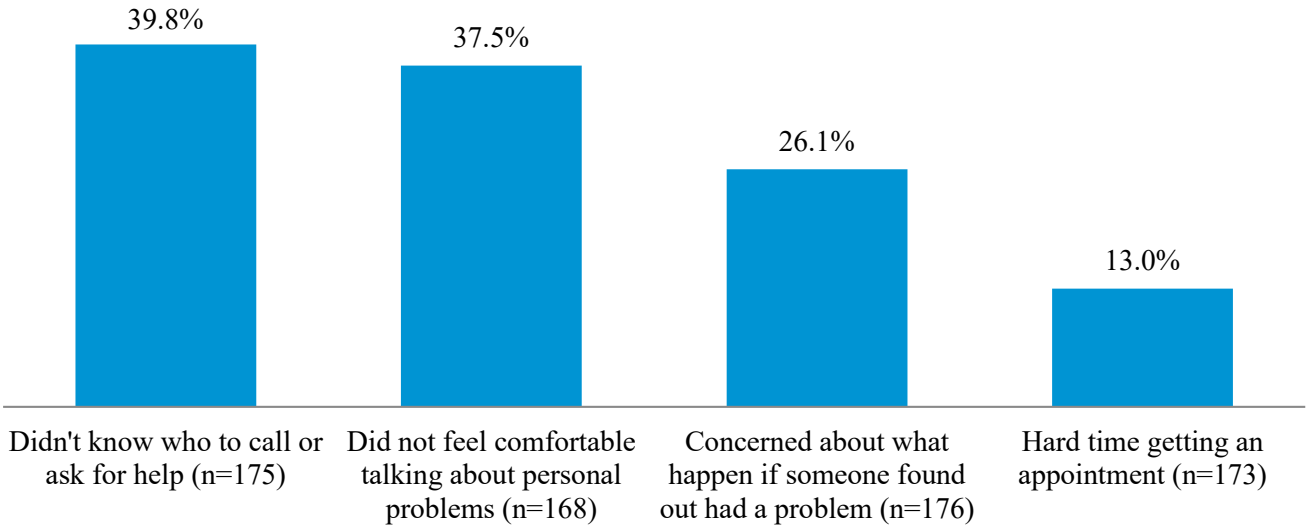


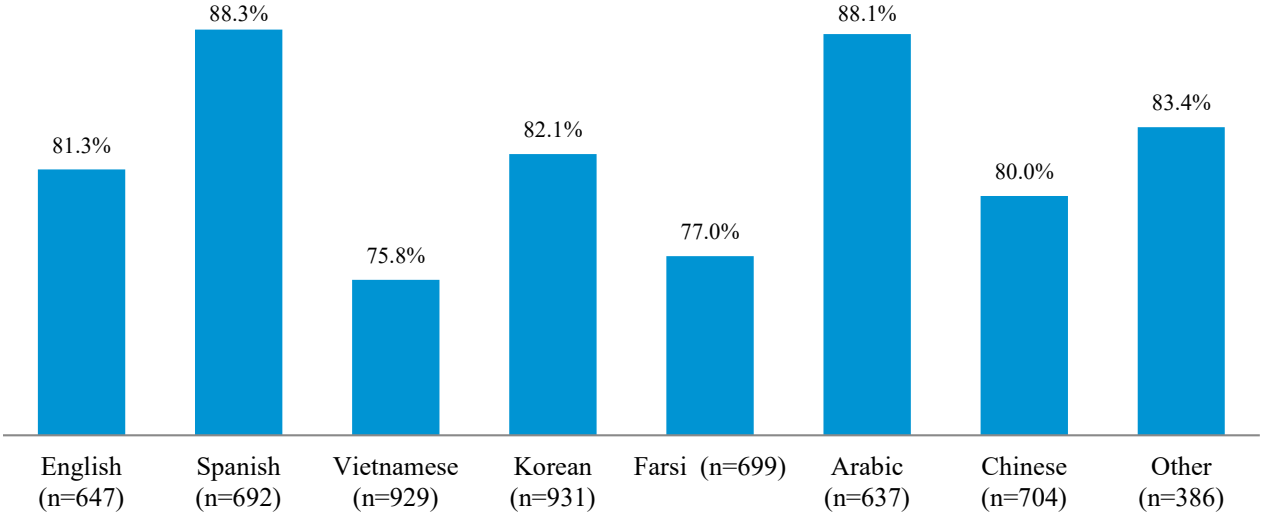
Exhibit 11. Reasons why members didn't see mental health specialist[7]



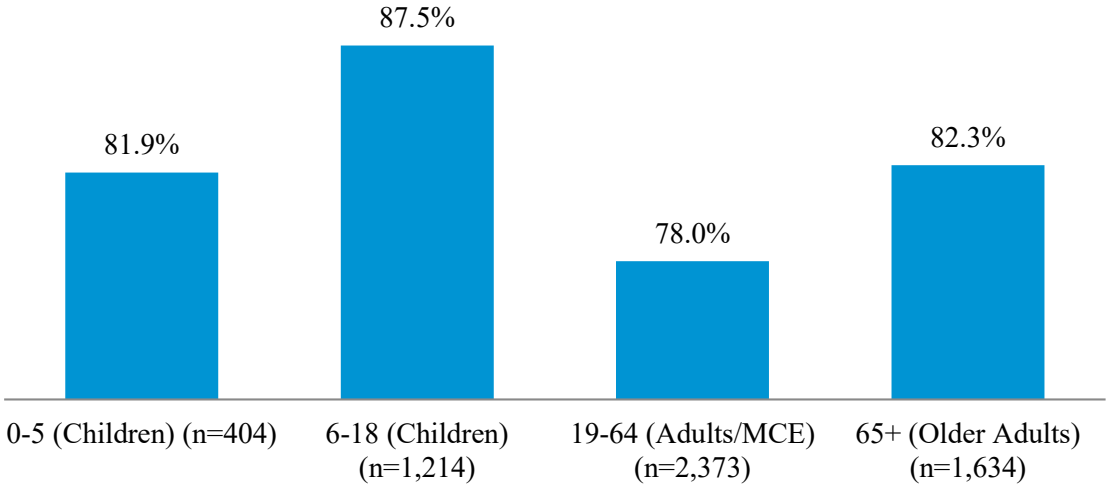
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

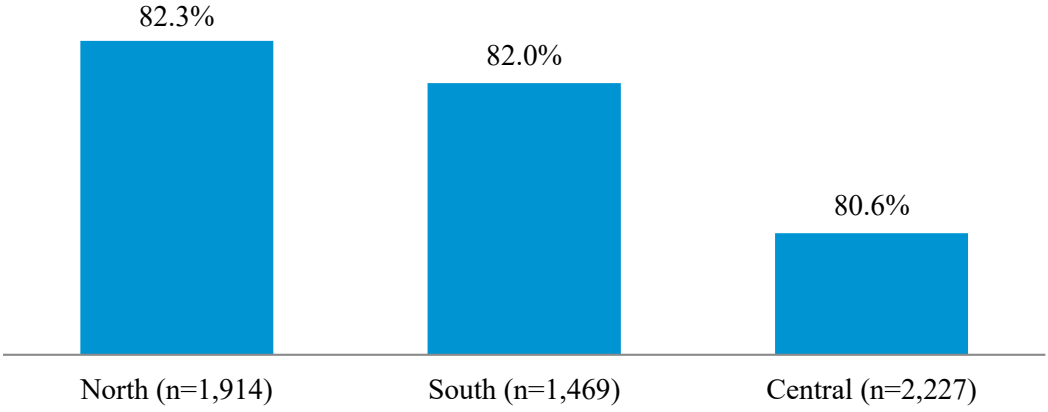
CalOptima language:



Age Category:



Region:

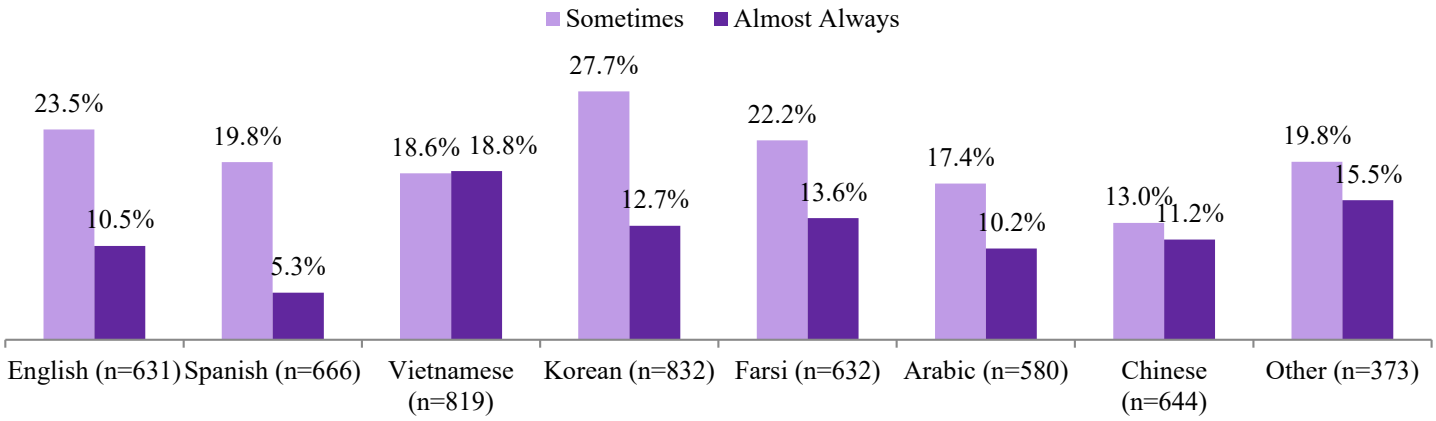


Social Determinants of Health

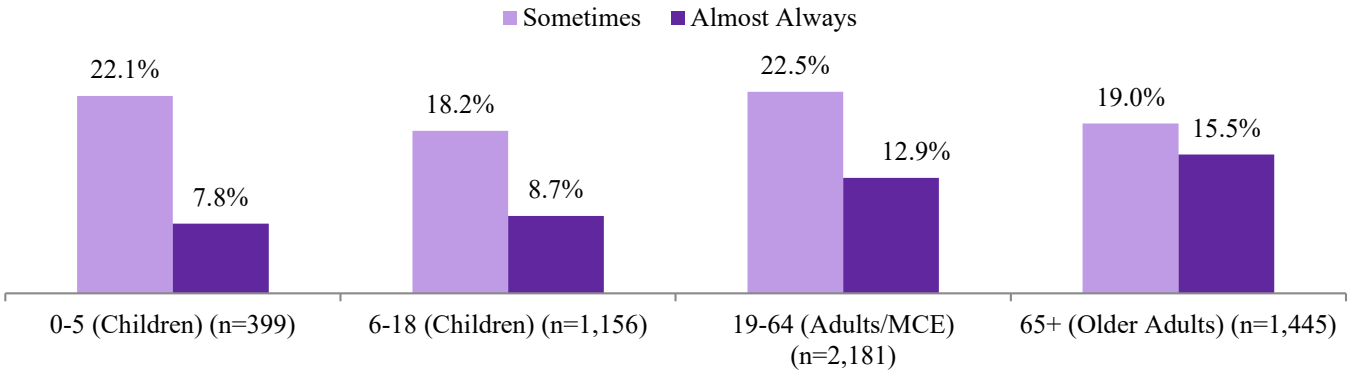
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

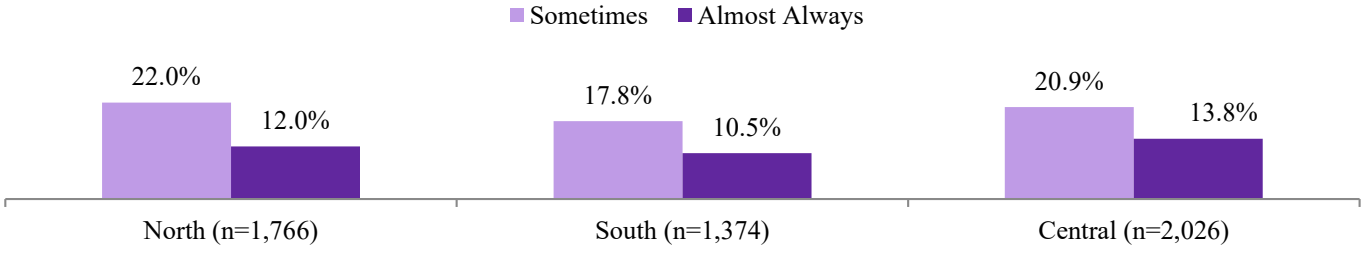
CalOptima language:



Age Category:

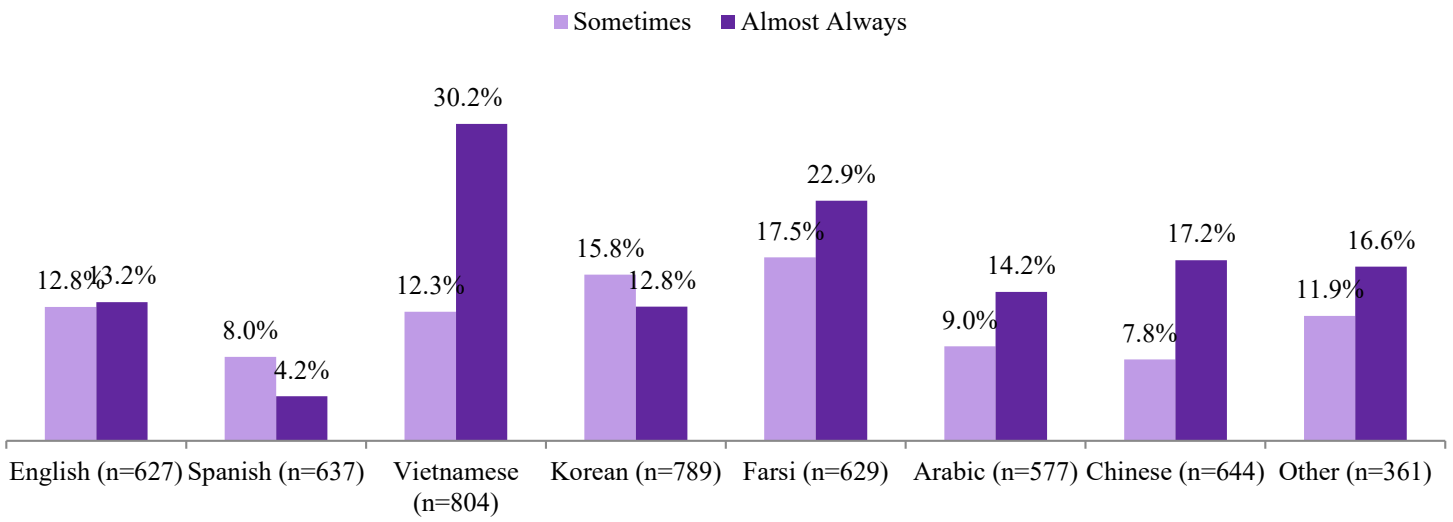


Region:

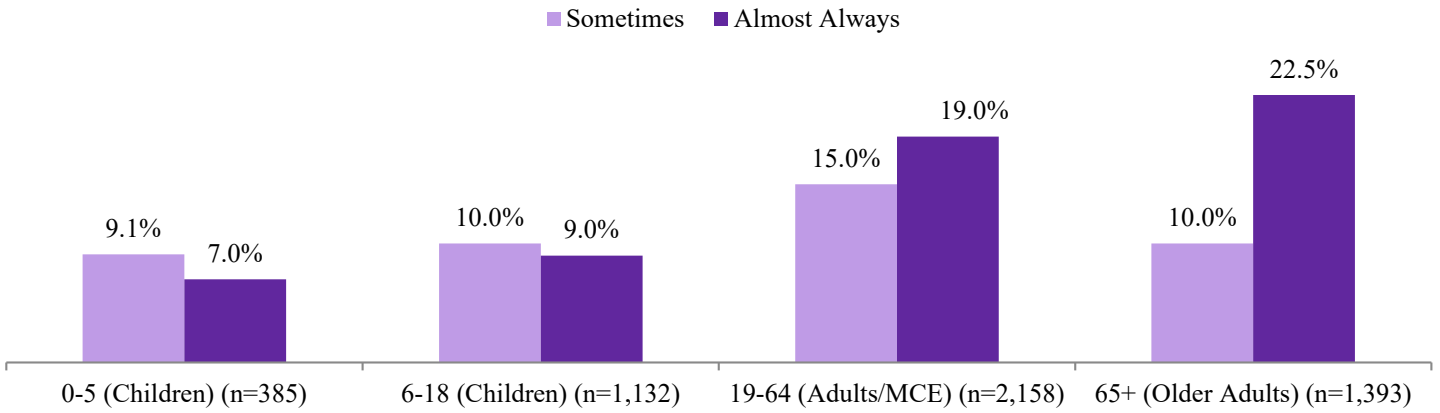


Housing:

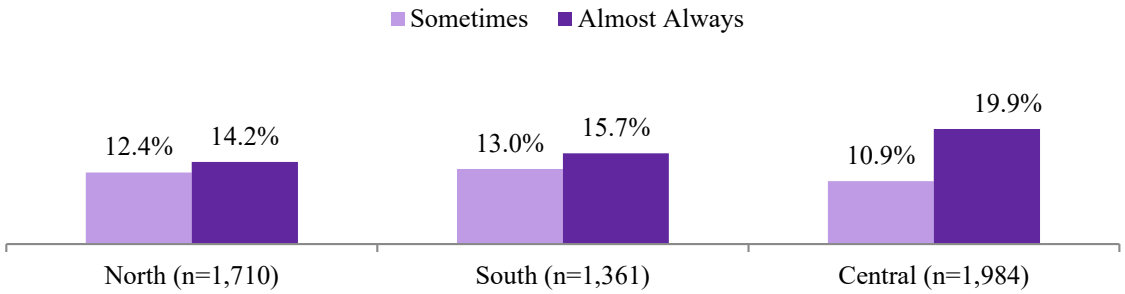
CalOptima language:



Age Category:

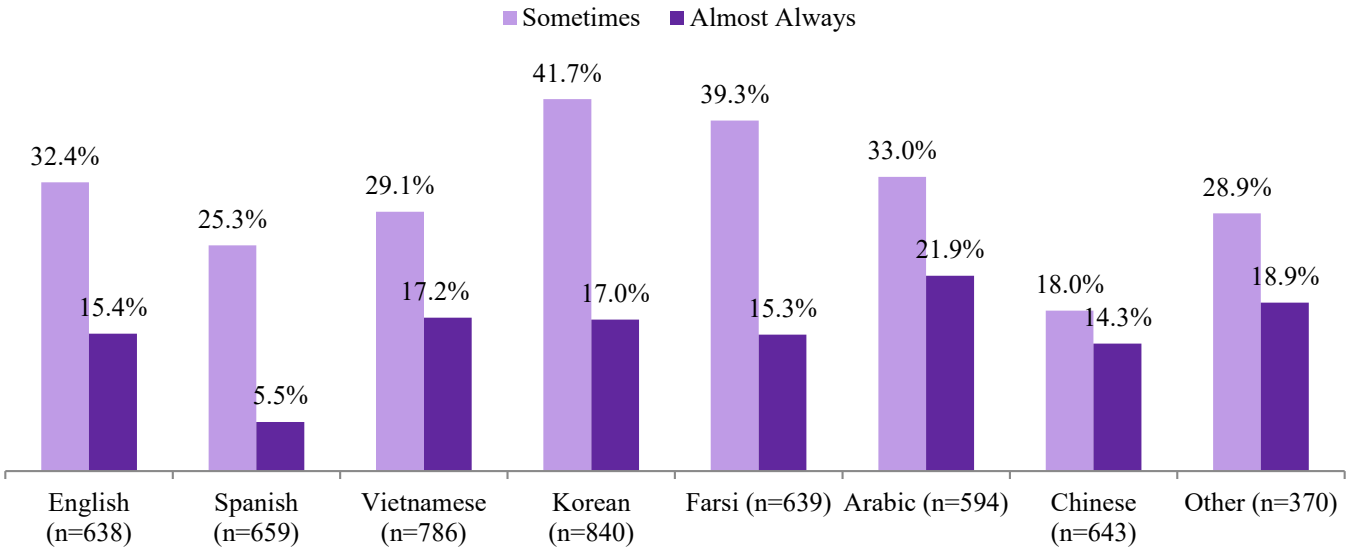


Region:

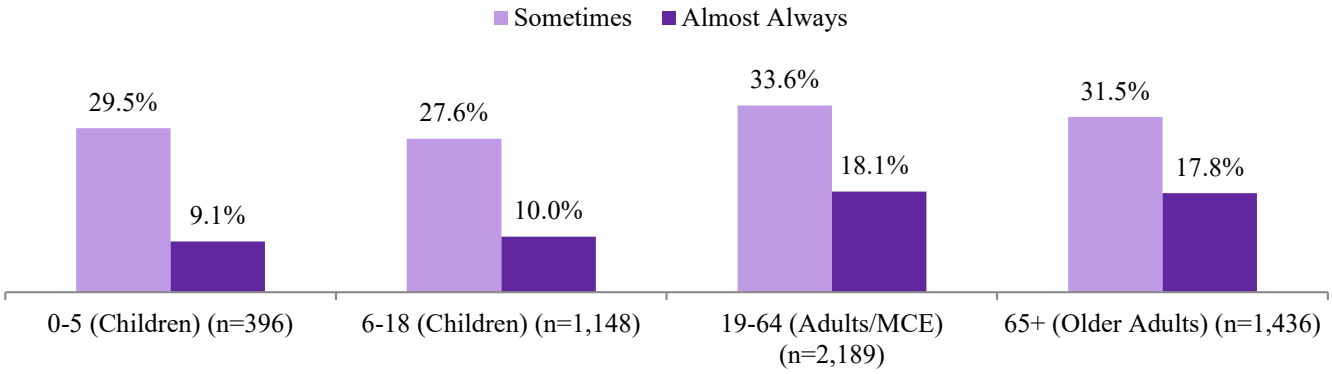


Money to buy things need:

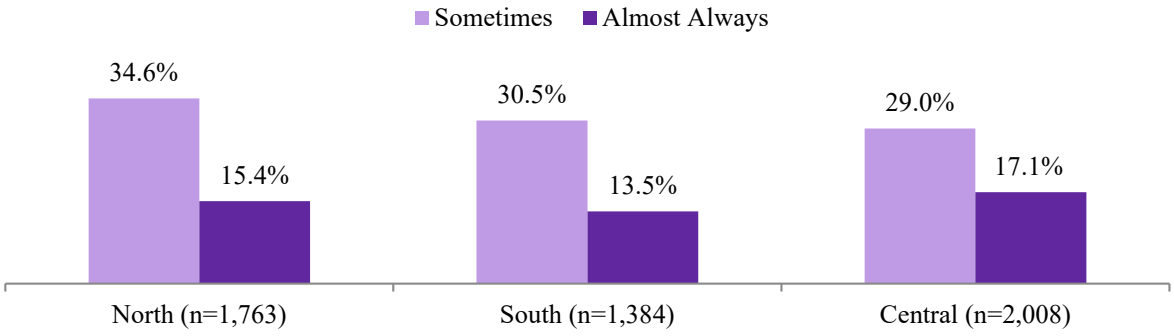
CalOptima language:



Age Category:

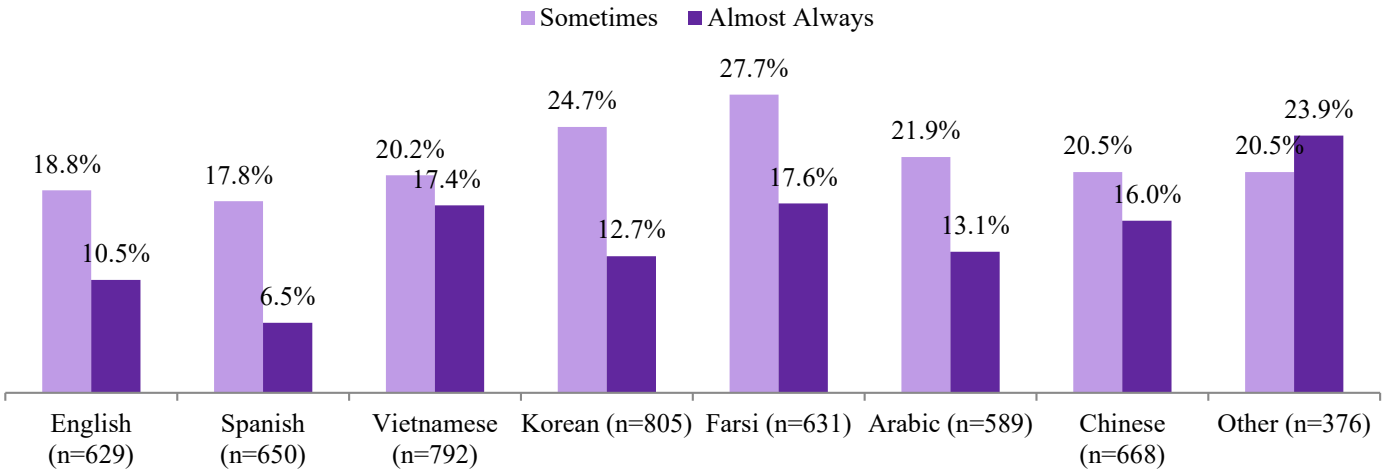


Region:

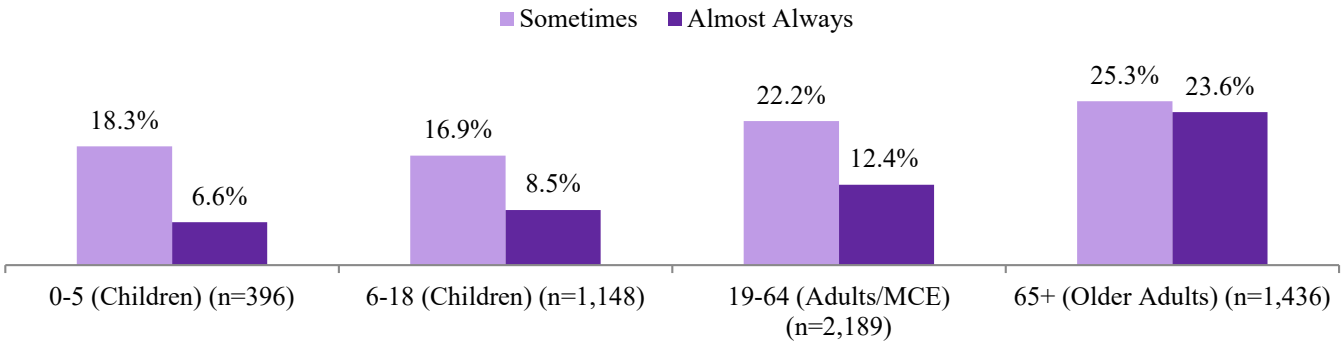


Transportation:

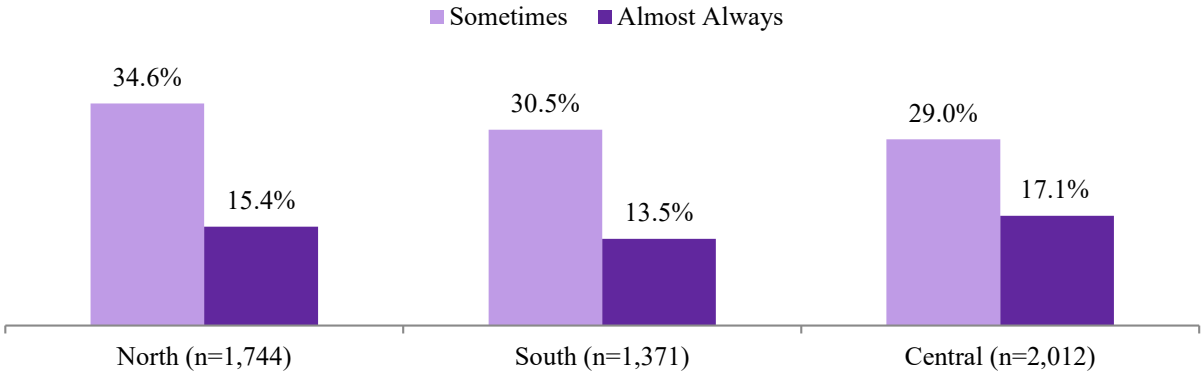
CalOptima language:



Age Category:

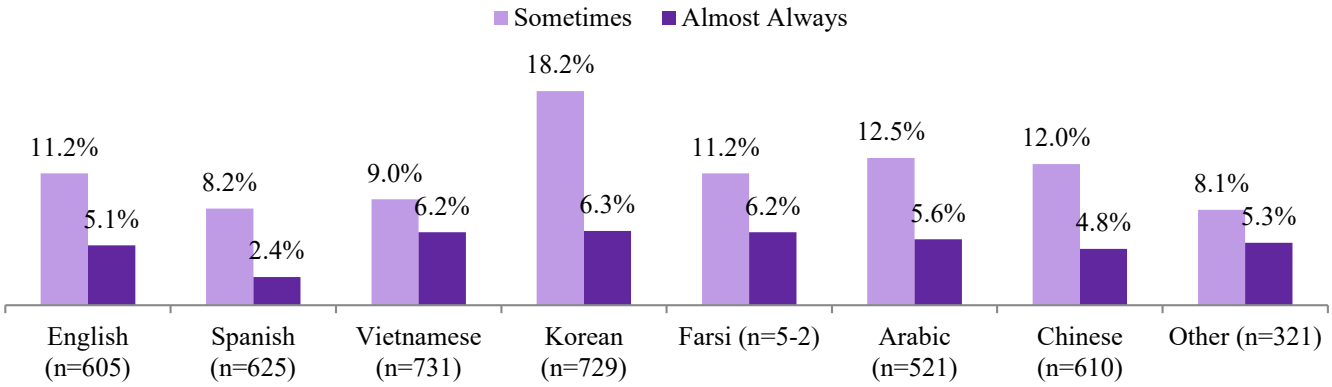


Region:

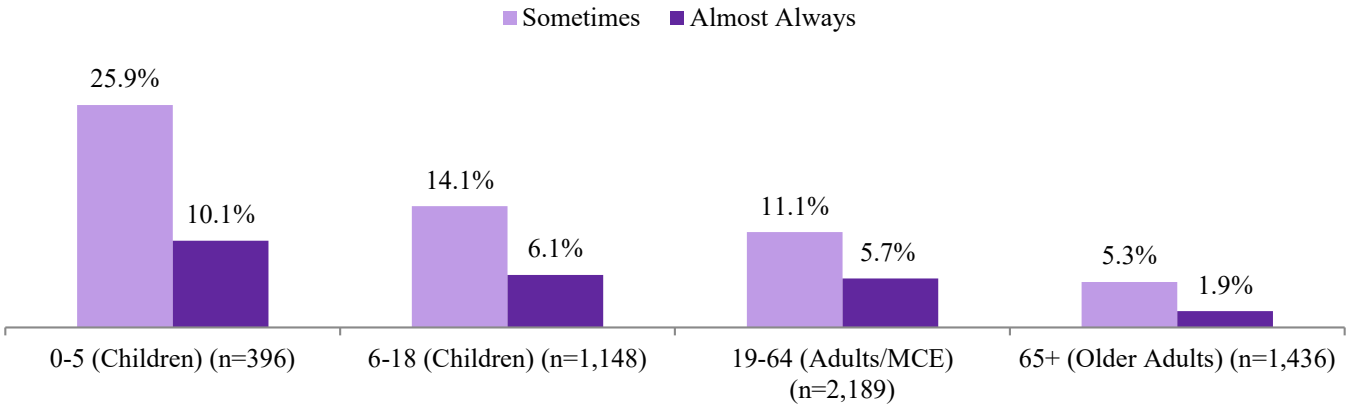


Child care:

CalOptima language:



Age Category:



Region:

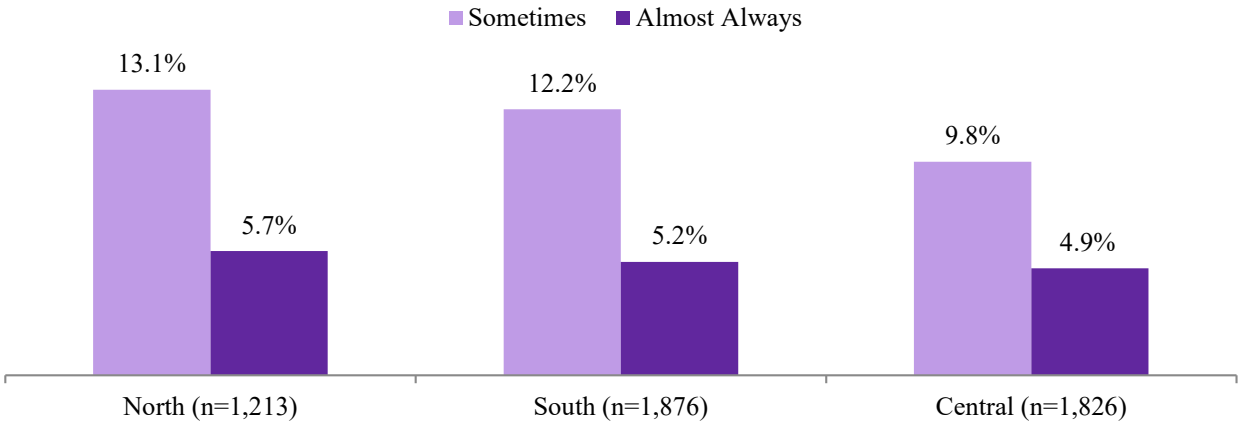
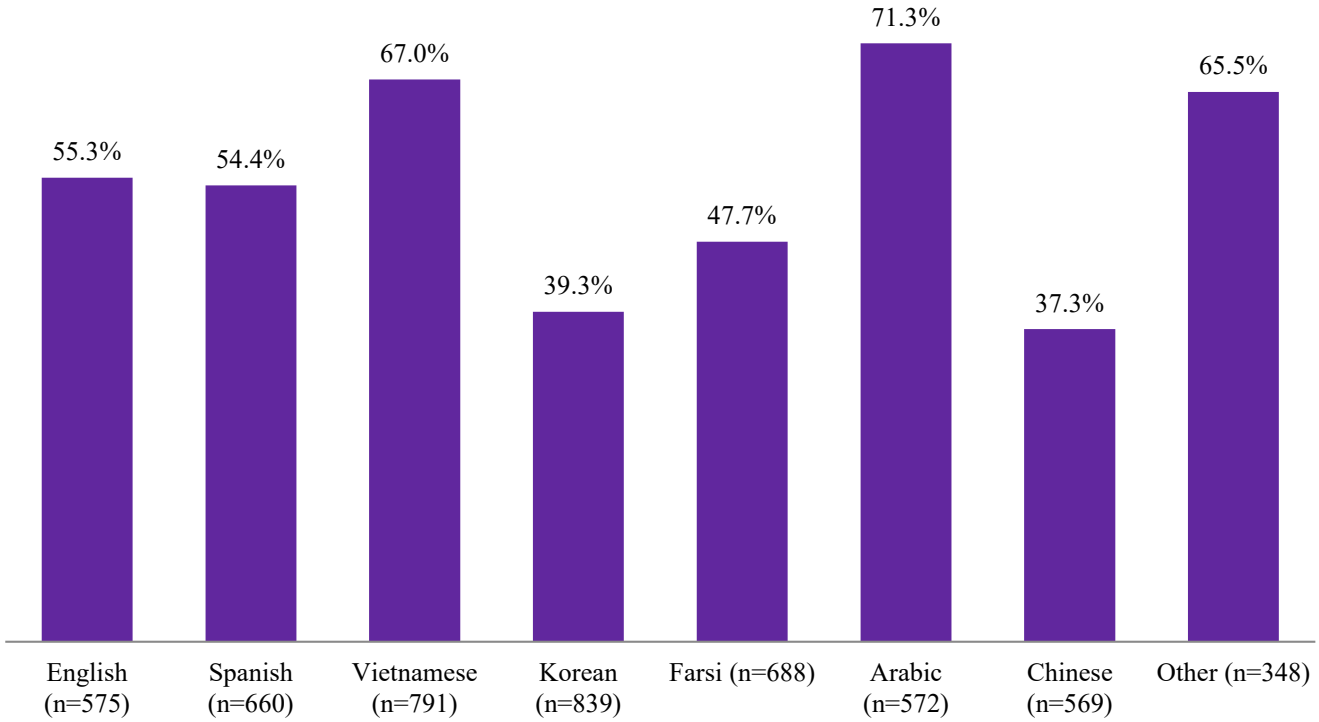


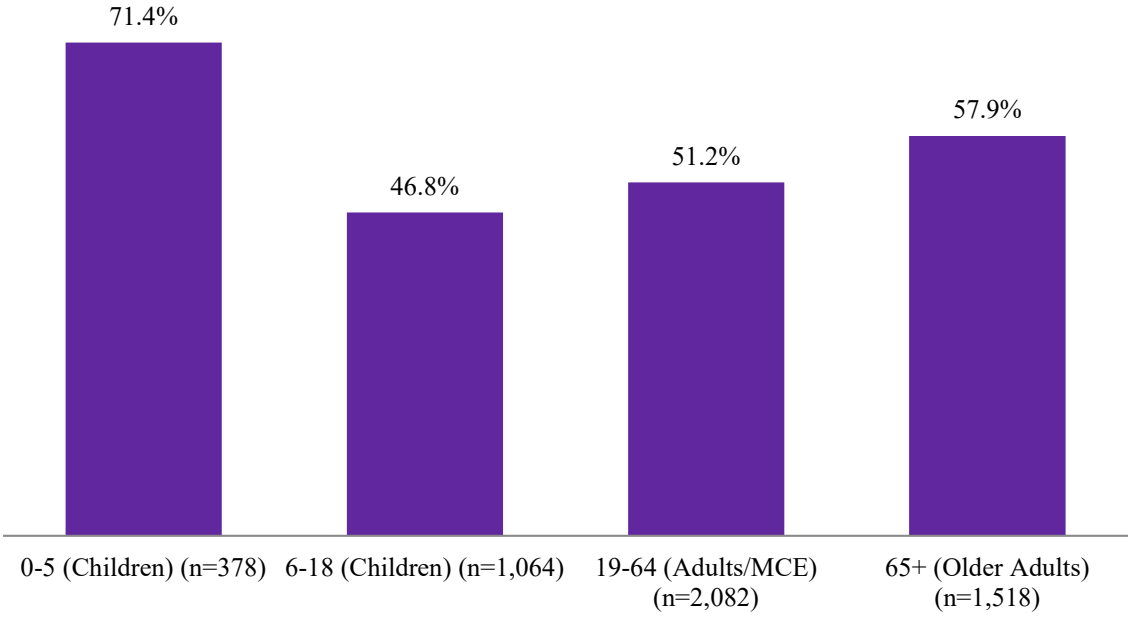
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

CalOptima language:

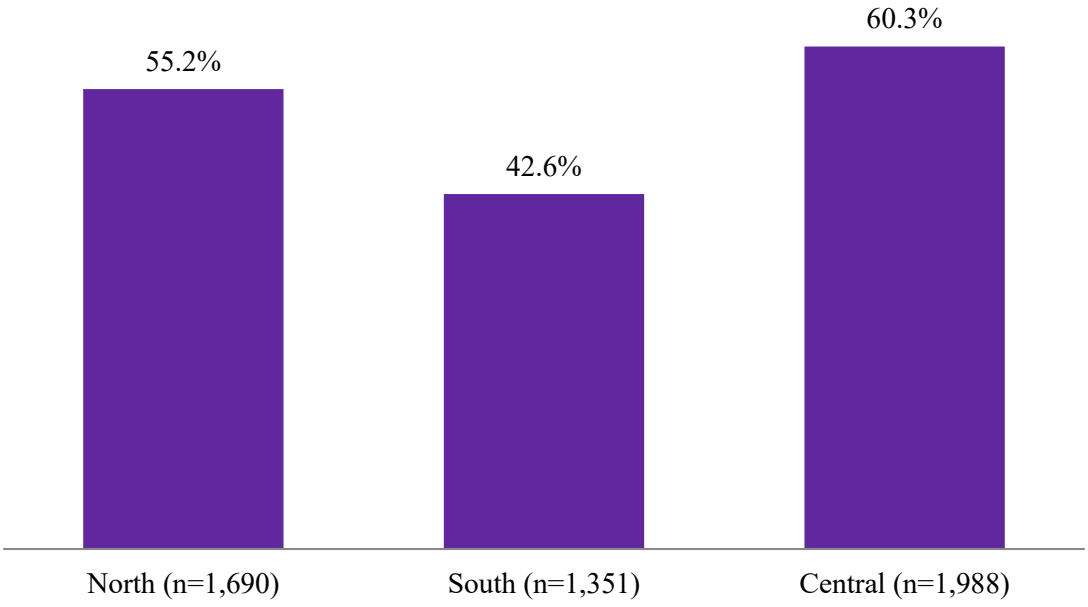


Age Category:



CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

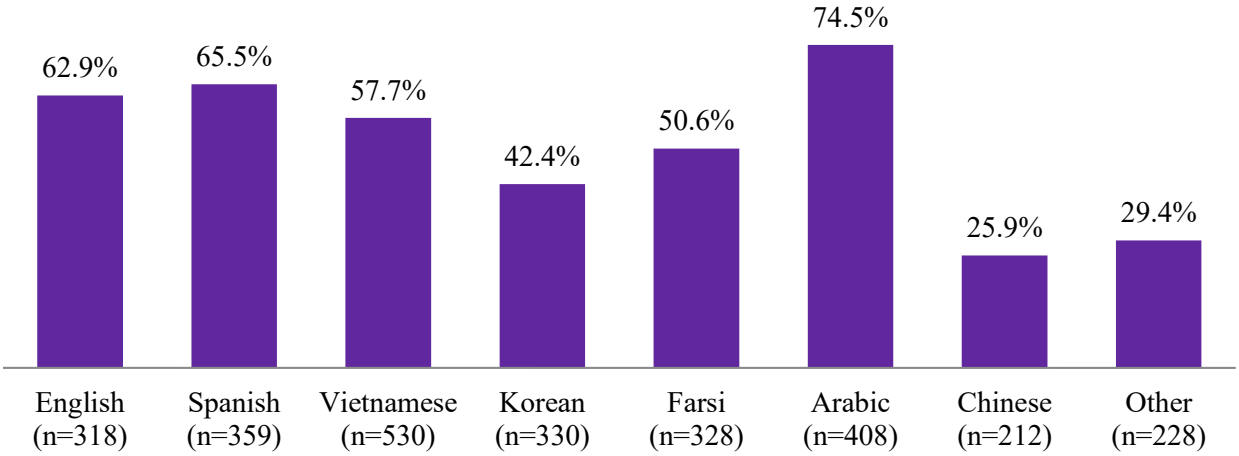
Region:



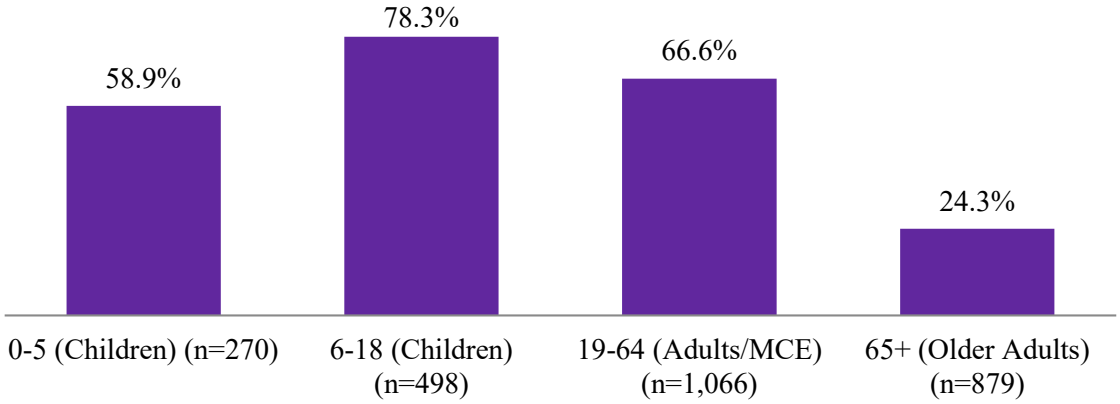
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

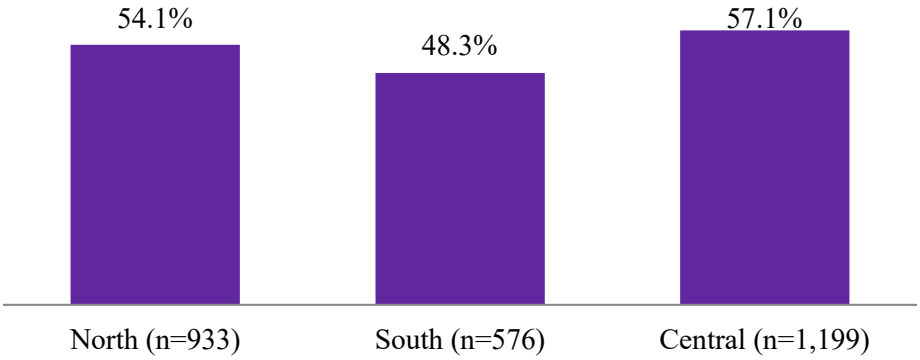
CalOptima language:



Age Category:



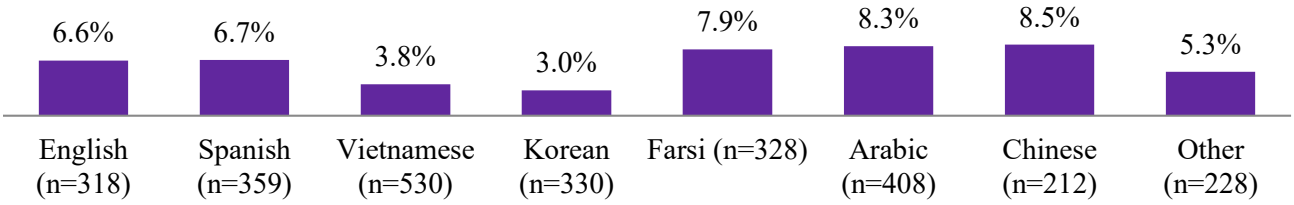
Region:



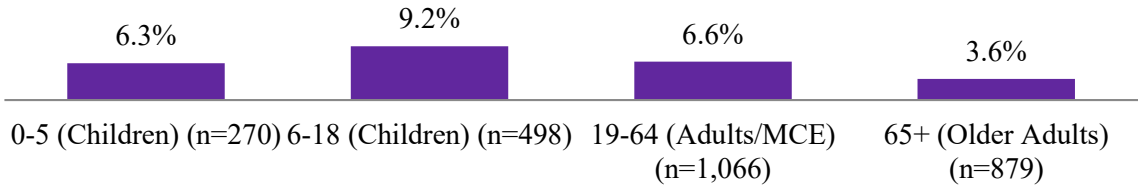
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

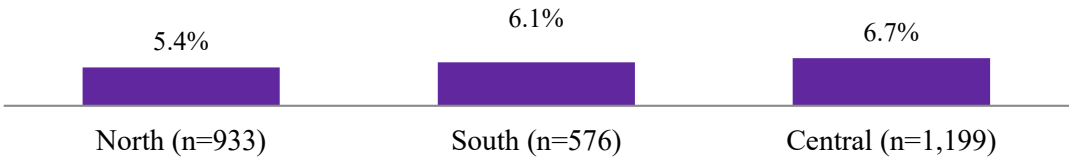
CalOptima language:



Age Category:

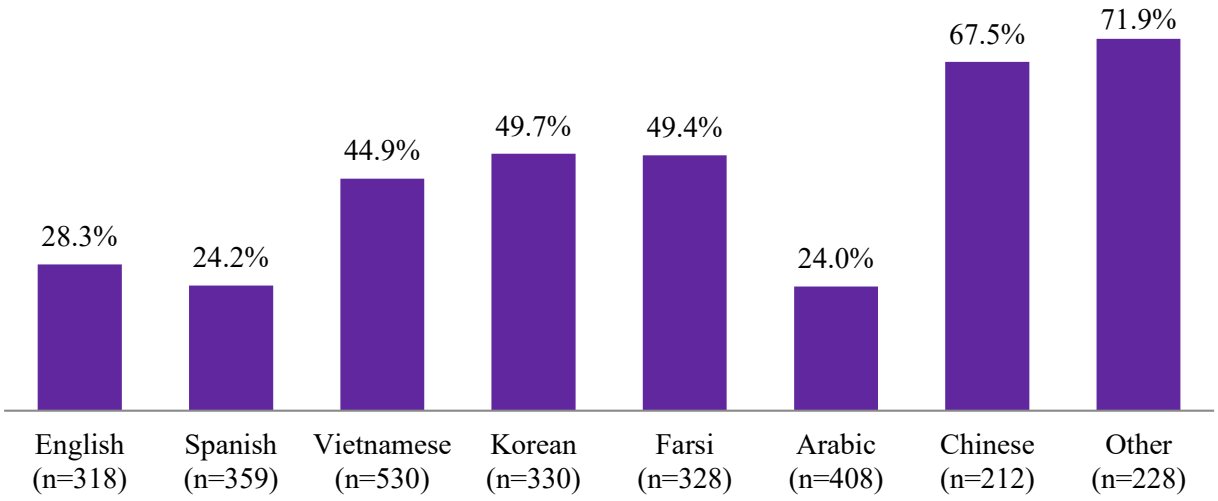


Region:

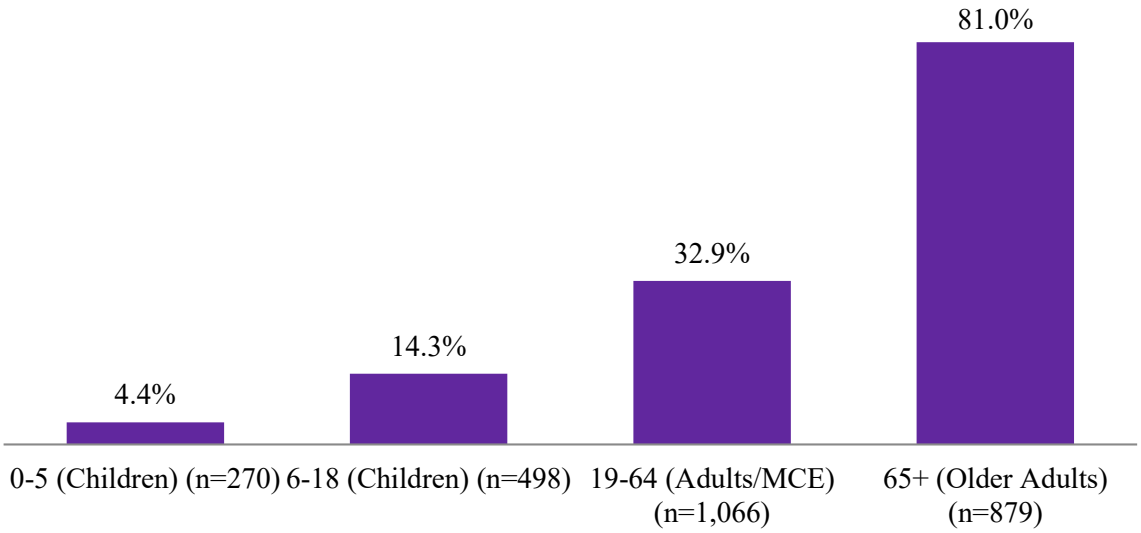


Receive SSI or SSDI as a public benefit:

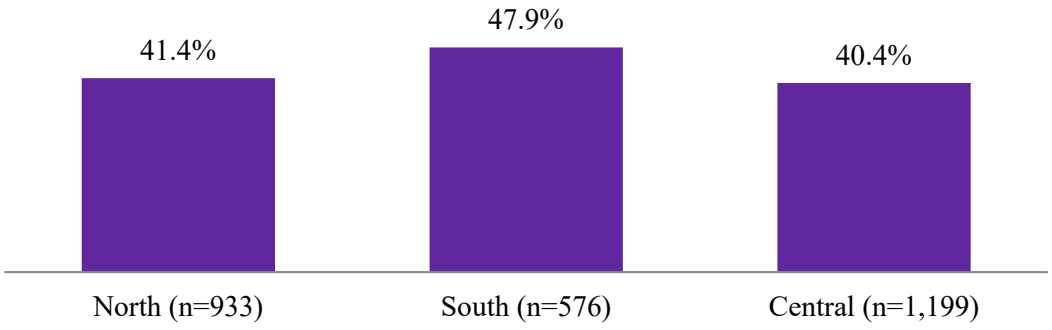
CalOptima language:



Age Category:

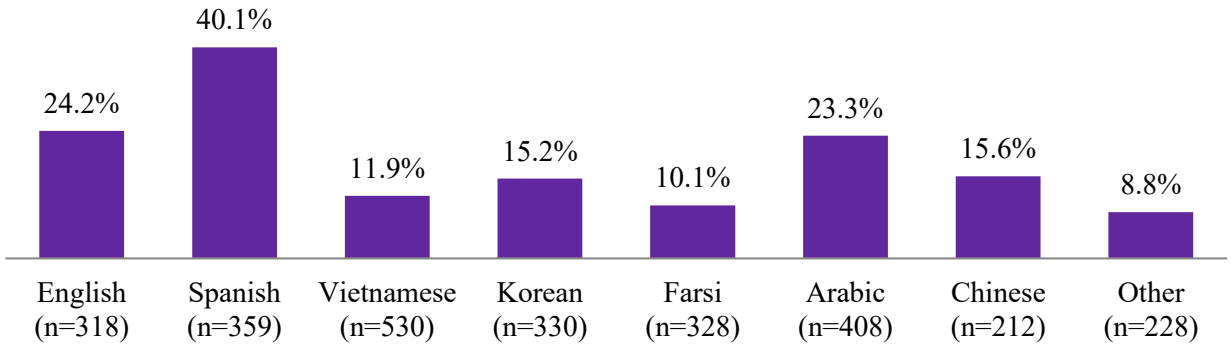


Region:

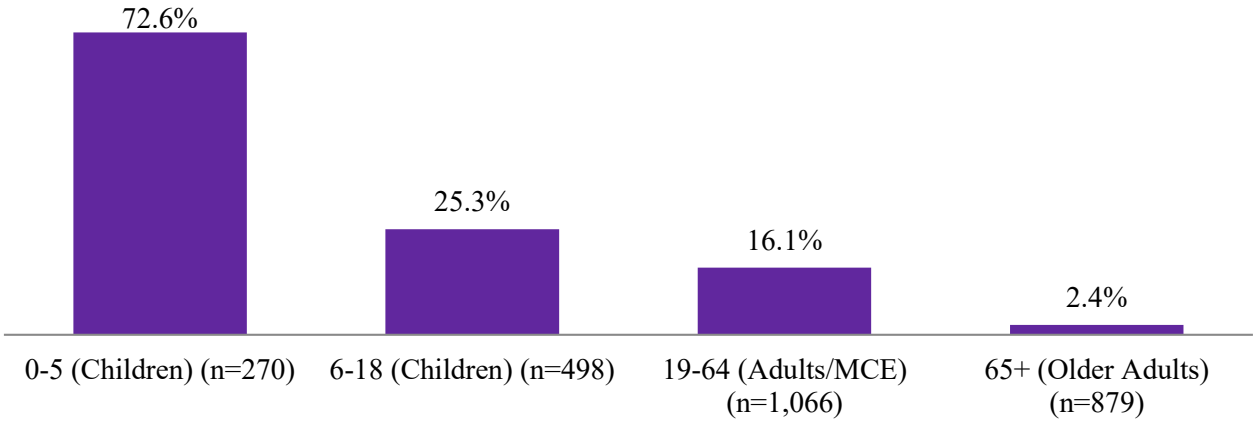


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

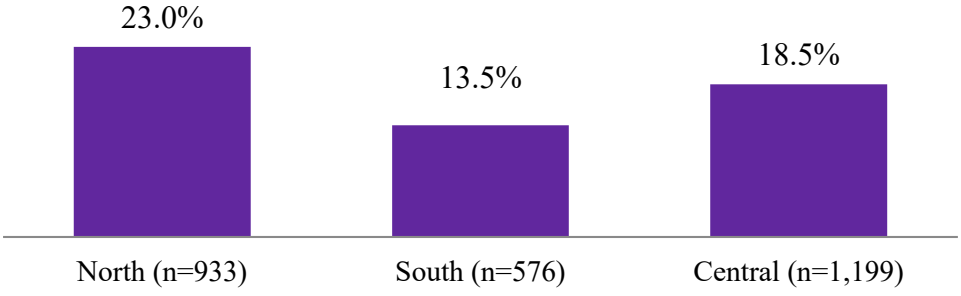


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467
Get enough sleep	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249
Have enough time for self	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

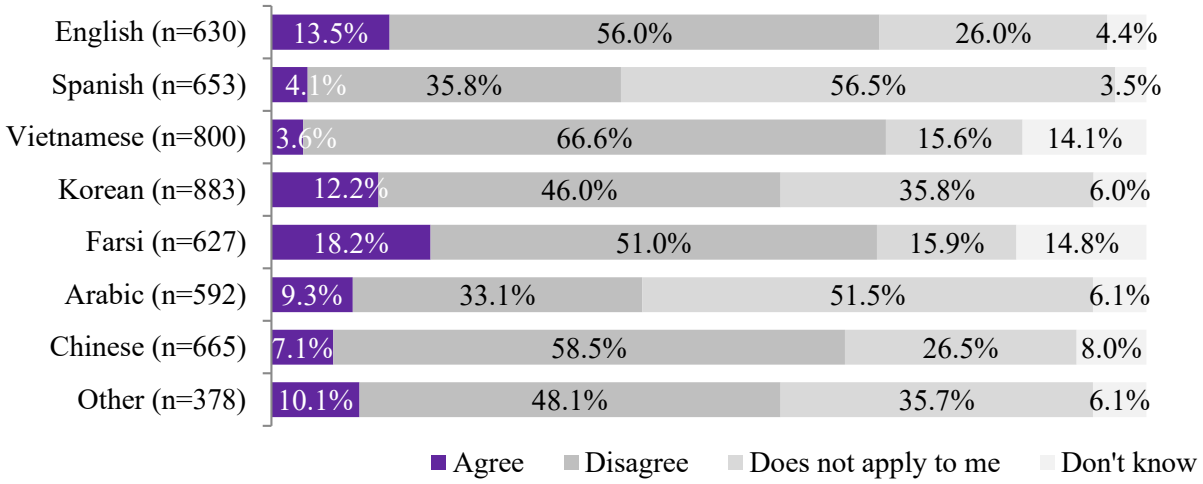
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

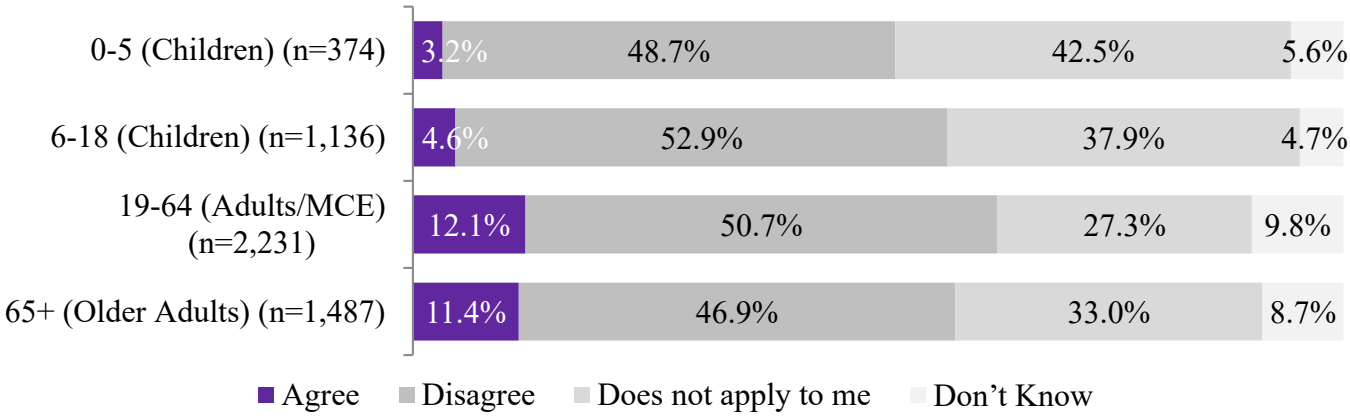
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

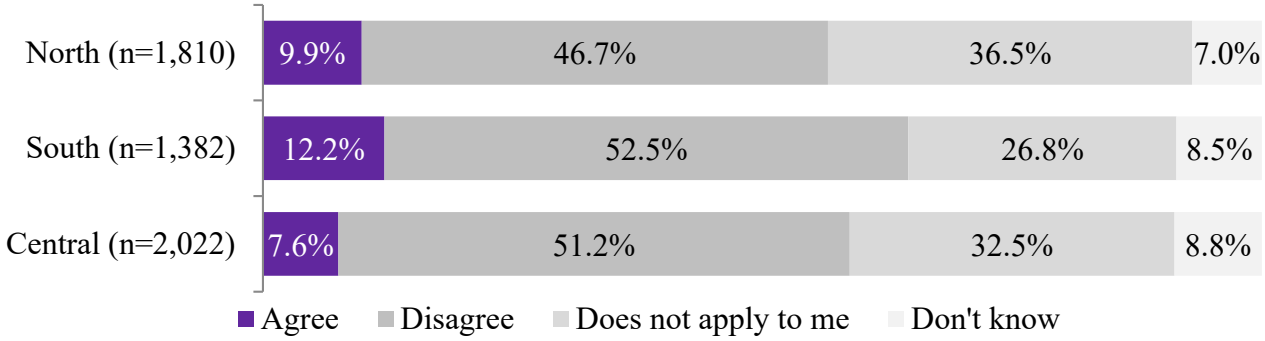
CalOptima language:



Age Category:

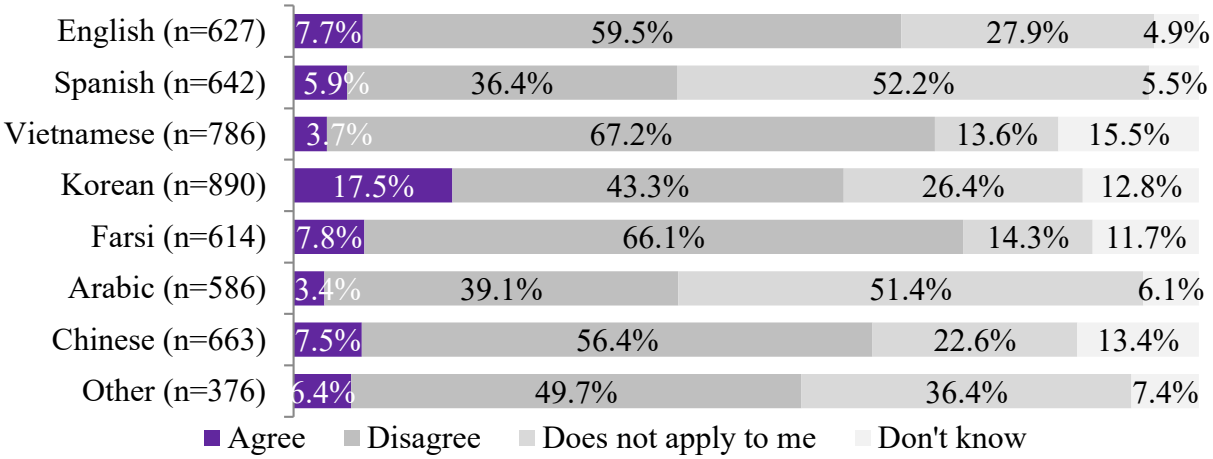


Region:

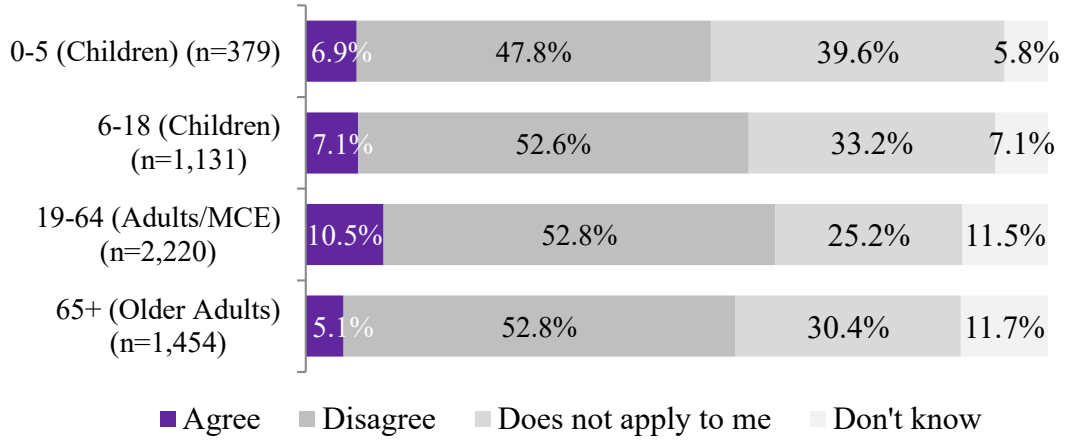


Feel not treated equally because of ethnic and culutral backgrounds:

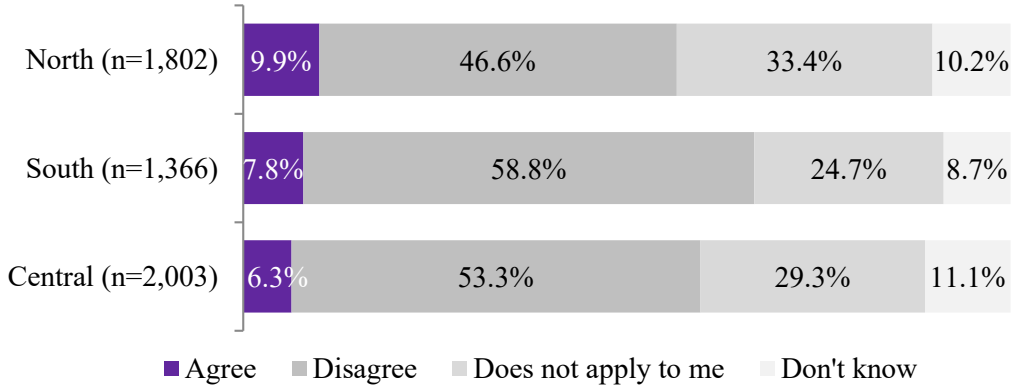
CalOptima language:



Age Category:

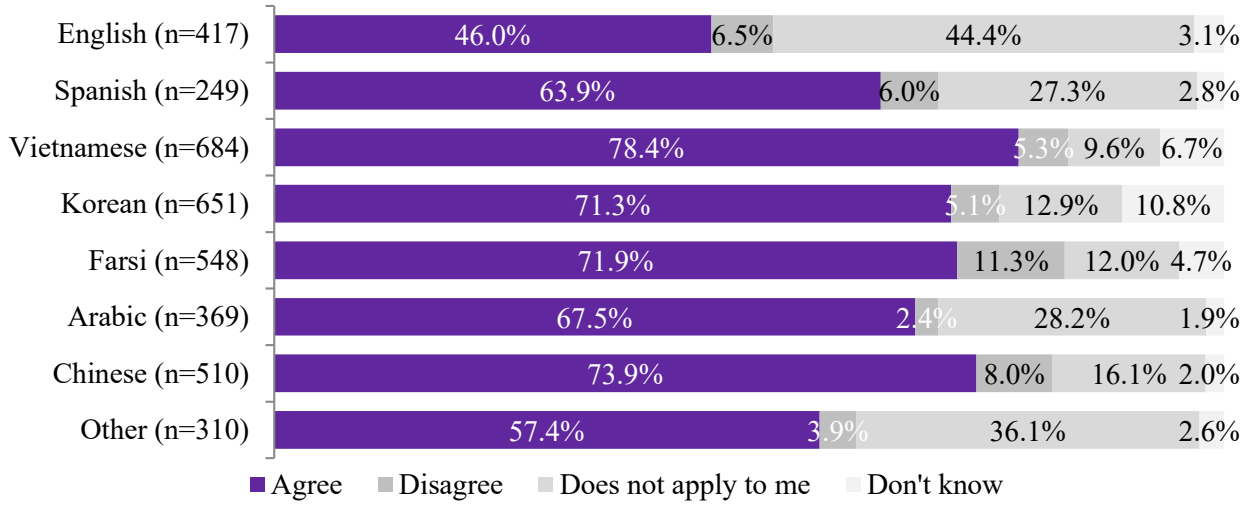


Region:



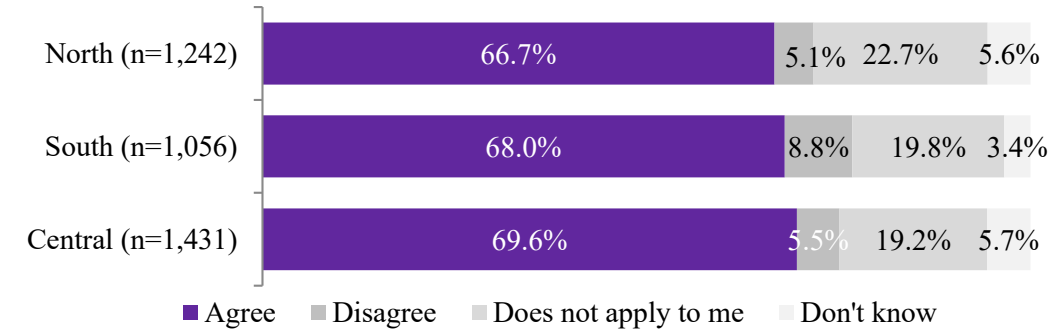
Feel child respects them as a parent[9]:

CalOptima language:



Age Category:

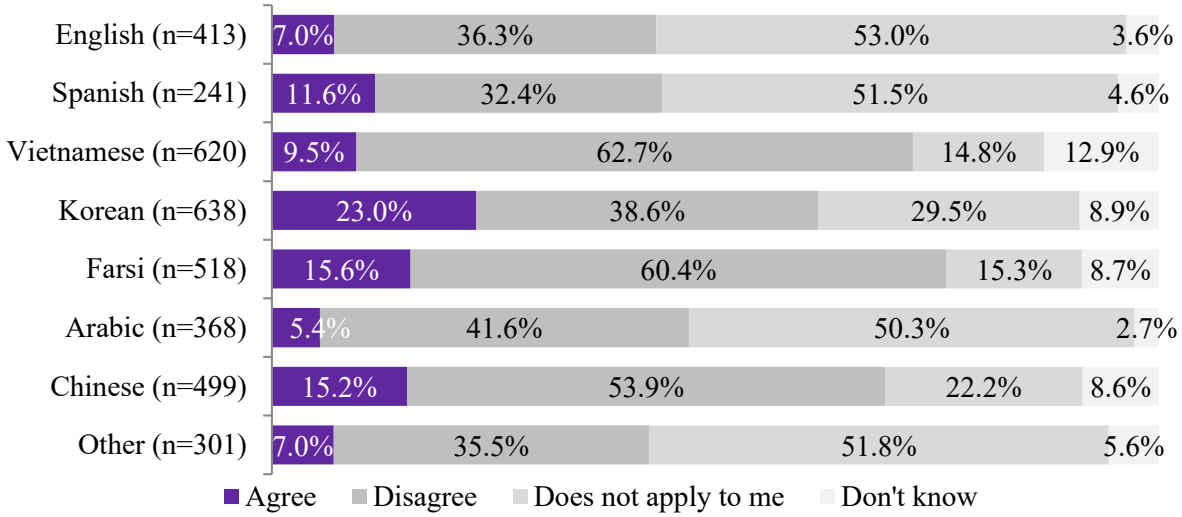
Region:



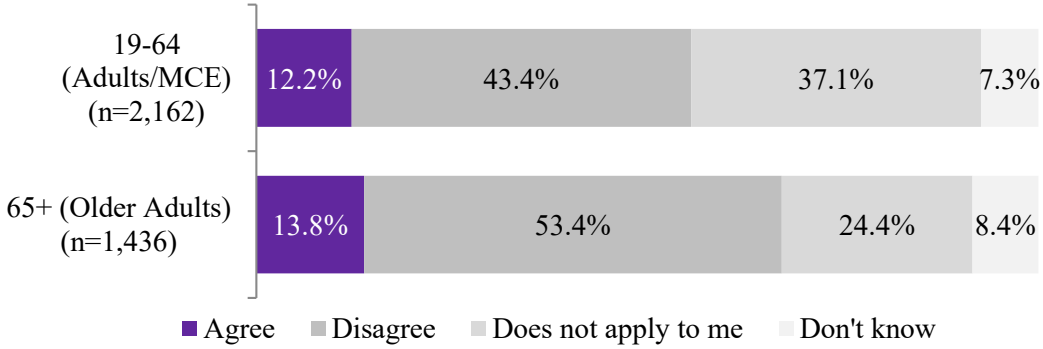
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

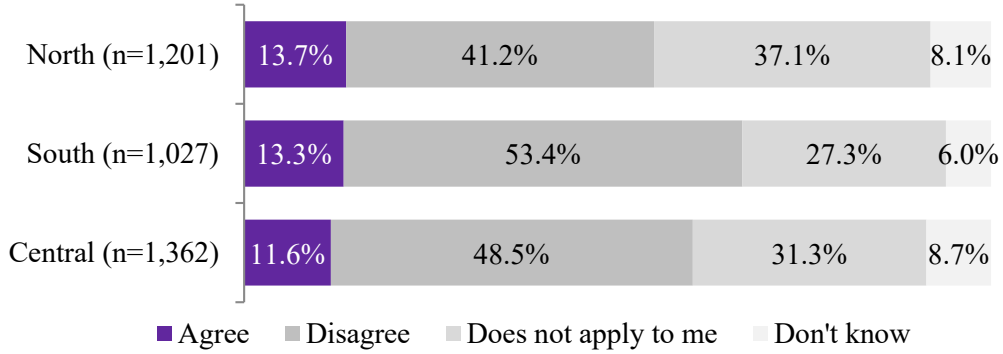
CalOptima language:



Age Category:



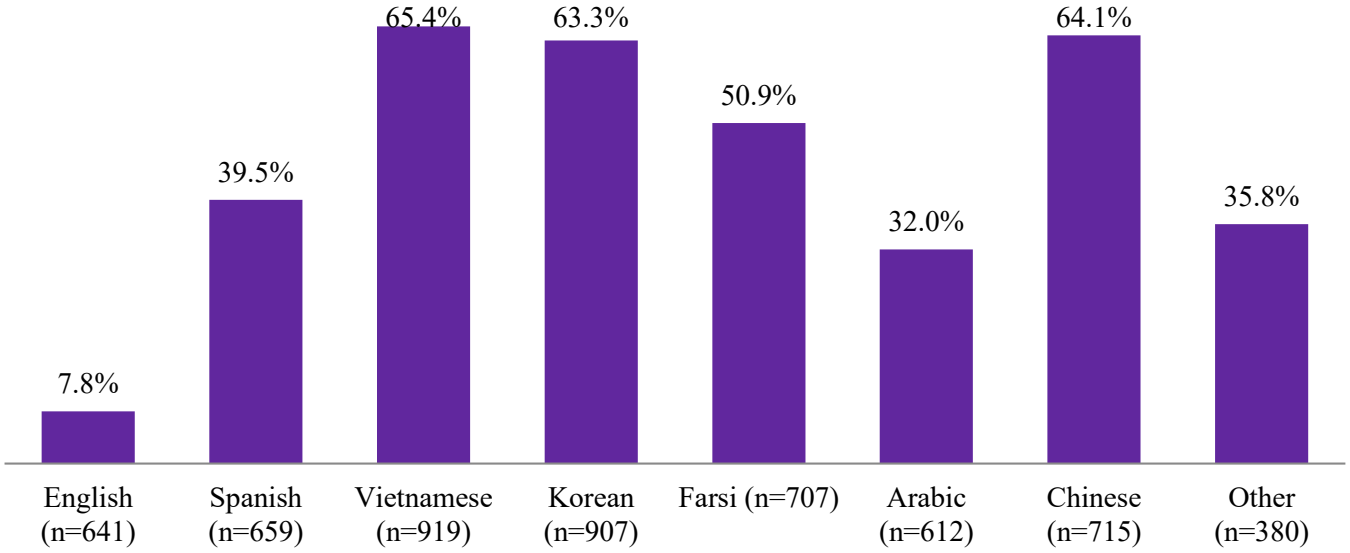
Region:



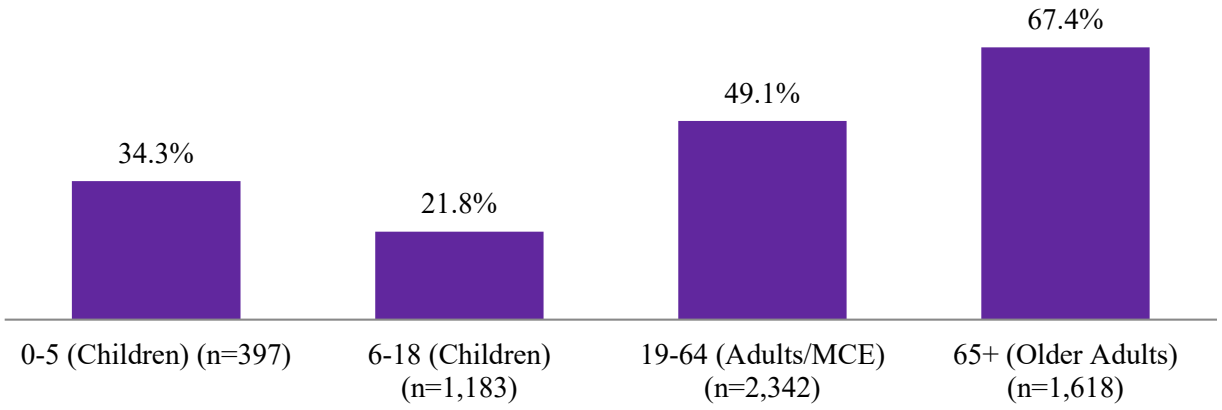
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

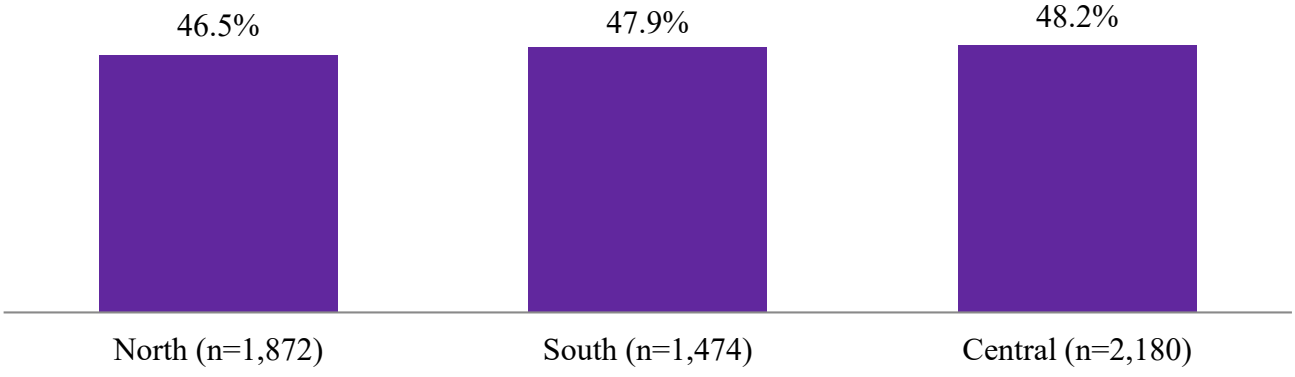


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

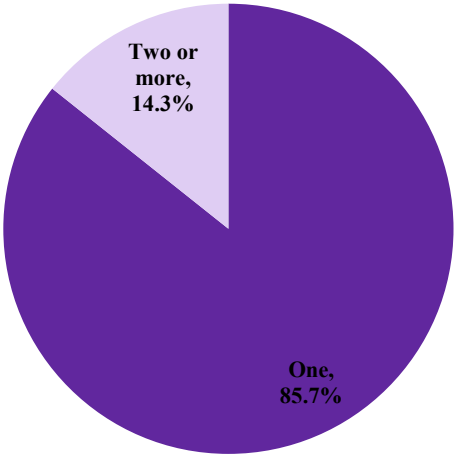
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

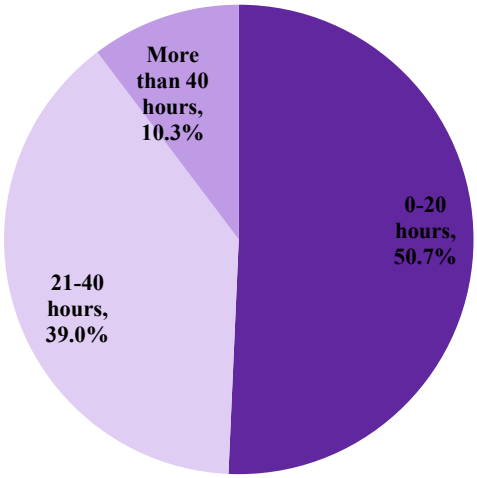
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

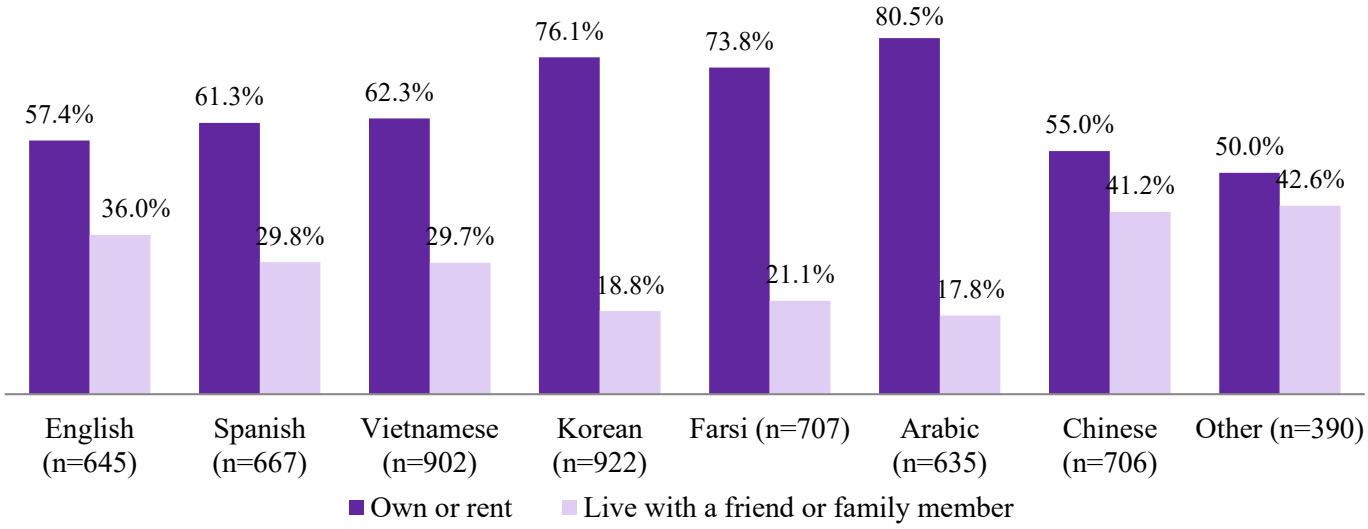


Number of hours that members work each week

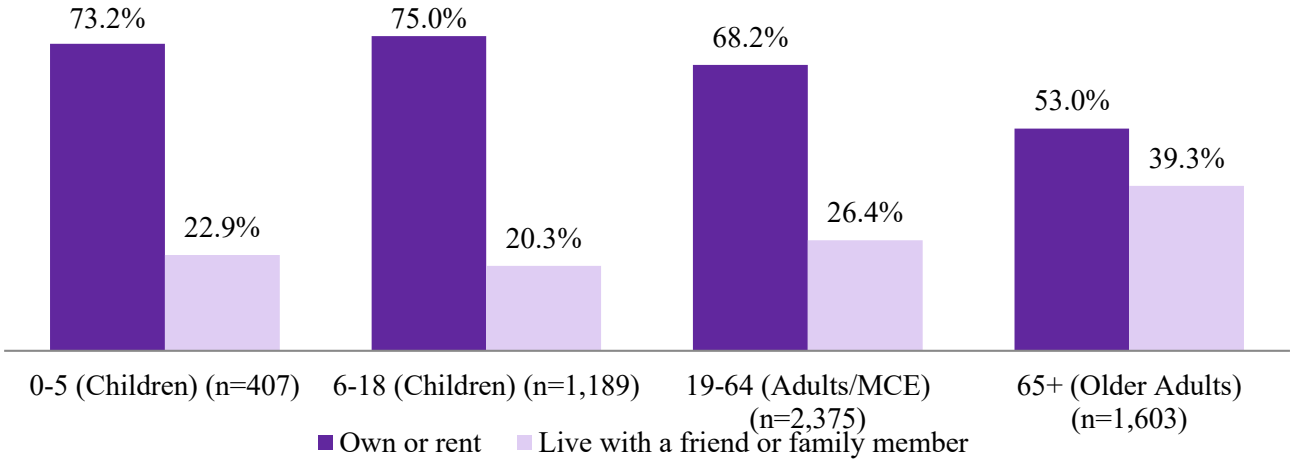


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

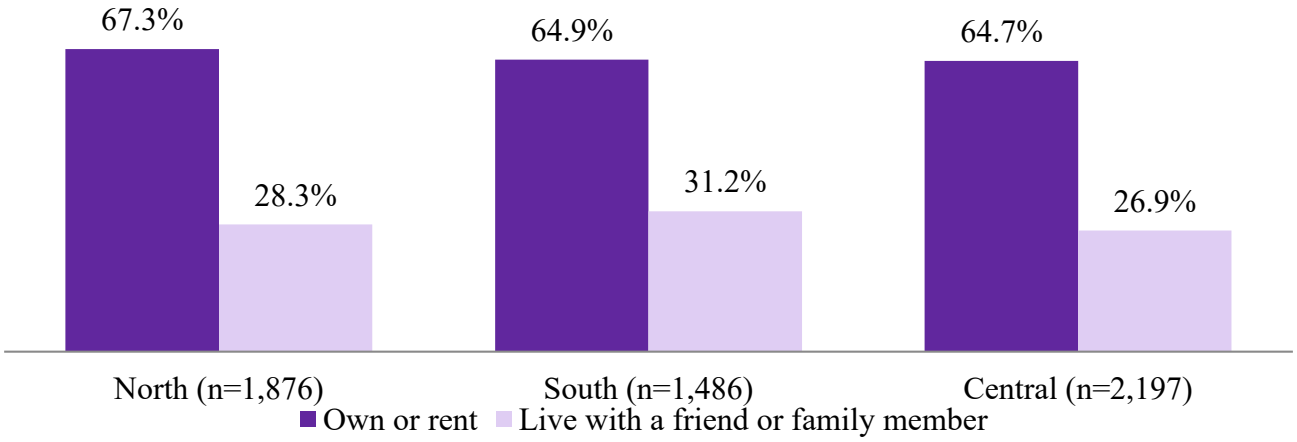
Exhibit 20. Members' living situation[14]



Age Category:



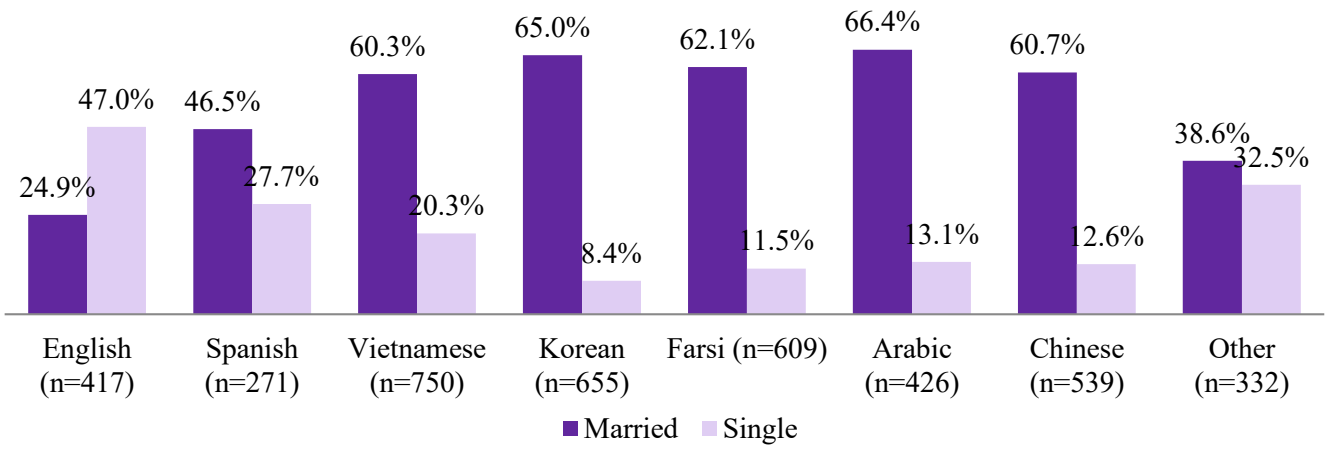
Region:



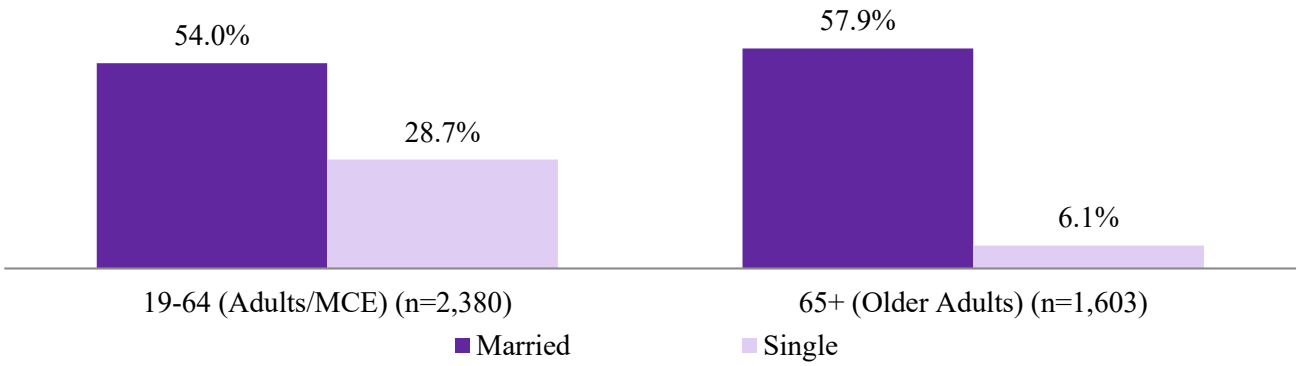
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

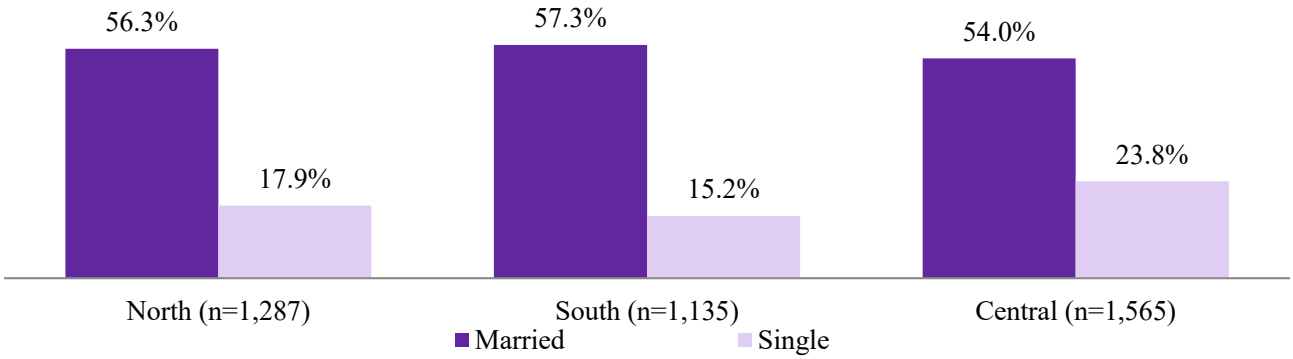
CalOptima language:



Age Category:



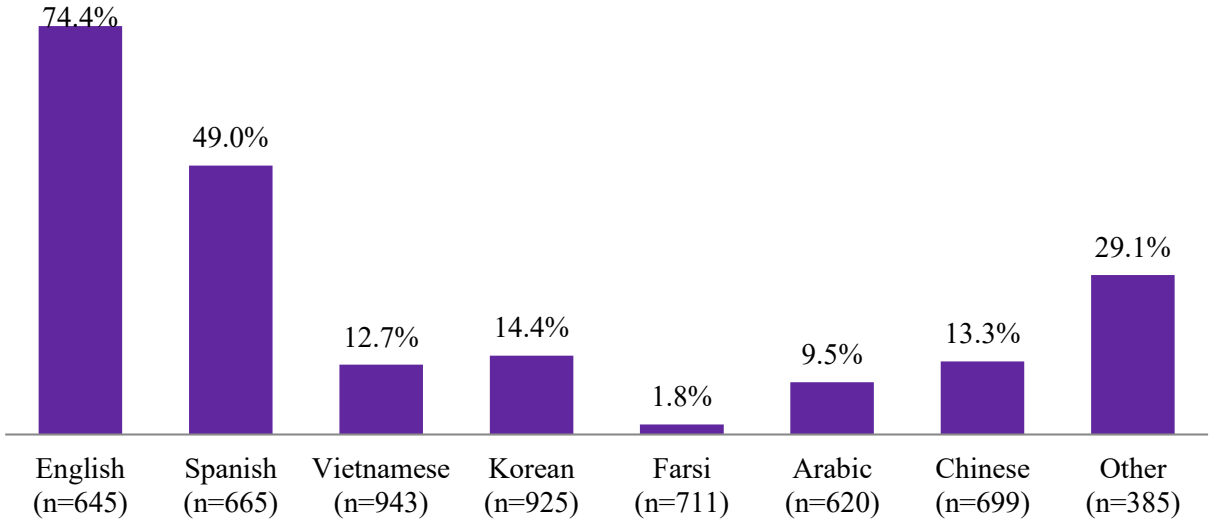
Region:



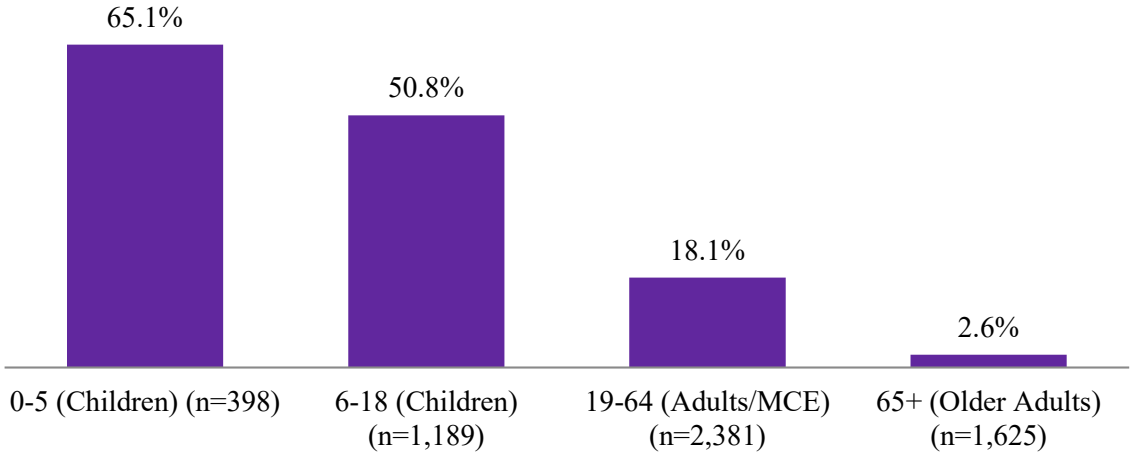
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

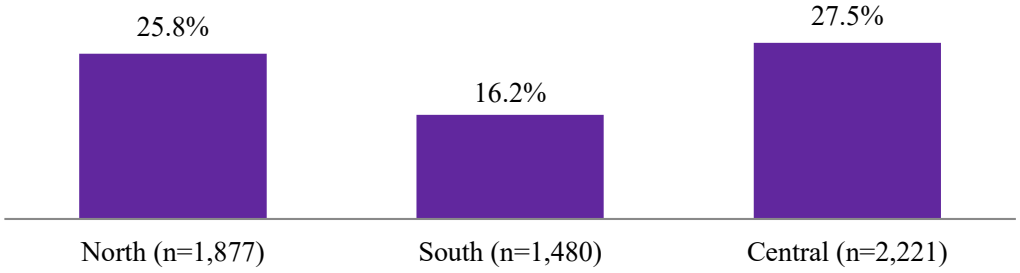
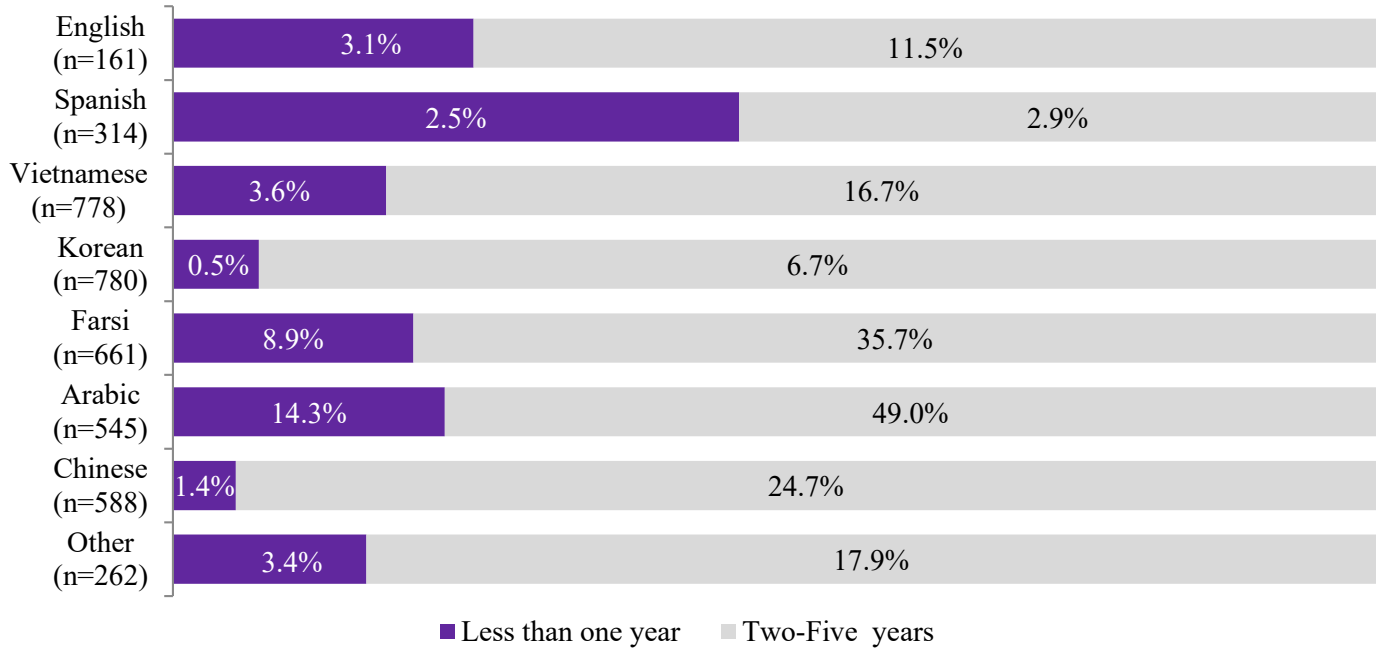
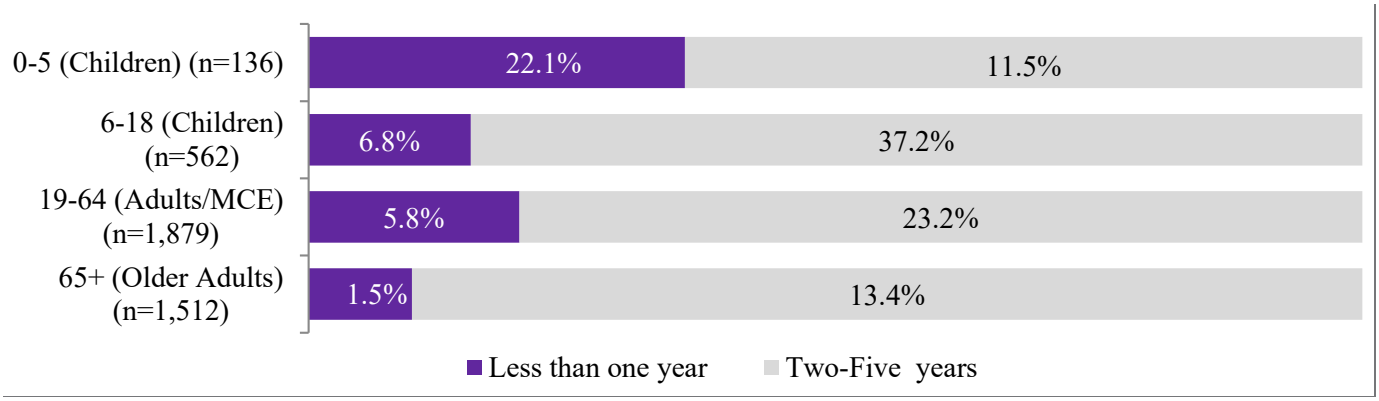


Exhibit 23. Length of time lived in the United States of those not born in the United States

CalOptima language:



Age Category:

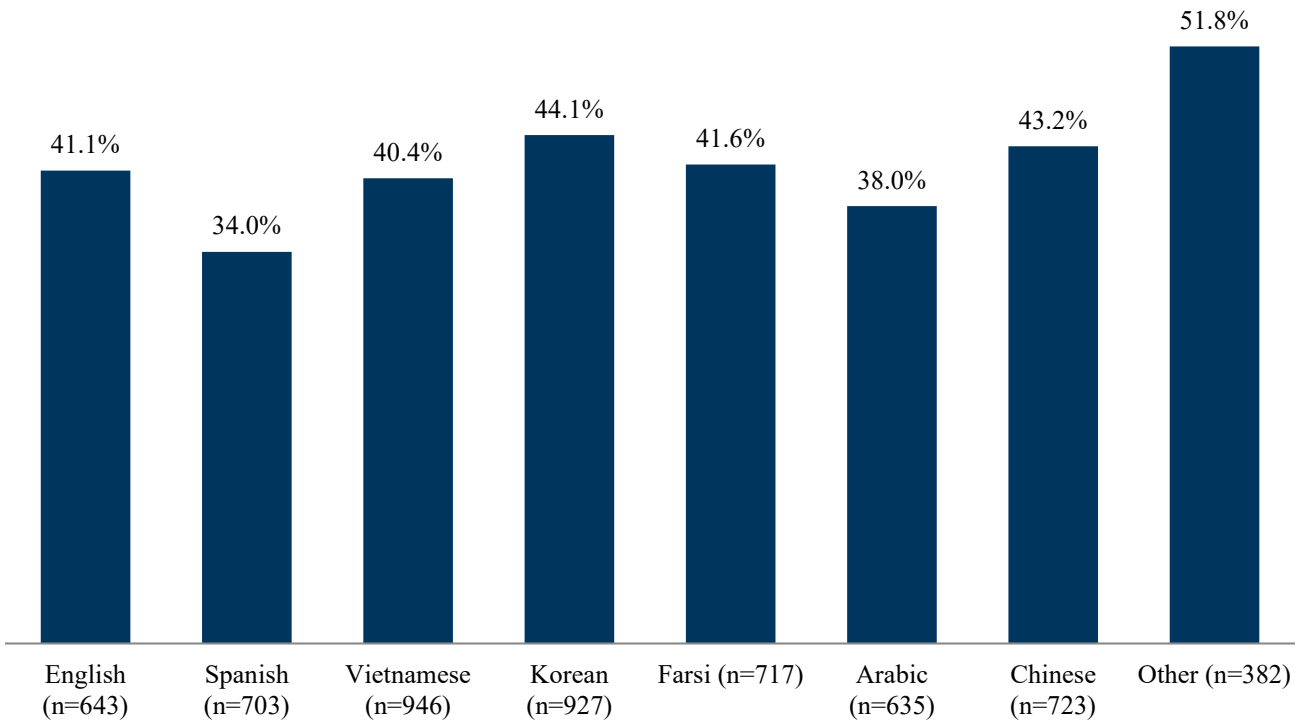


Region:

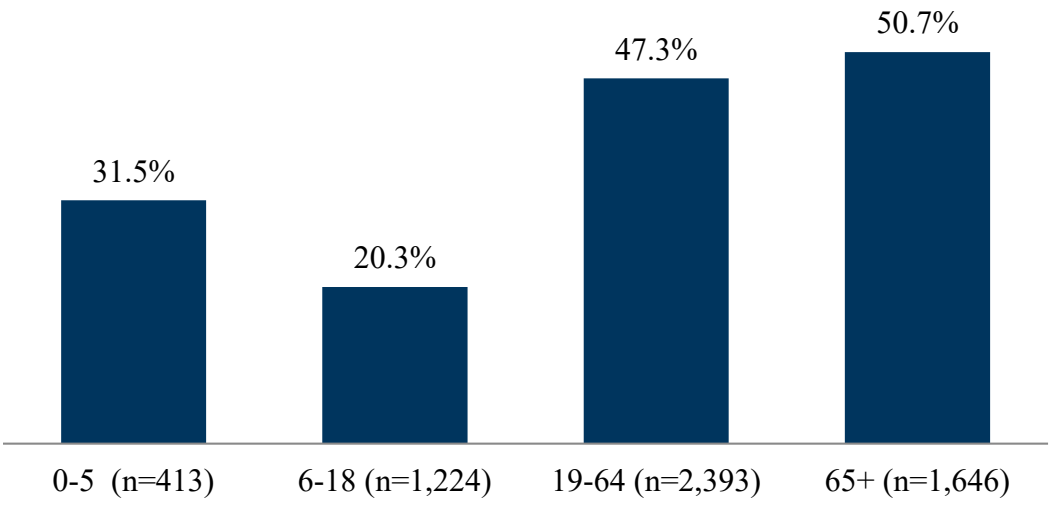
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

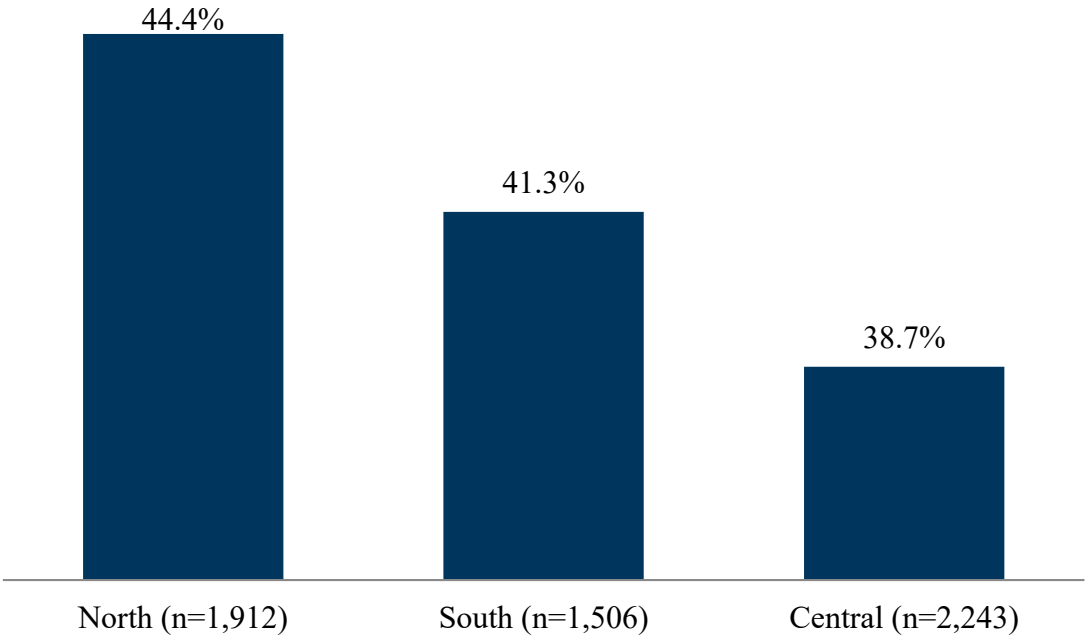


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

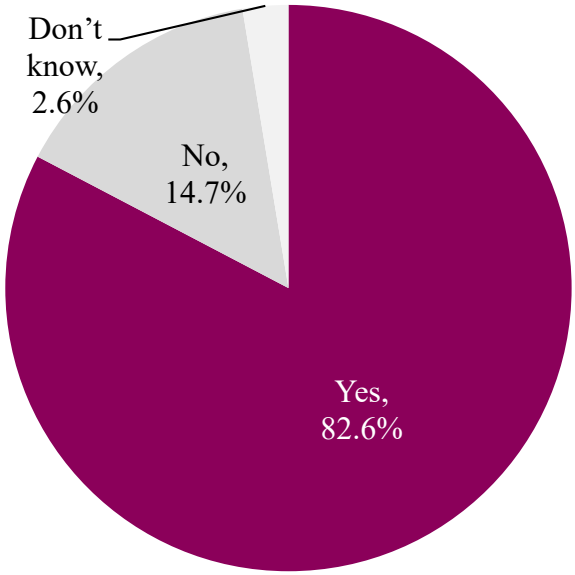


Exhibit 28. Where respondents go to see their doctor (n=5,743)

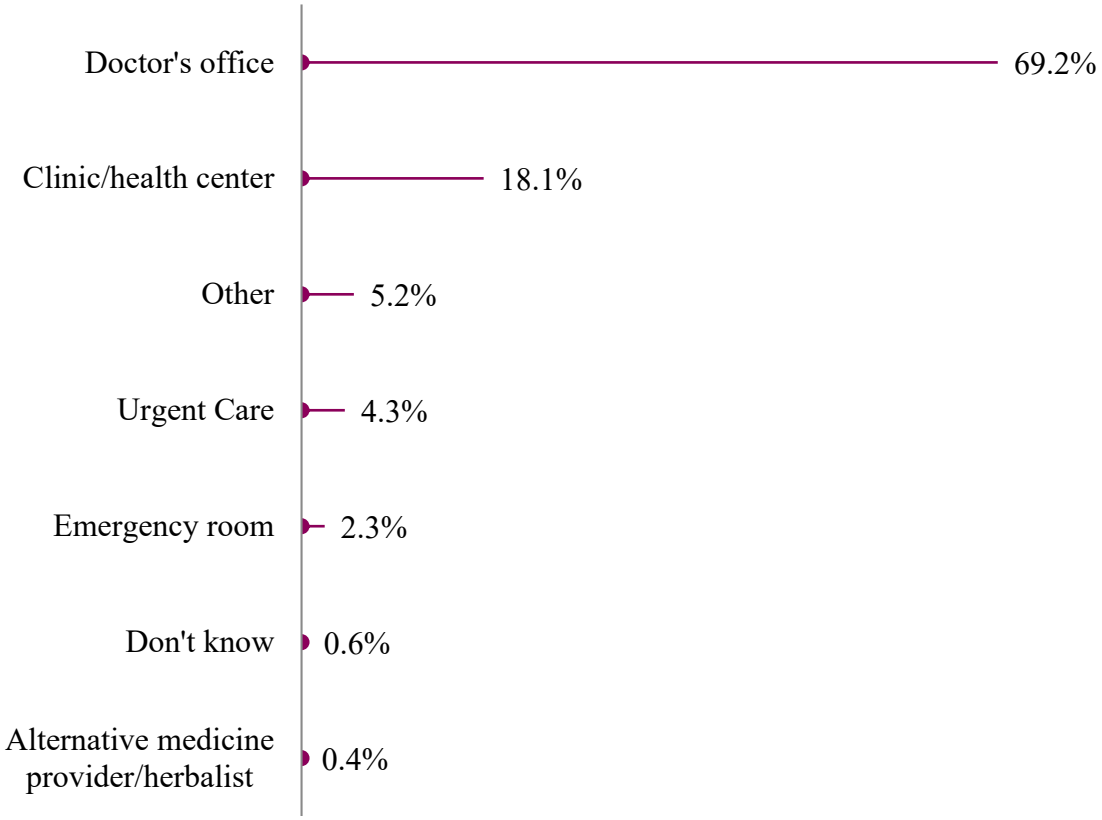


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

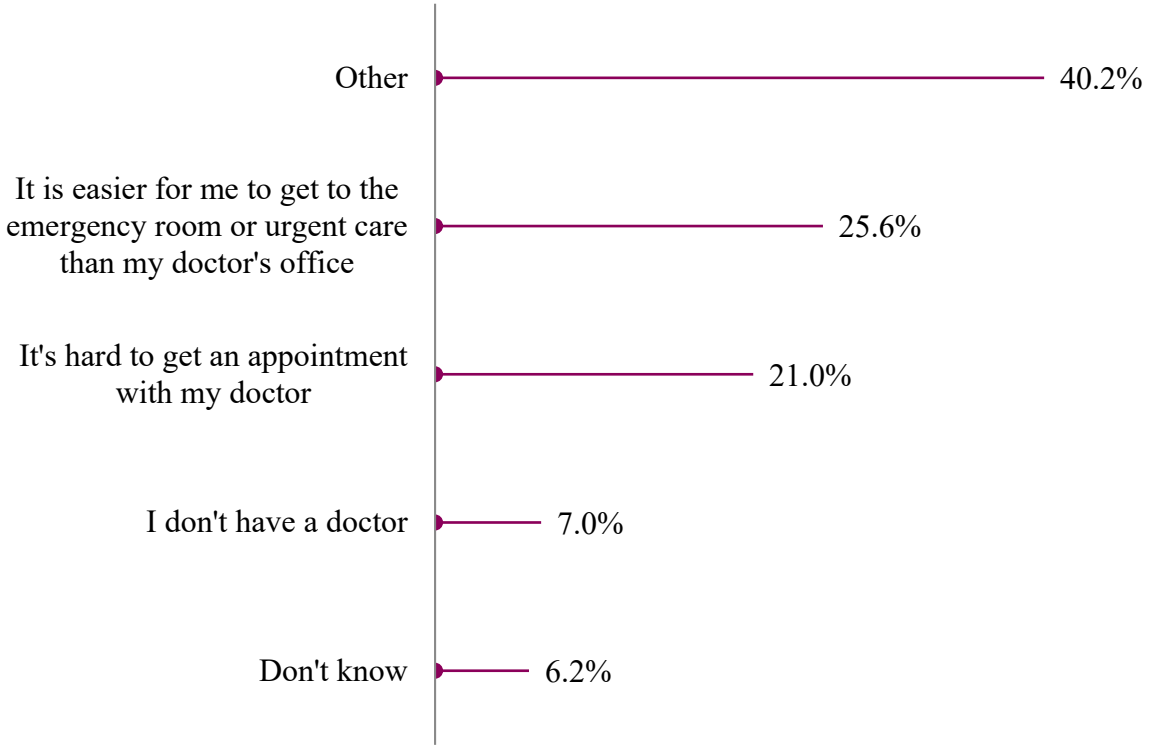


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

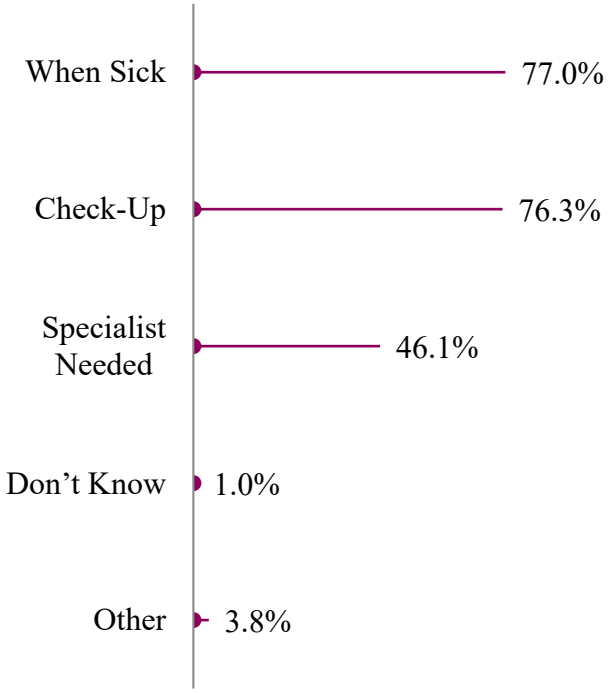
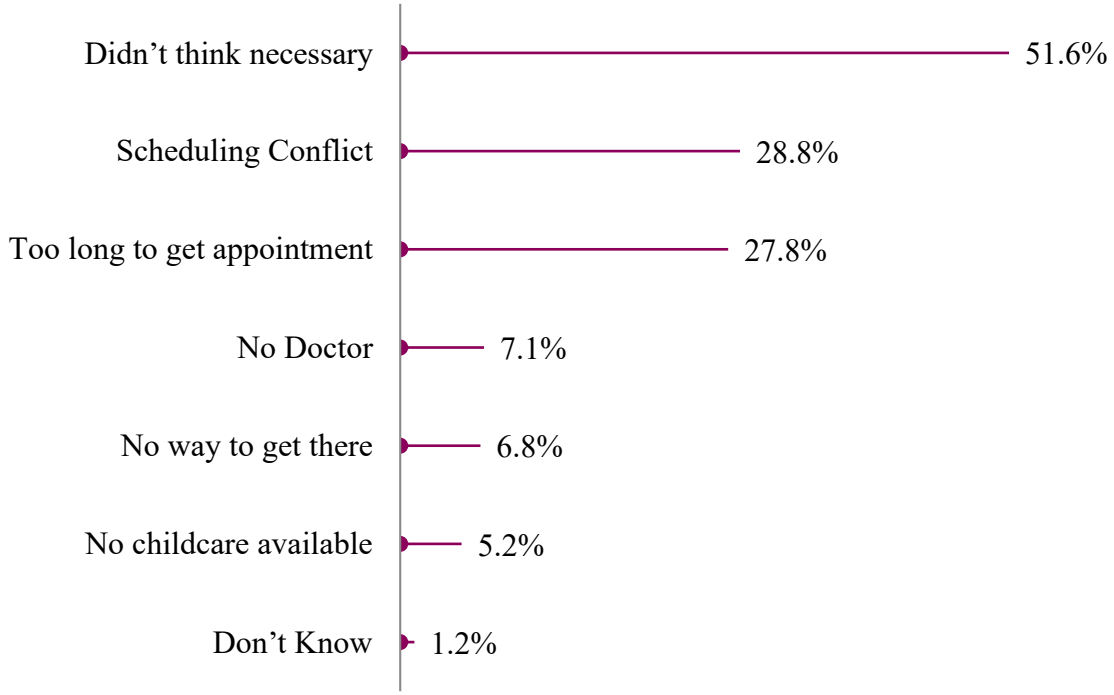


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

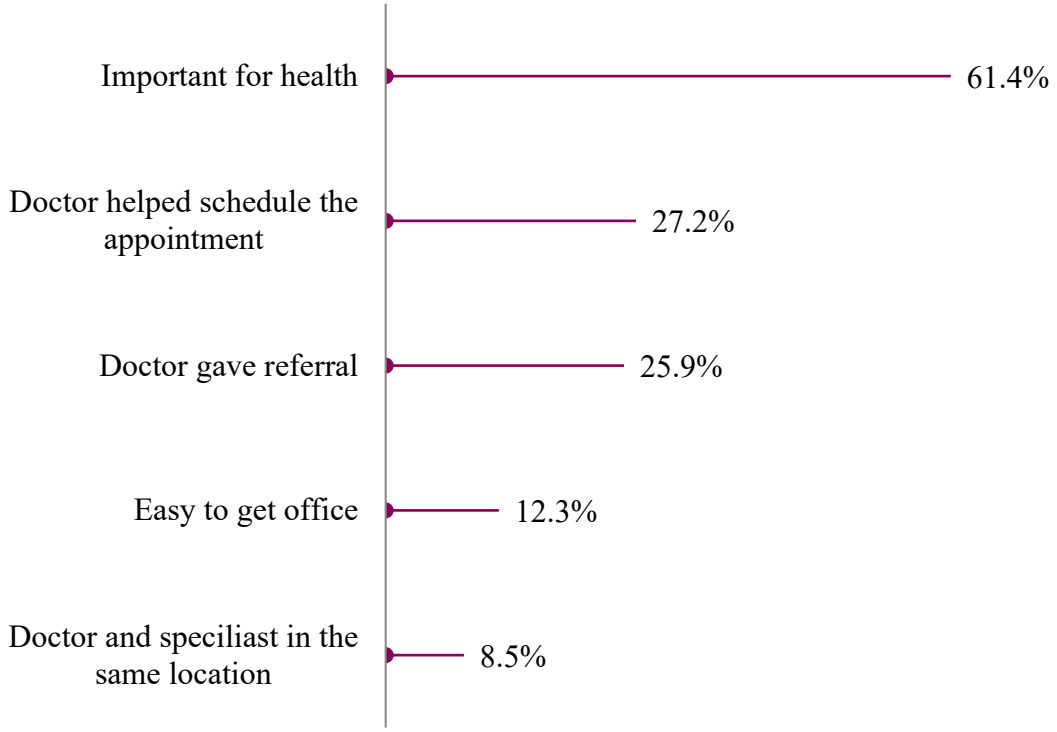
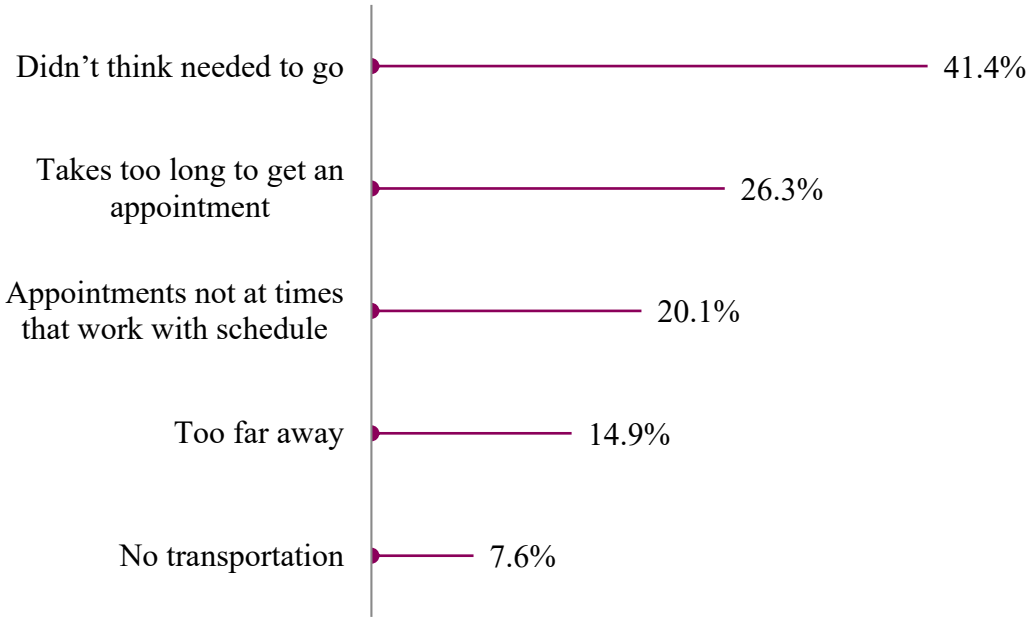
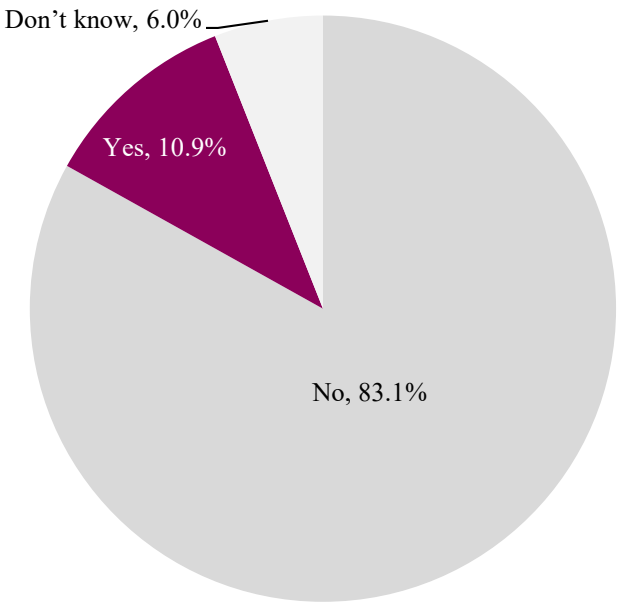


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

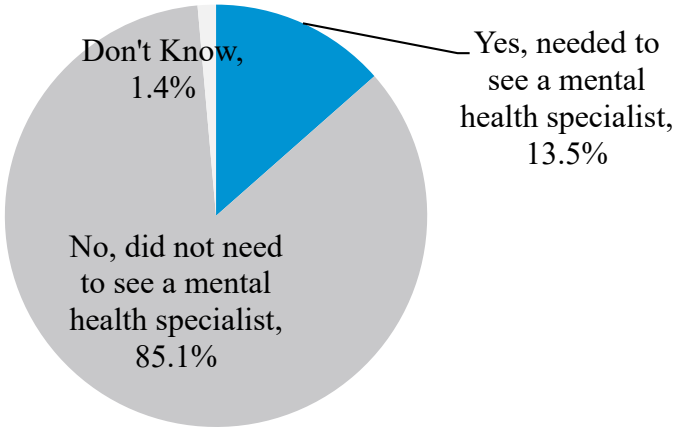


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

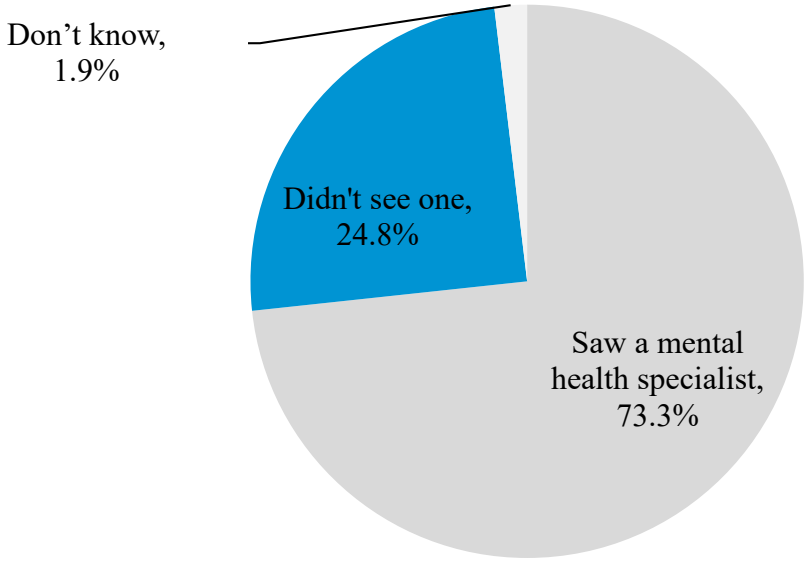


Exhibit 37. Reasons why members didn't see mental health specialist[24]

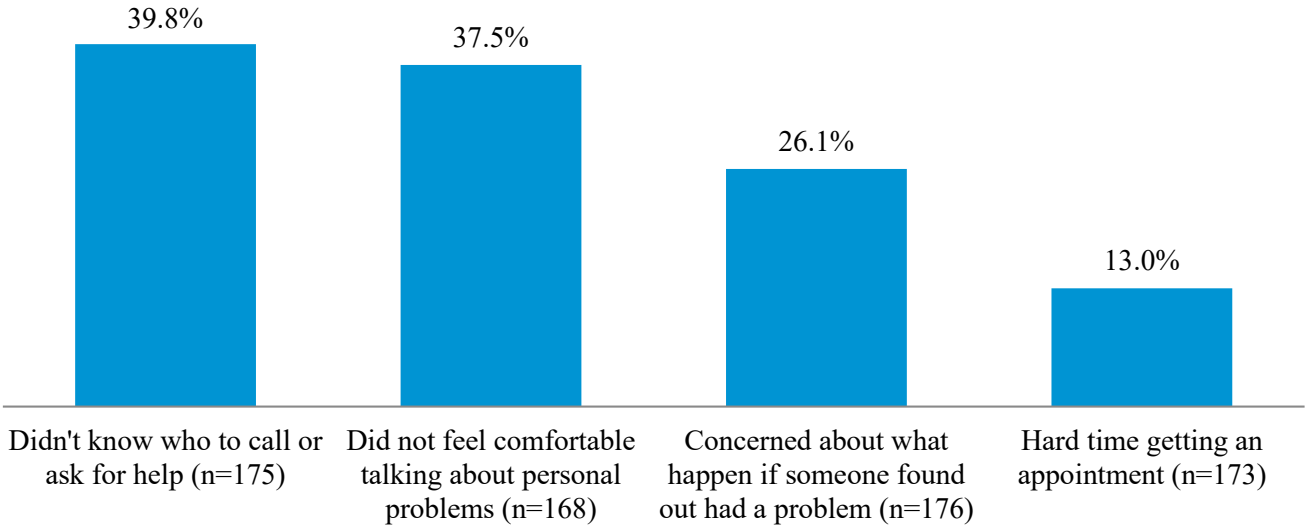
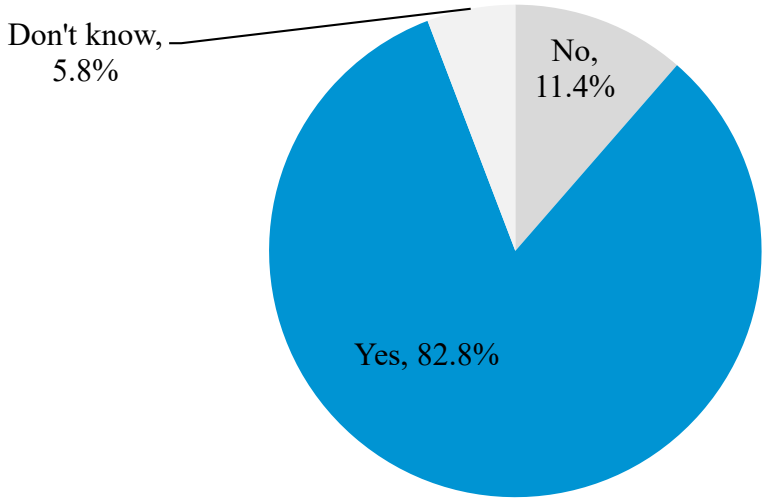


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

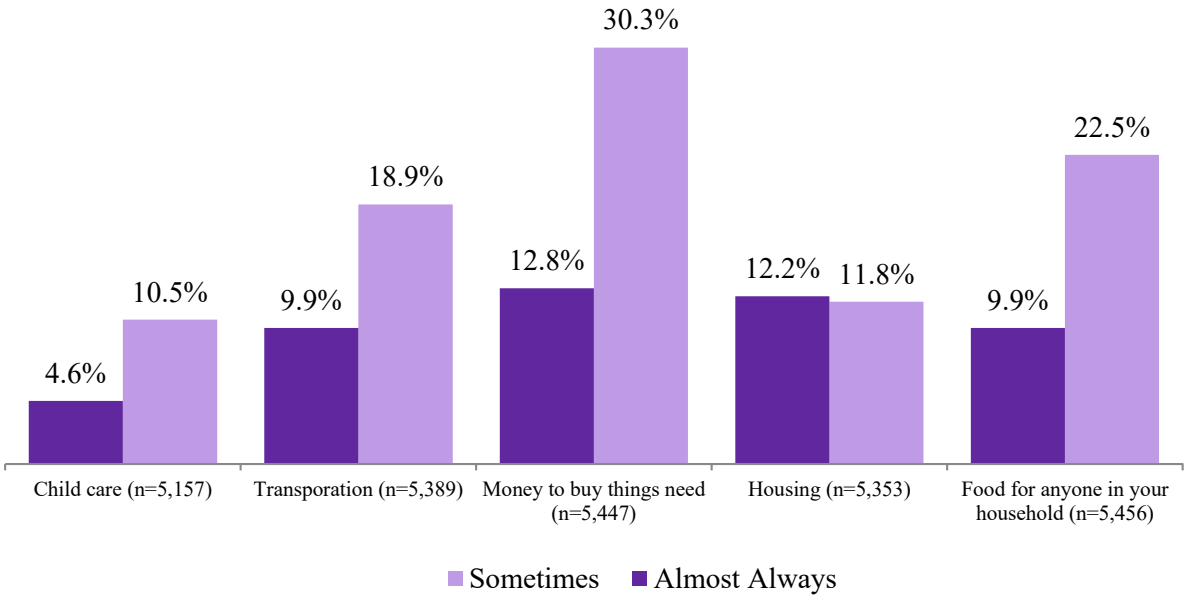


Exhibit 41. Percent of members who receive public benefits (n=5,117):

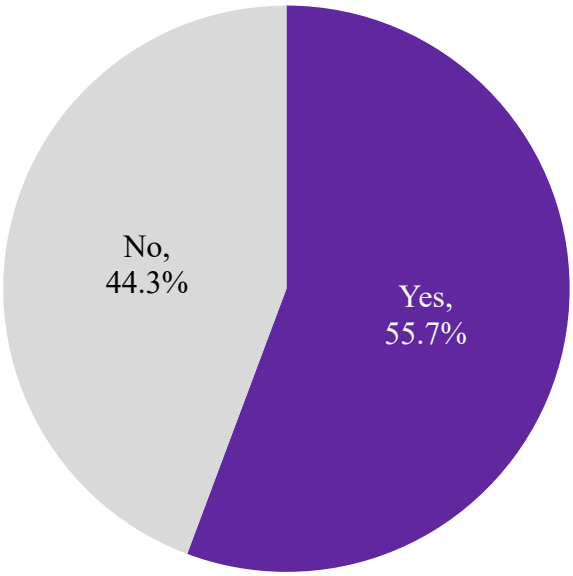
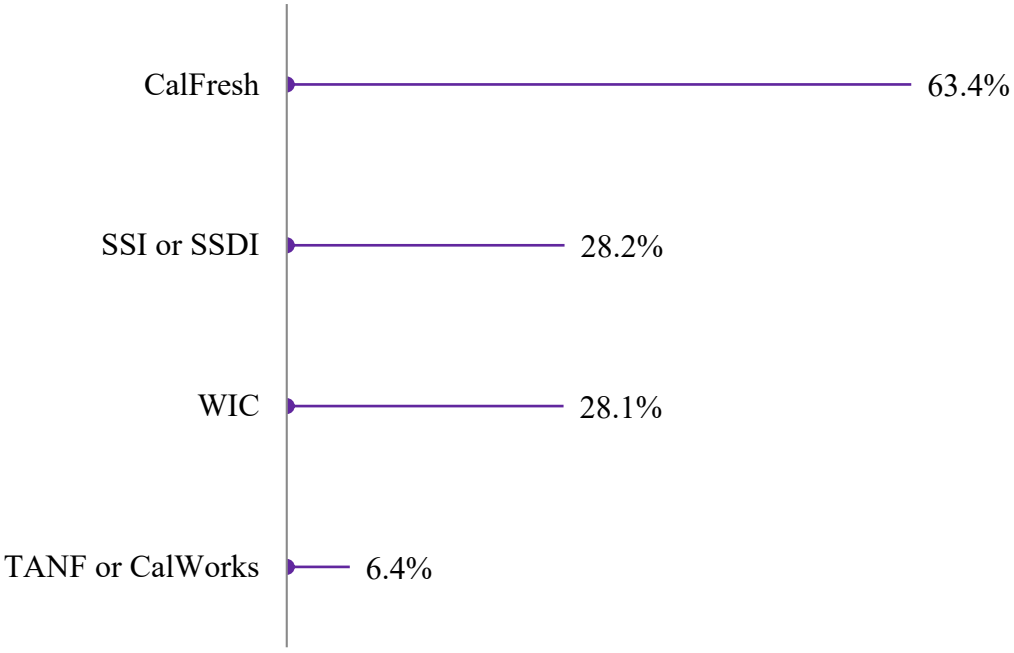


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

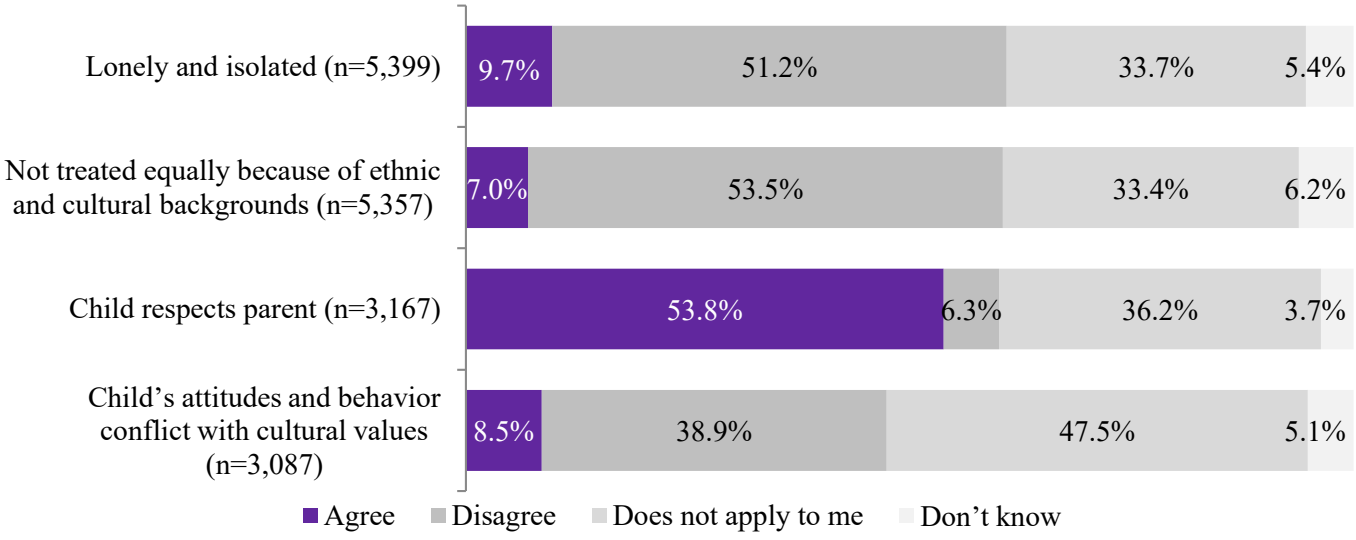


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

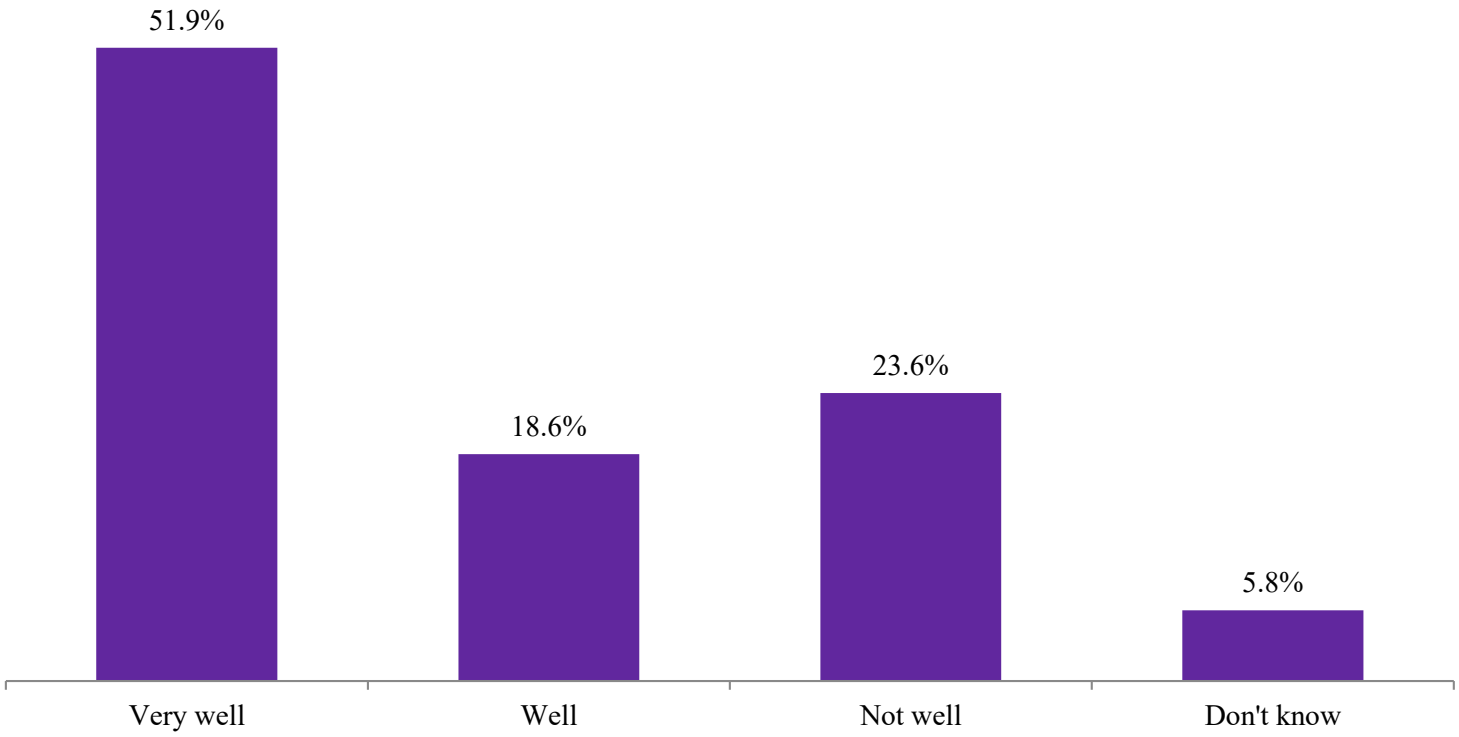


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

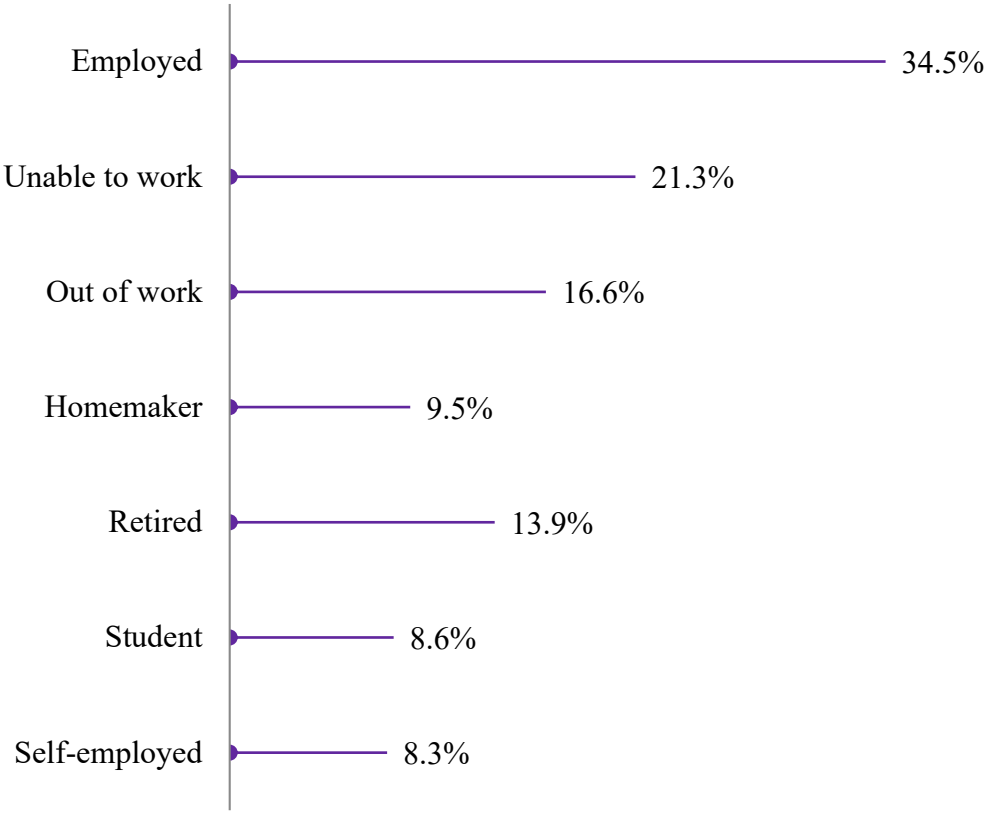
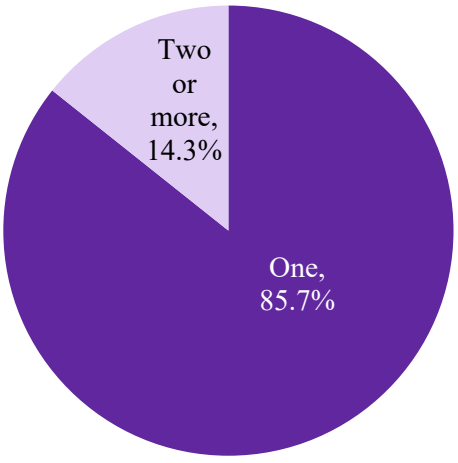
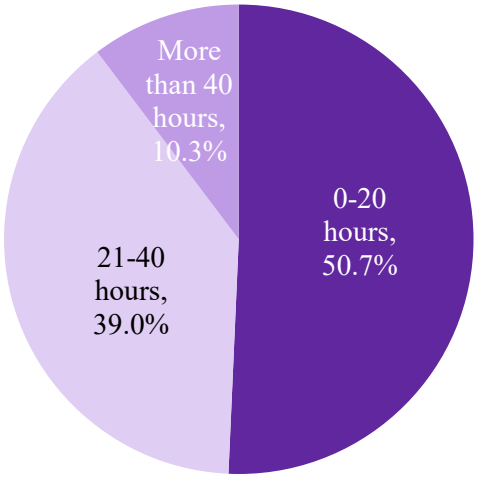


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

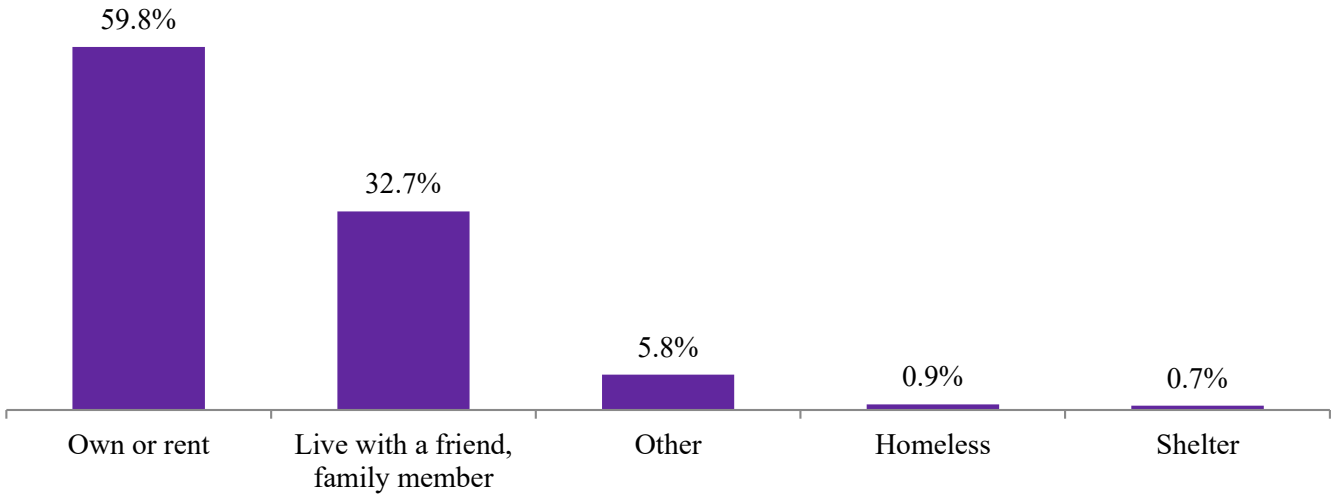
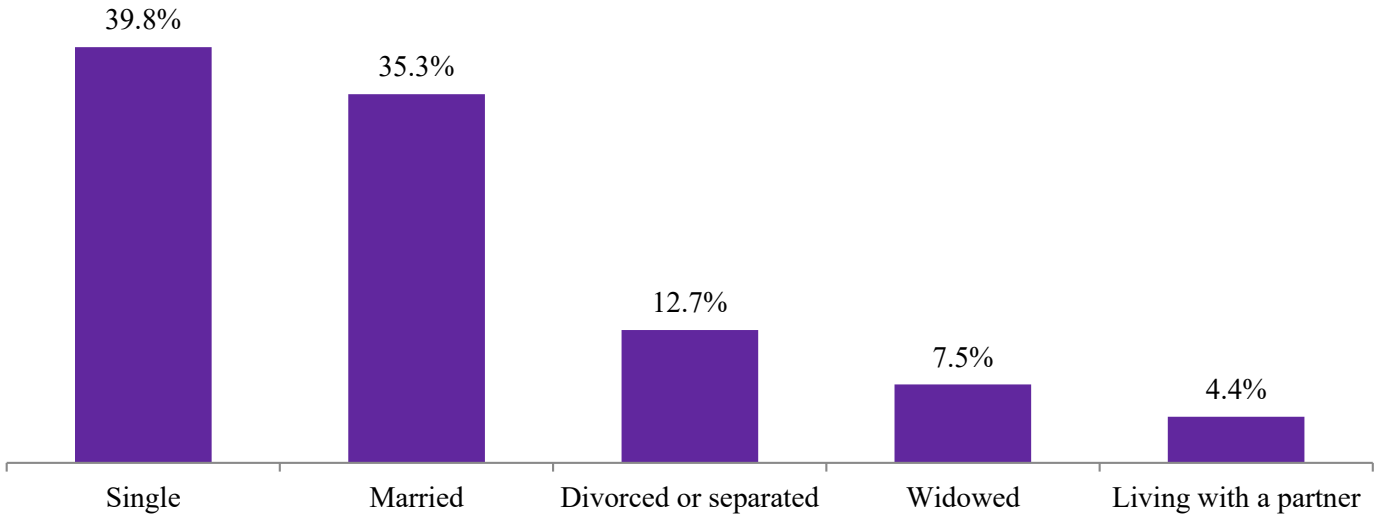


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

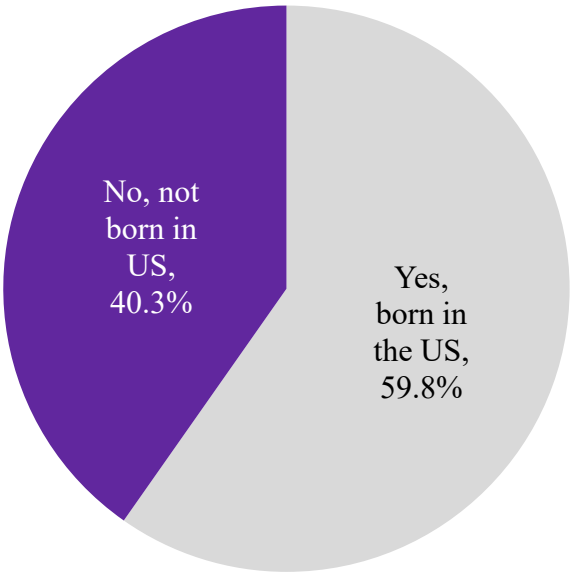
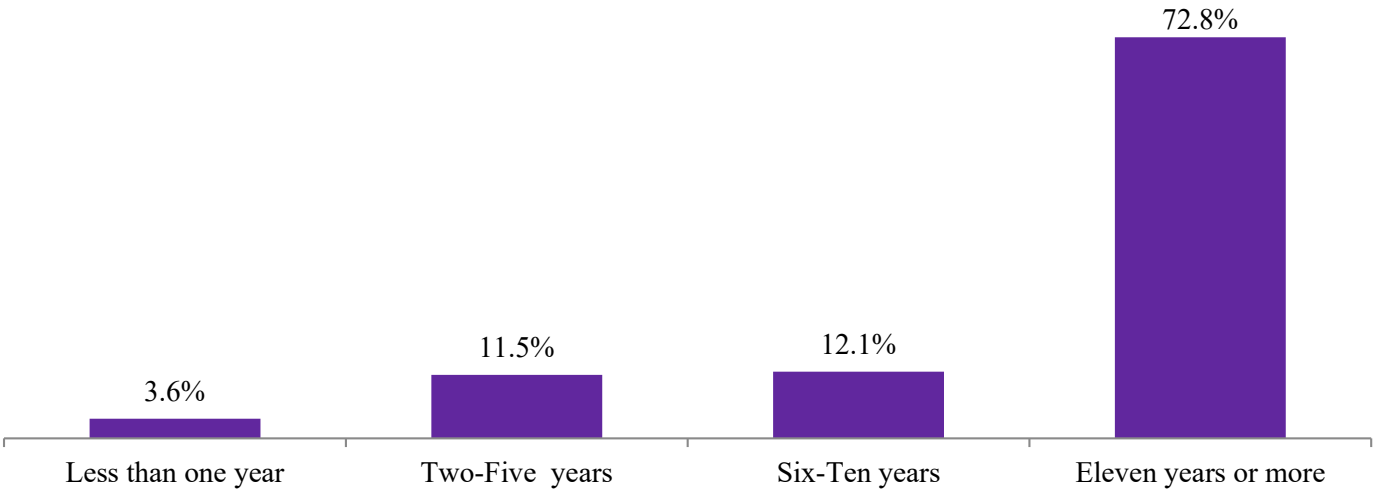


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

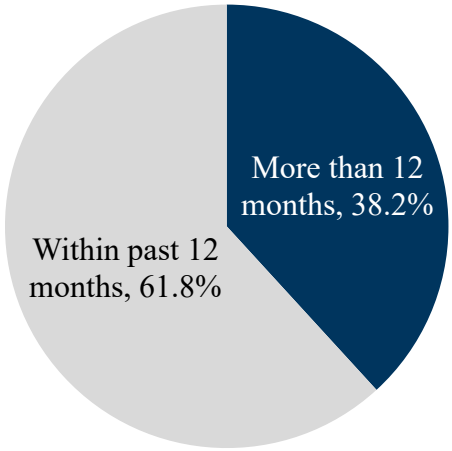
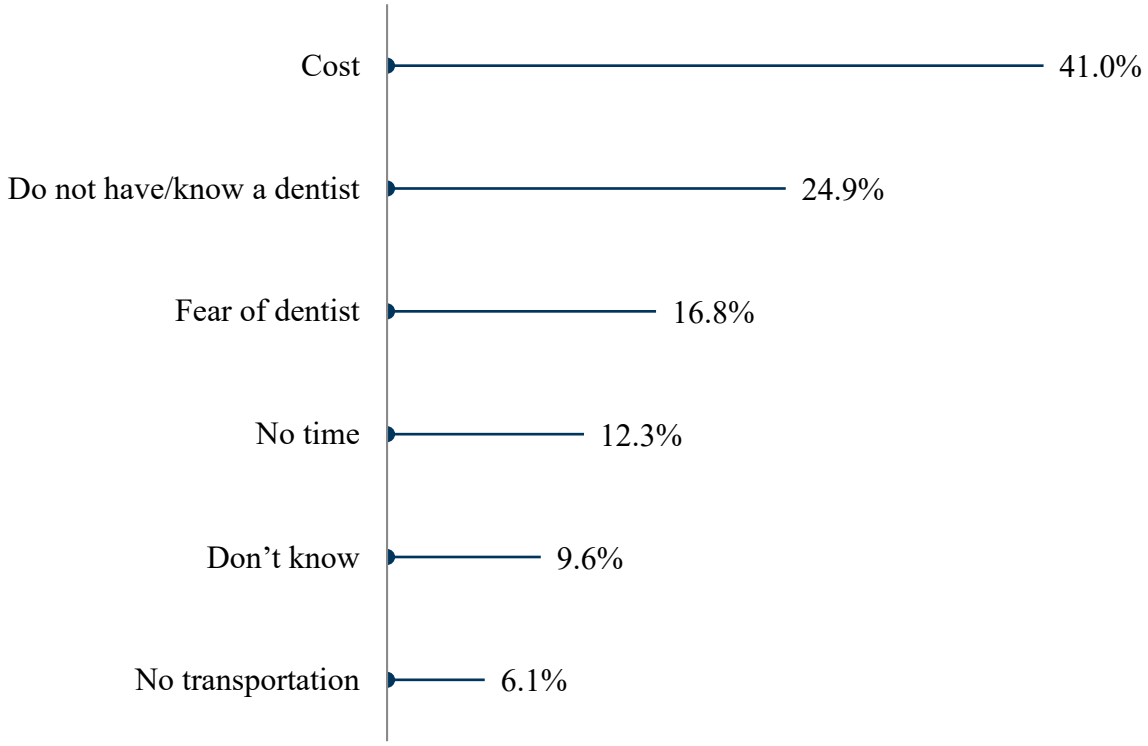
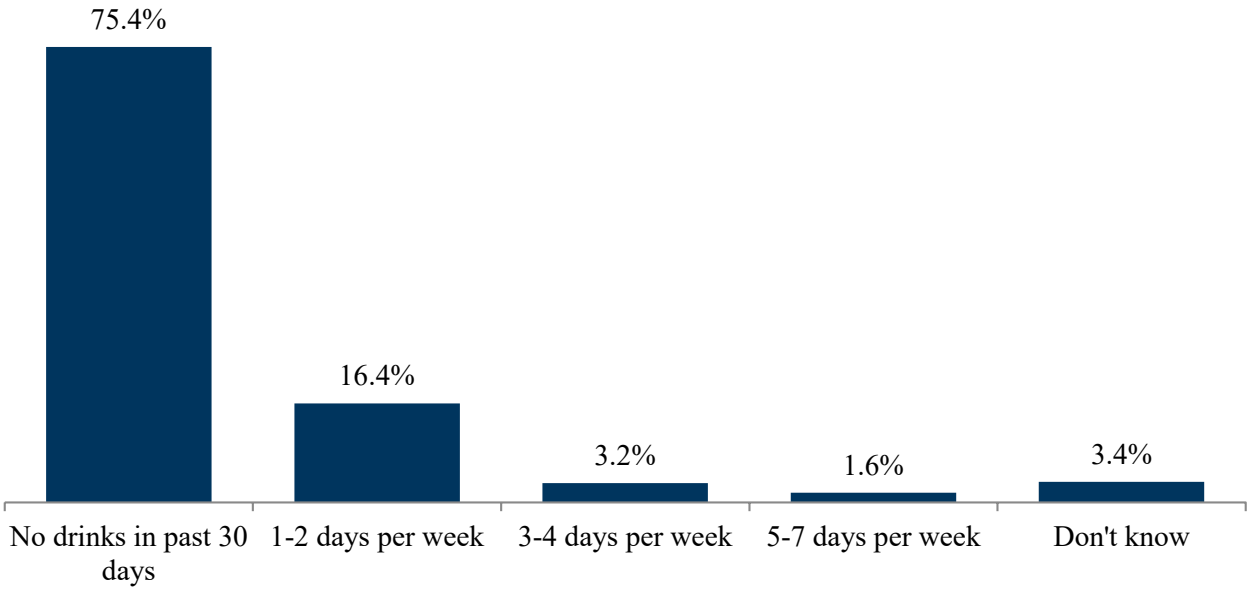


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

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

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

Back to Agenda

Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

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

5/30/2018 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

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

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

Back to Agenda

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

Back to Agenda

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

Back to Agenda

Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

Back to Agenda

CalOptima
A Public Agency
Better. Together.

A Better Study

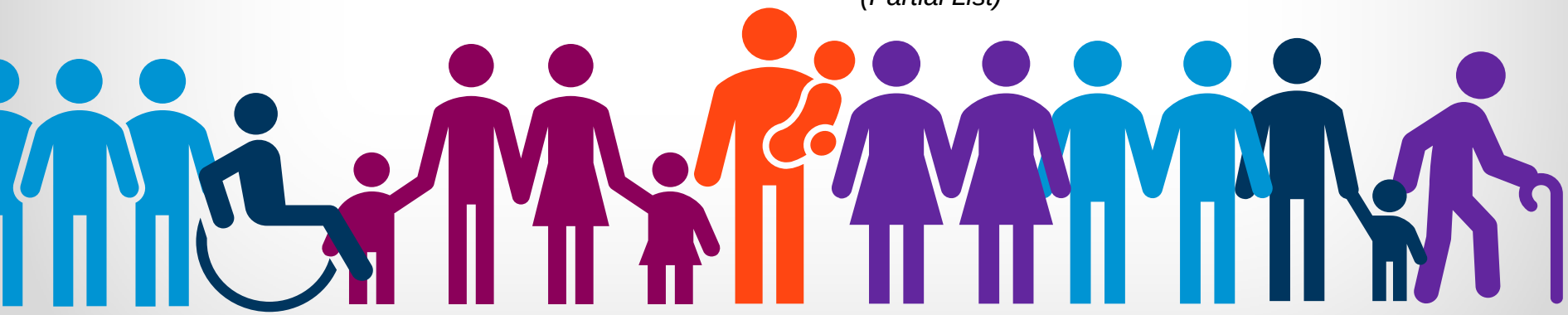
- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

Back to Agenda

More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County

Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

Back to Agenda

CalOptima
A Public Agency
Better. Together.

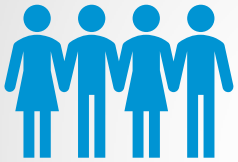
More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

Back to Agenda

More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

Back to Agenda

CalOptima A Public Agency Better. Together.

More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

Back to Agenda

CalOptima
A Public Agency
Better. Together.

More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

Back to Agenda

CalOptima A Public Agency Better. Together.

Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

Back to Agenda

Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Back to Agenda

Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

Back to Agenda

Lack of Awareness (Cont.)

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

25%

Don't have or know of a dentist

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Back to Agenda

Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

Back to Agenda

Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Back to Agenda

Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

Back to Agenda

CalOptima
A Public Agency
Better. Together.

RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

Back to Agenda

CalOptima
A Public Agency
Better. Together.

RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

Back to Agenda

CalOptima
A Public Agency
Better. Together.

RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category
Children's Mental Health

Back to Agenda

CalOptima
A Public Agency
Better. Together.

RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

Back to Agenda

RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

Back to Agenda

CalOptima A Public Agency Better. Together.

RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category
Supporting the Safety Net

Back to Agenda

RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category
Supporting the Safety Net

Back to Agenda

CalOptima
A Public Agency
Better. Together.

RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category
Children's Health

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

Back to Agenda

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

CalOptima
A Public Agency
Better. Together.

In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

Back to Agenda

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

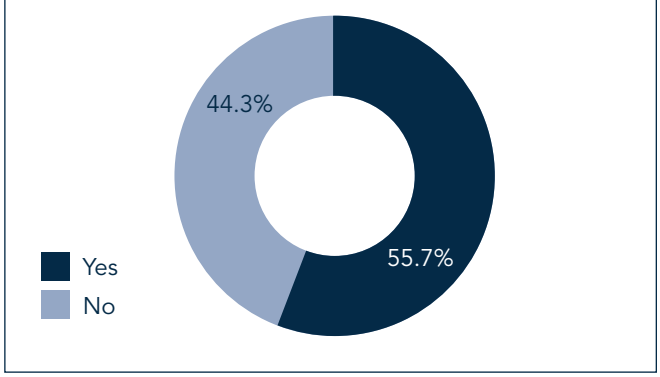
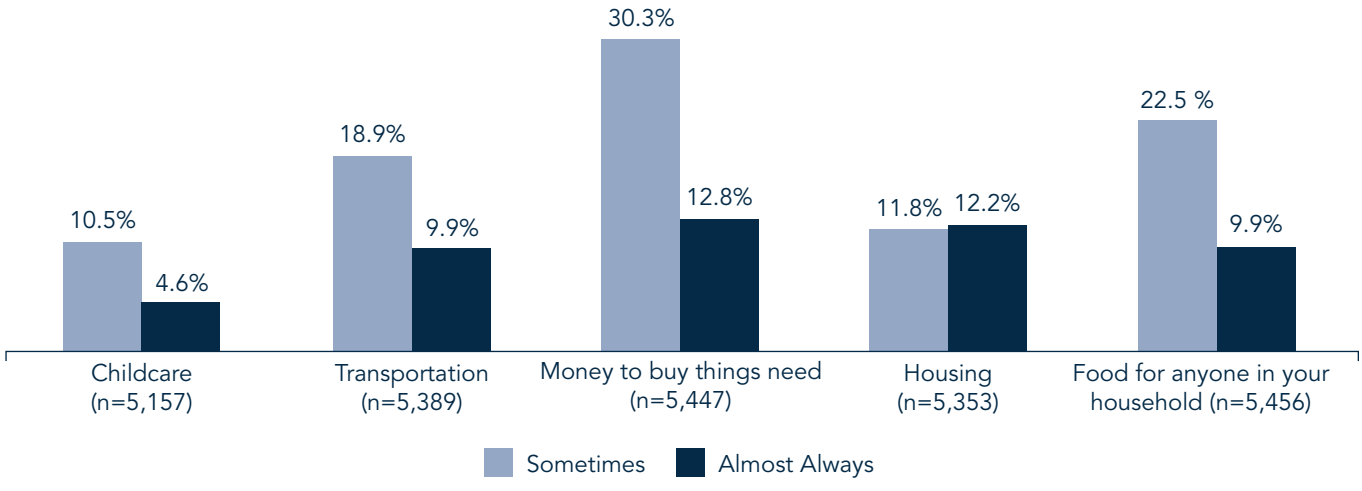


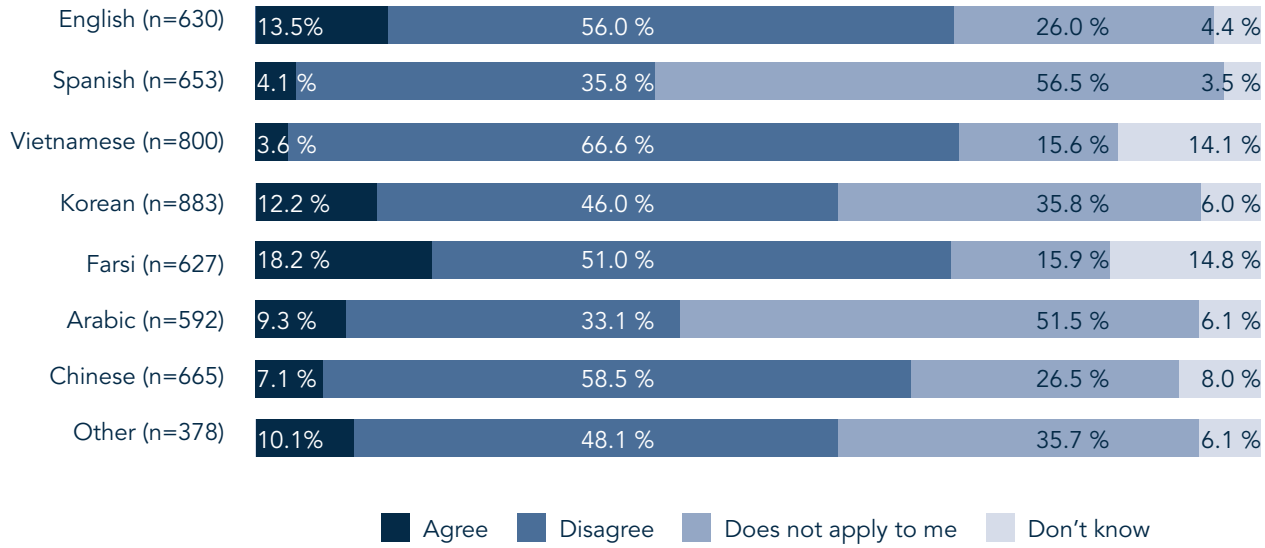
Exhibit 3: Percent of members who needed help with basic needs in the past six months



Back to Agenda

Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

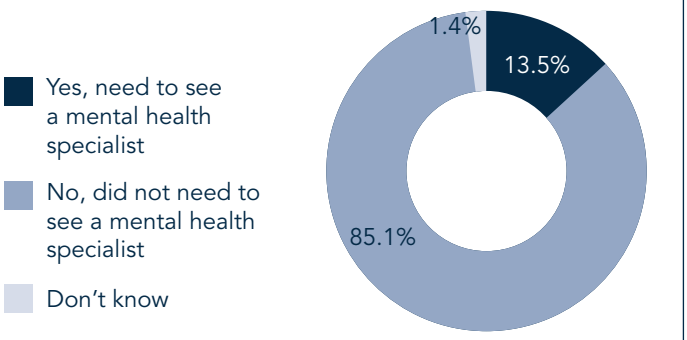
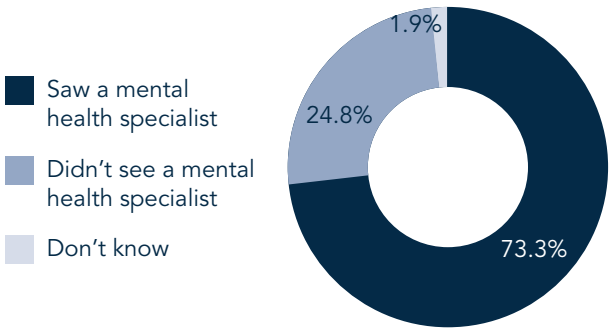
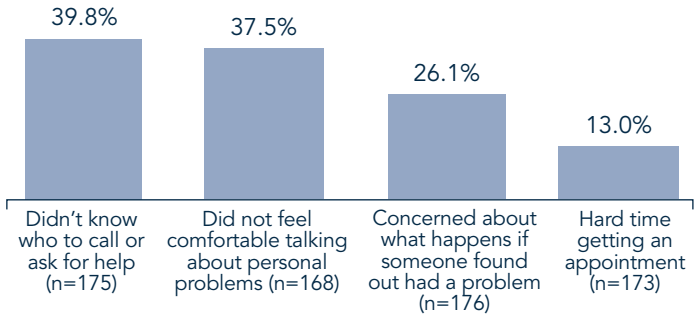


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

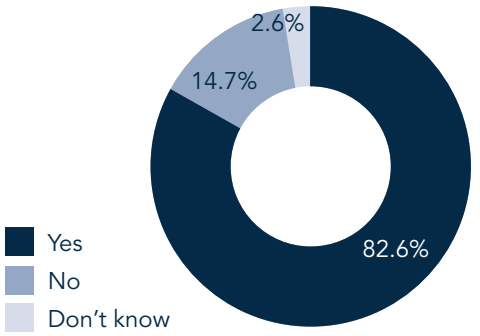
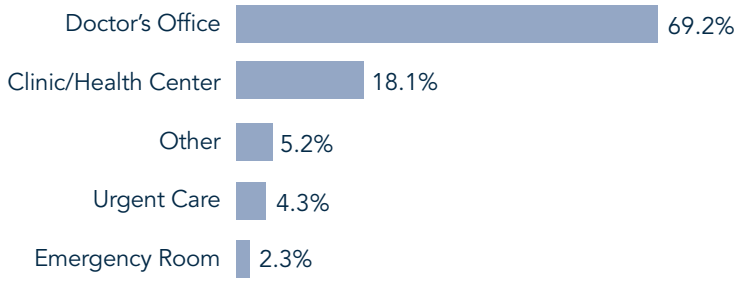


Exhibit 9: Where respondents go to see their doctor (n=5,743)

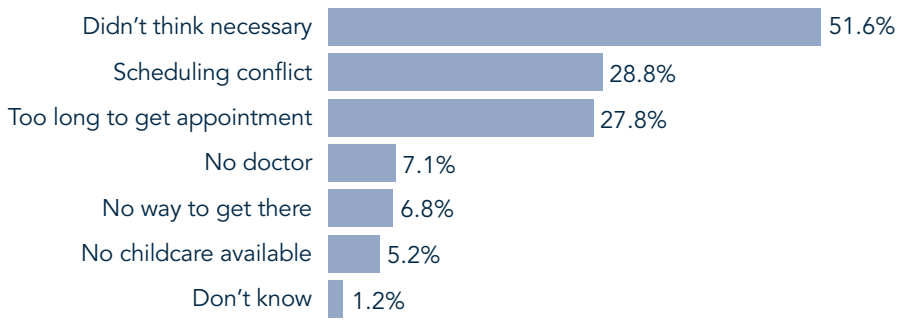


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

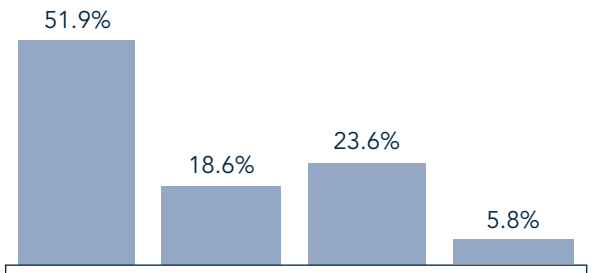
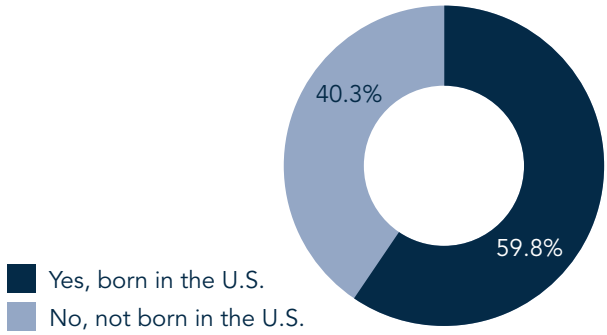


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

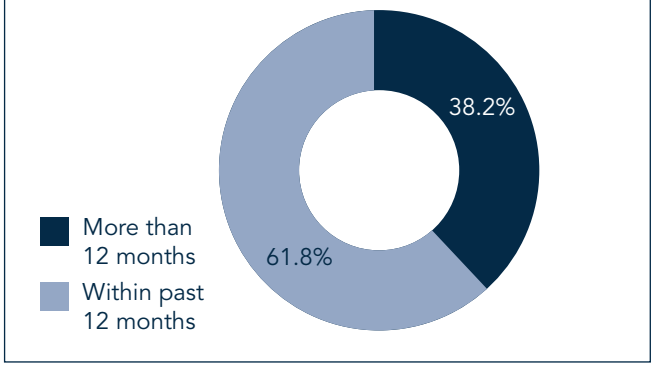
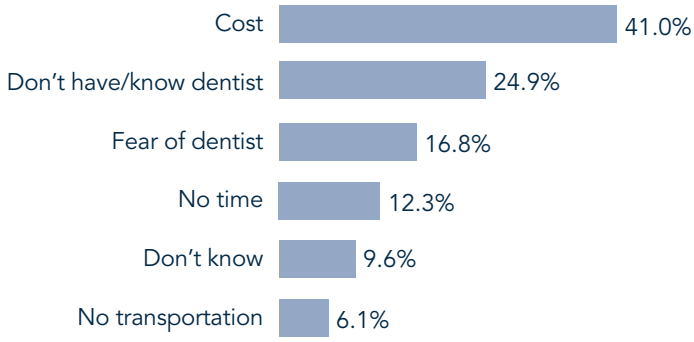


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

DRAFT

harder + co | community research

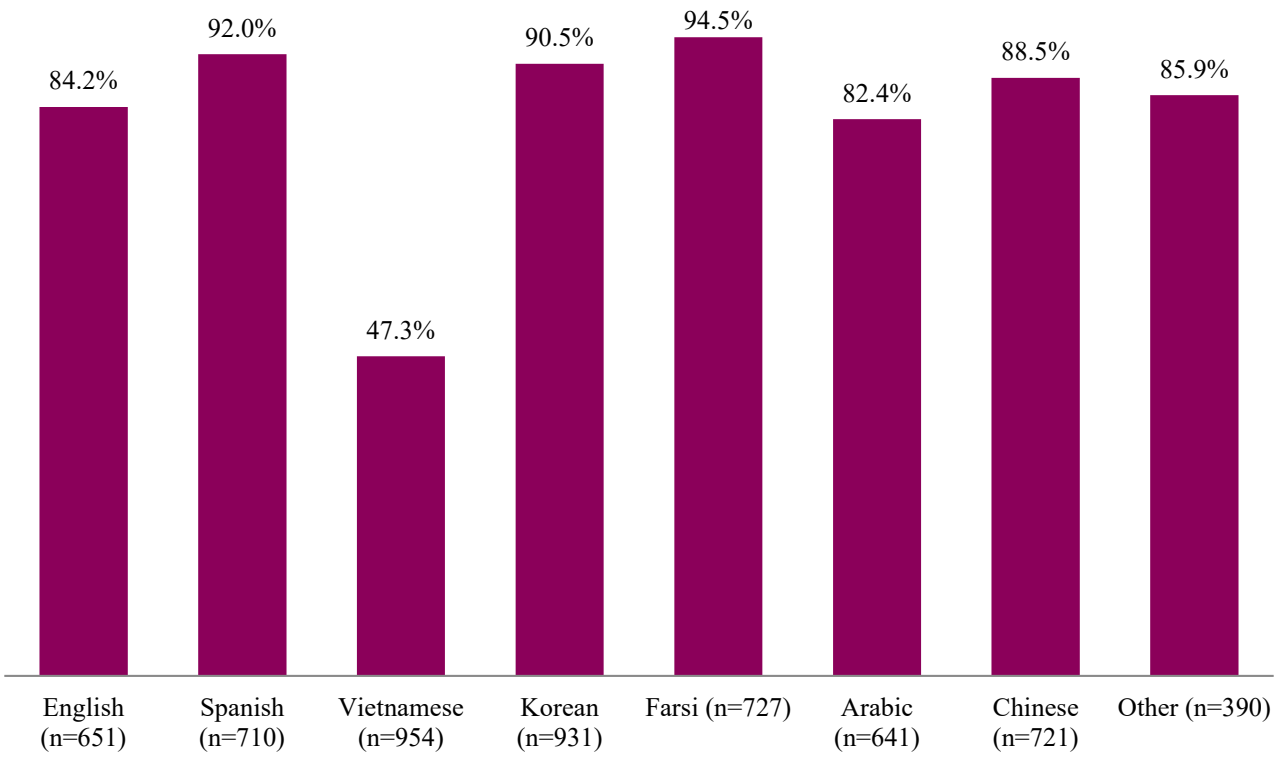
CalOptima A Public Agency Better. Together.

Back to Agenda

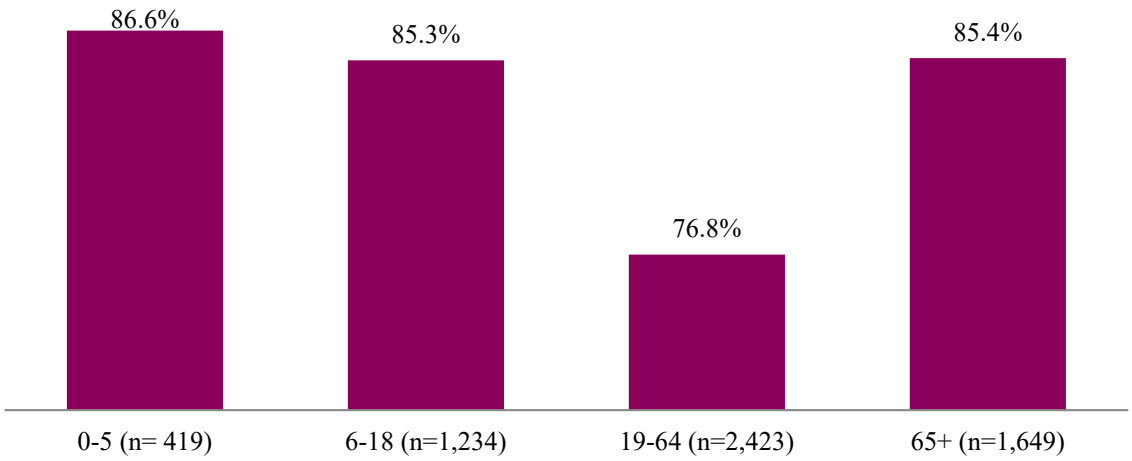
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

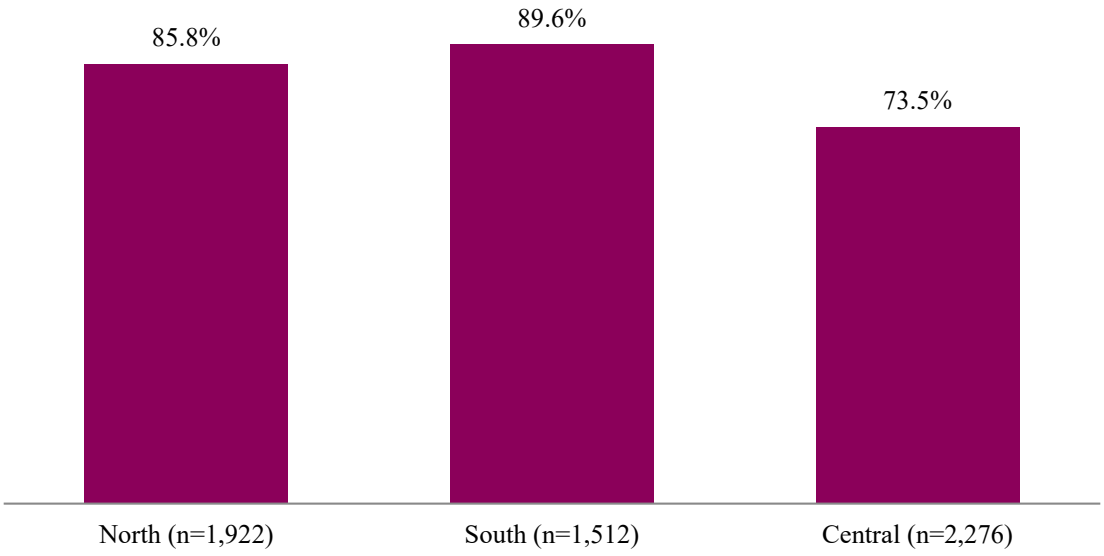


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

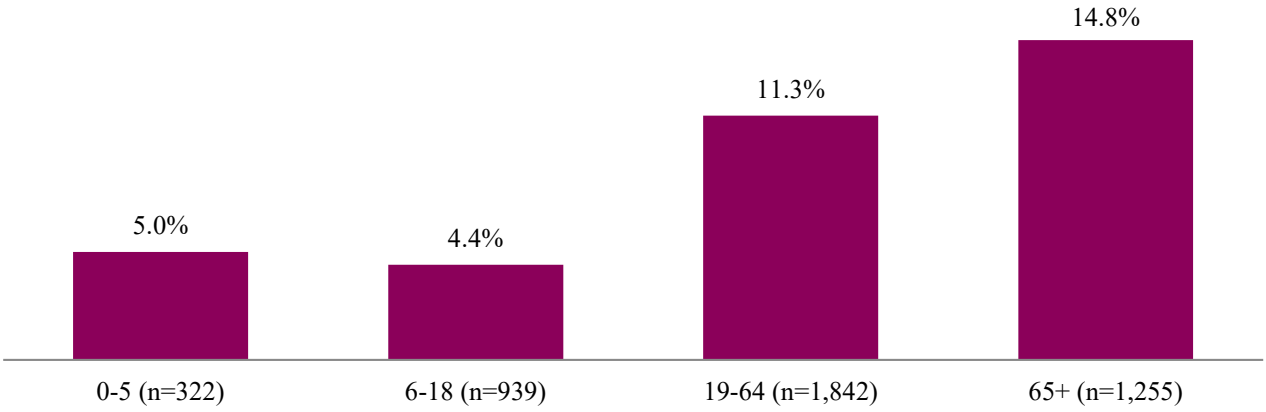
Region:

Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

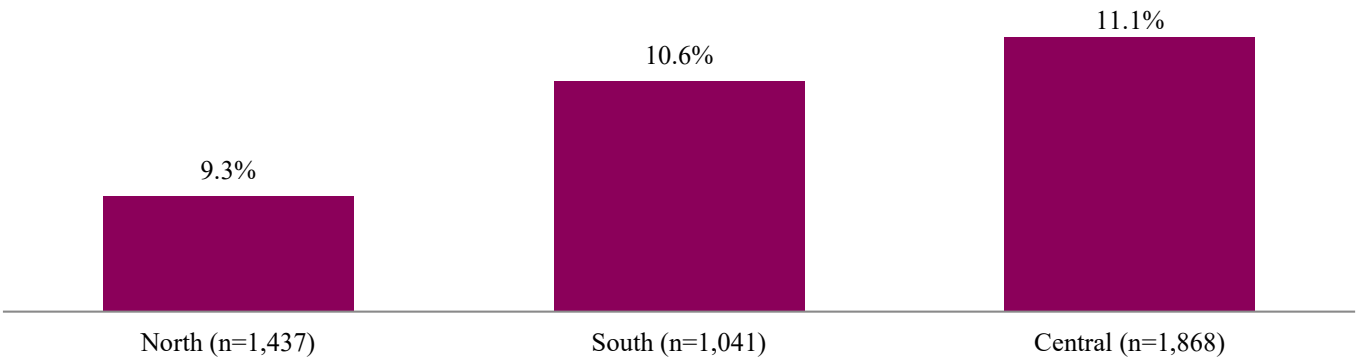
Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

CalOptima language:

Age Category:



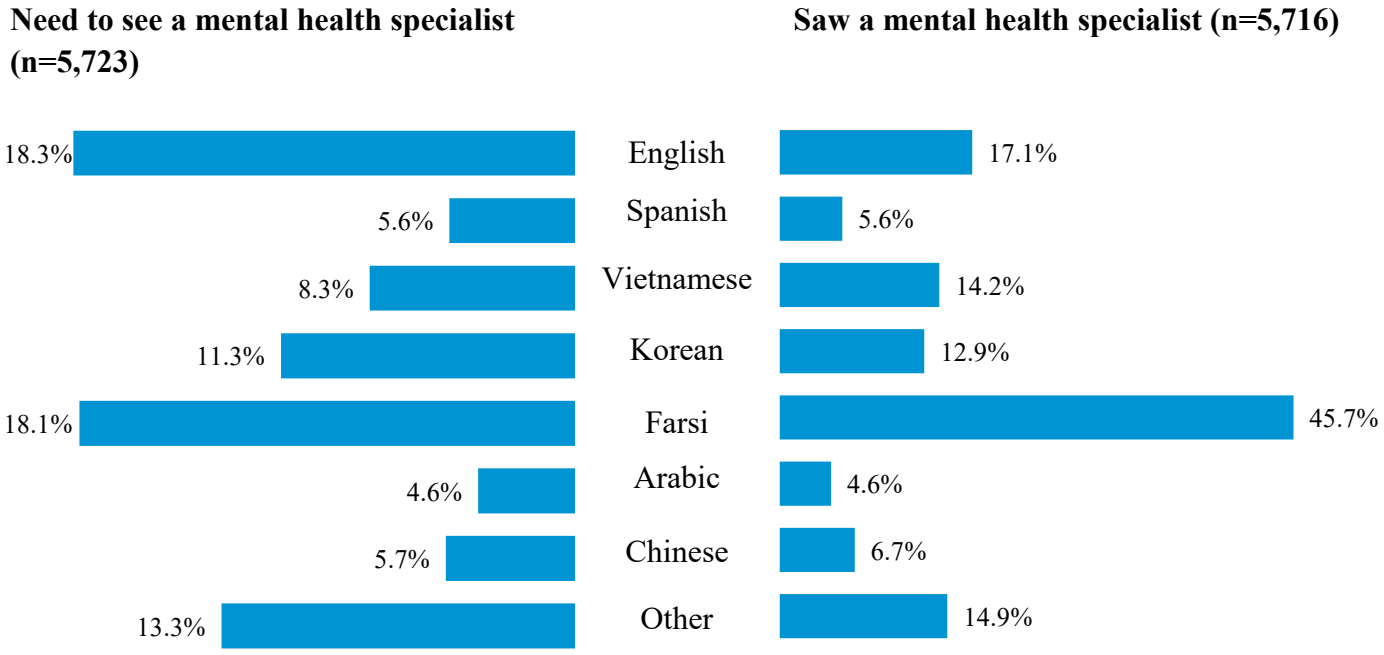
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

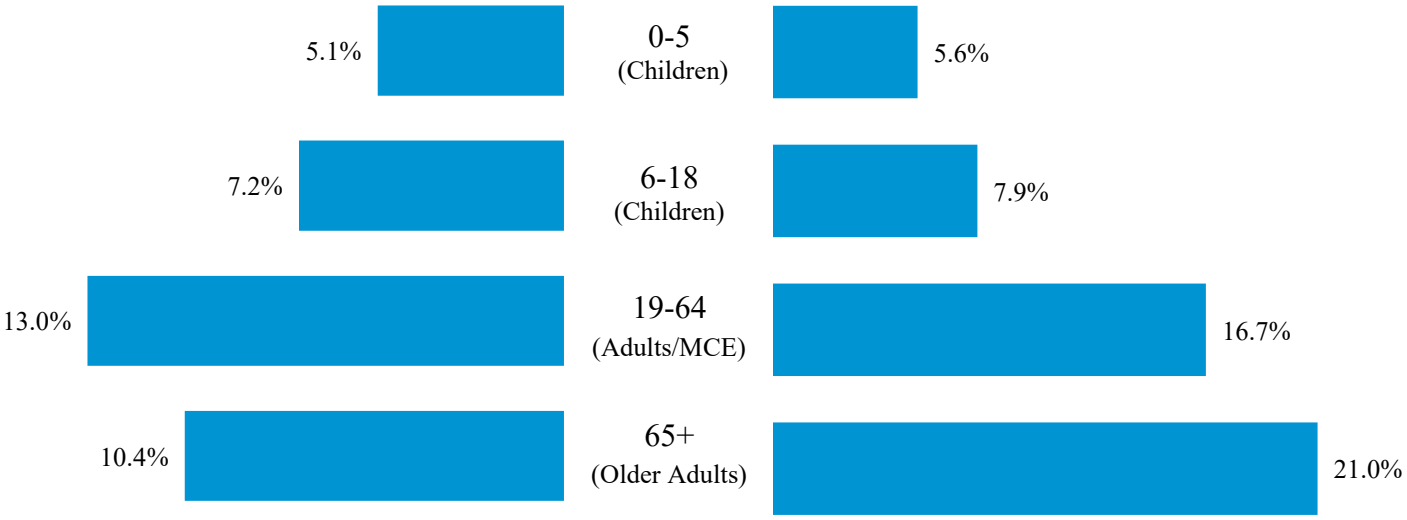


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

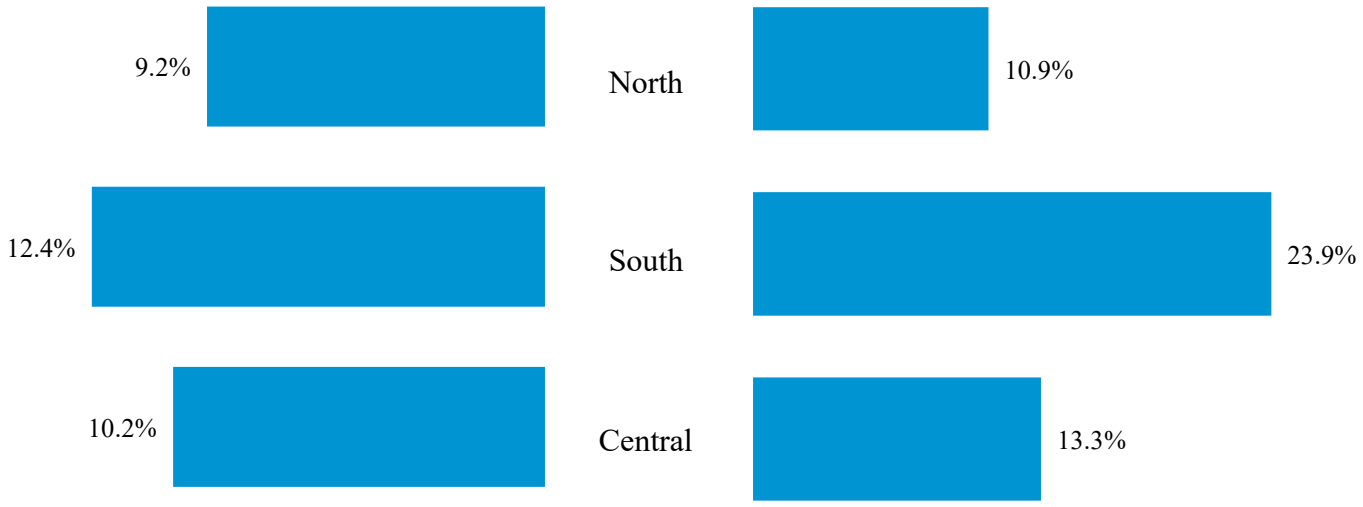
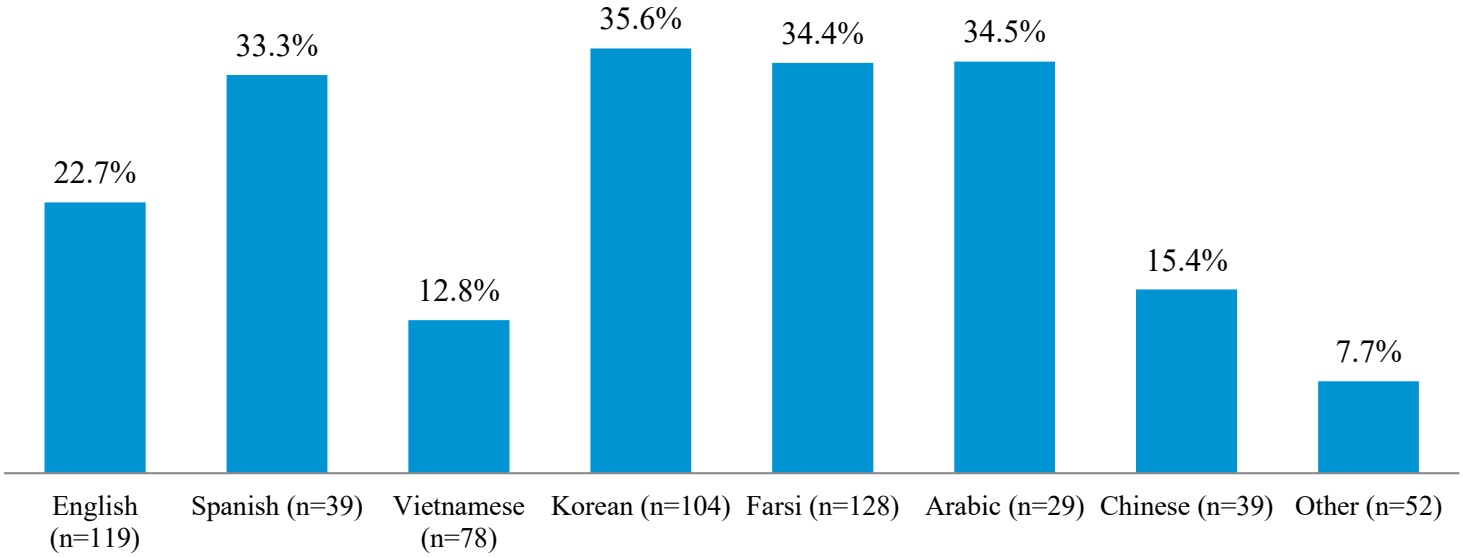
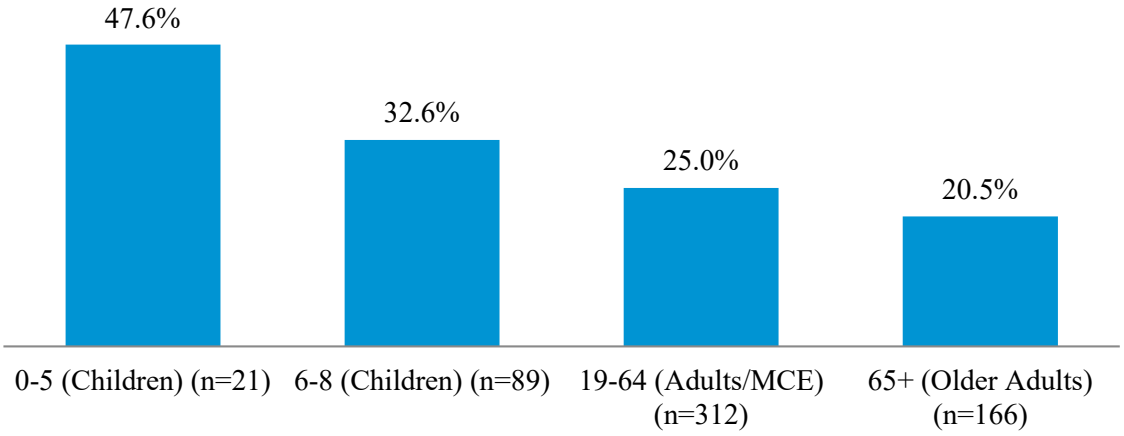


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

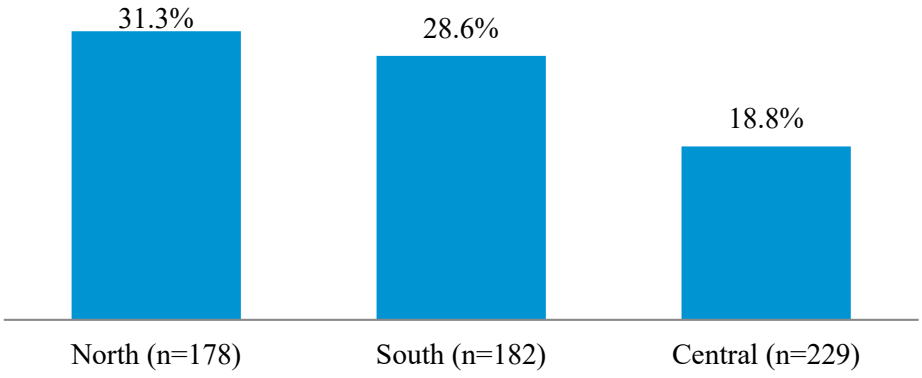
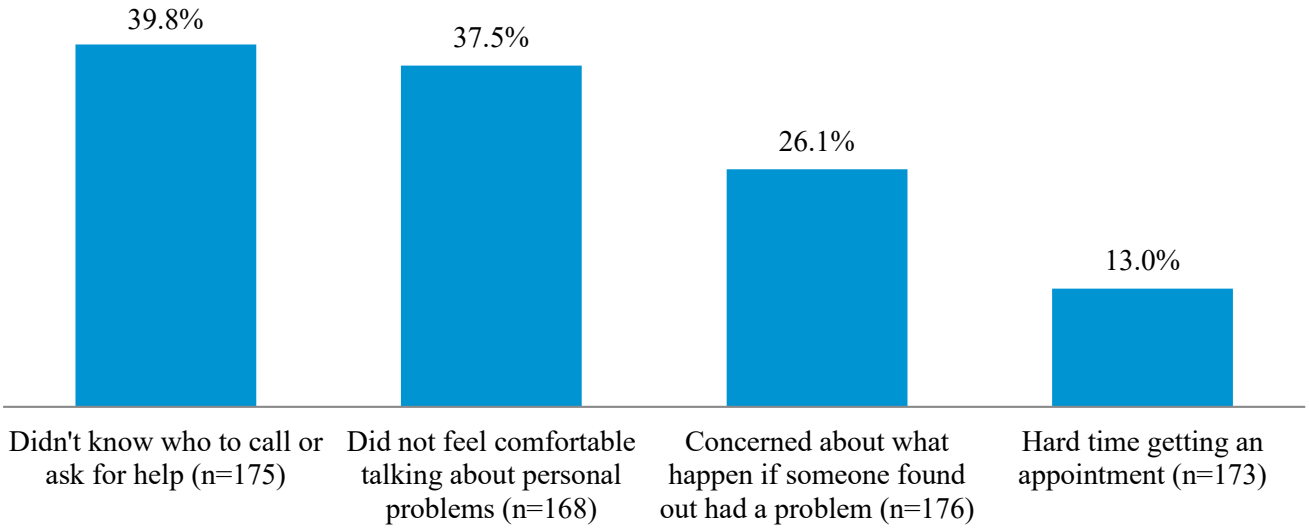


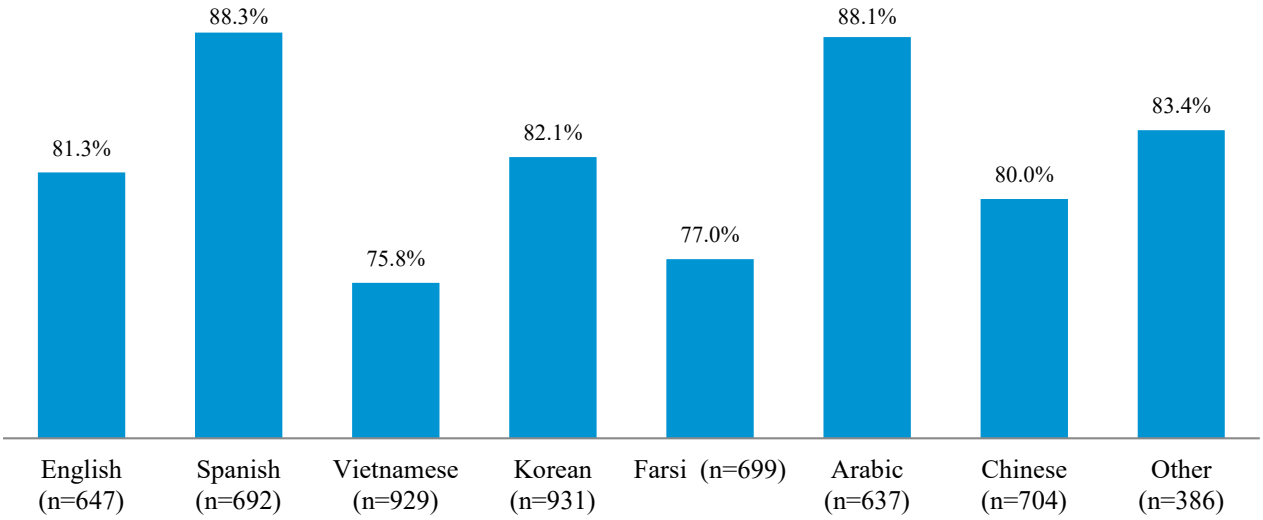
Exhibit 11. Reasons why members didn't see mental health specialist[7]



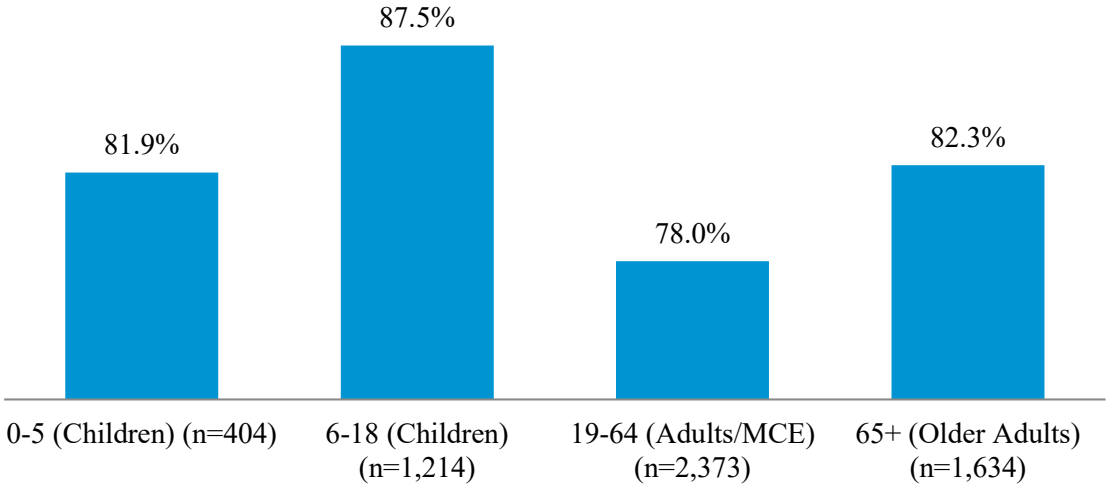
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

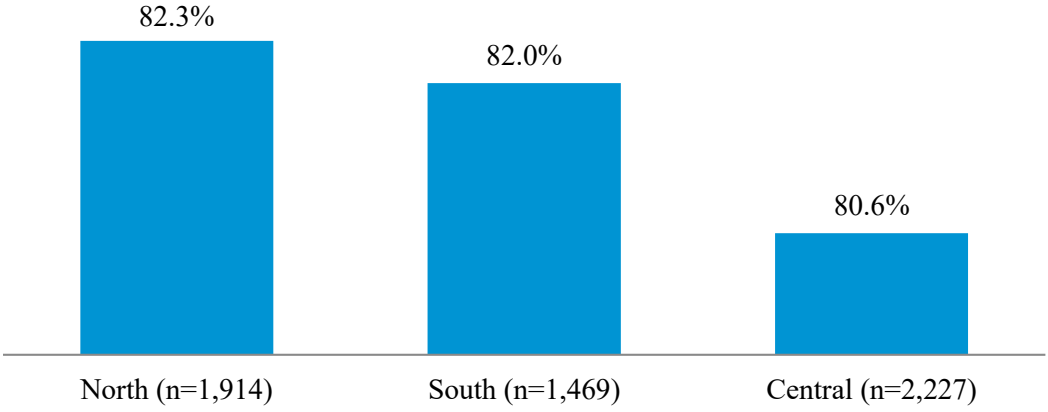
CalOptima language:



Age Category:



Region:

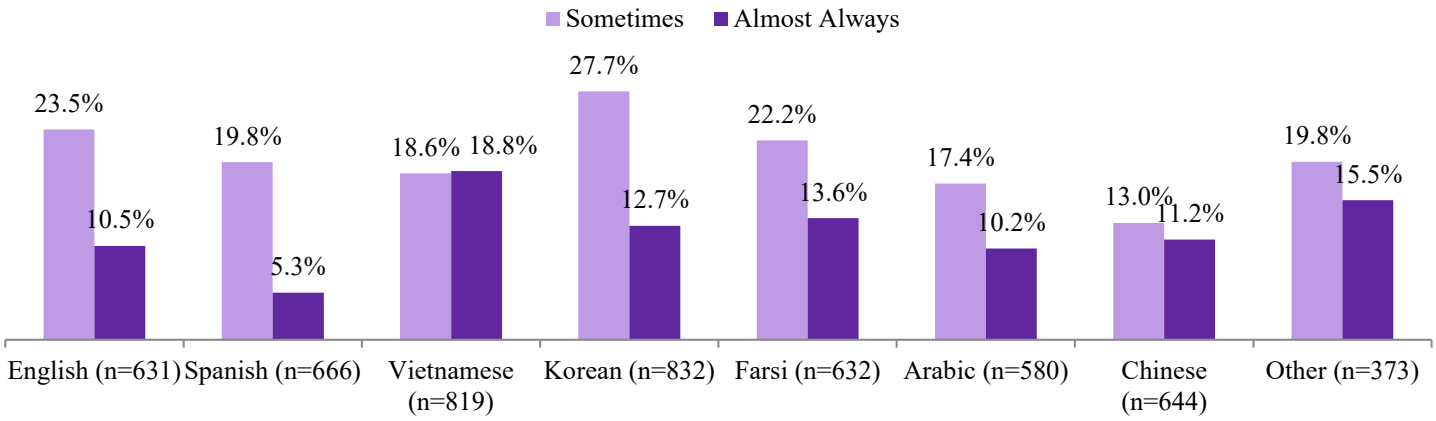


Social Determinants of Health

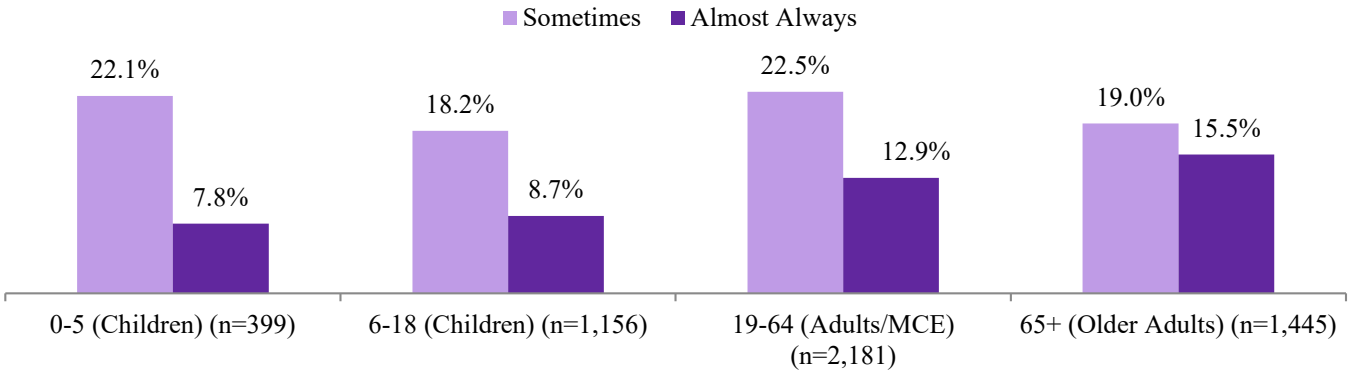
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

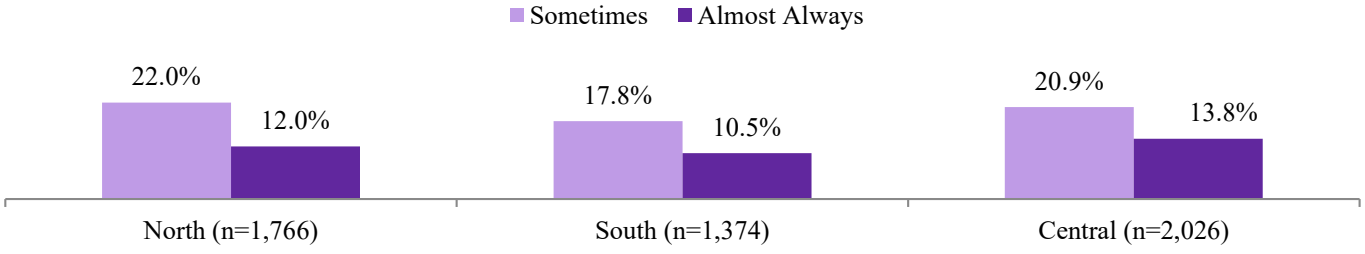
CalOptima language:



Age Category:

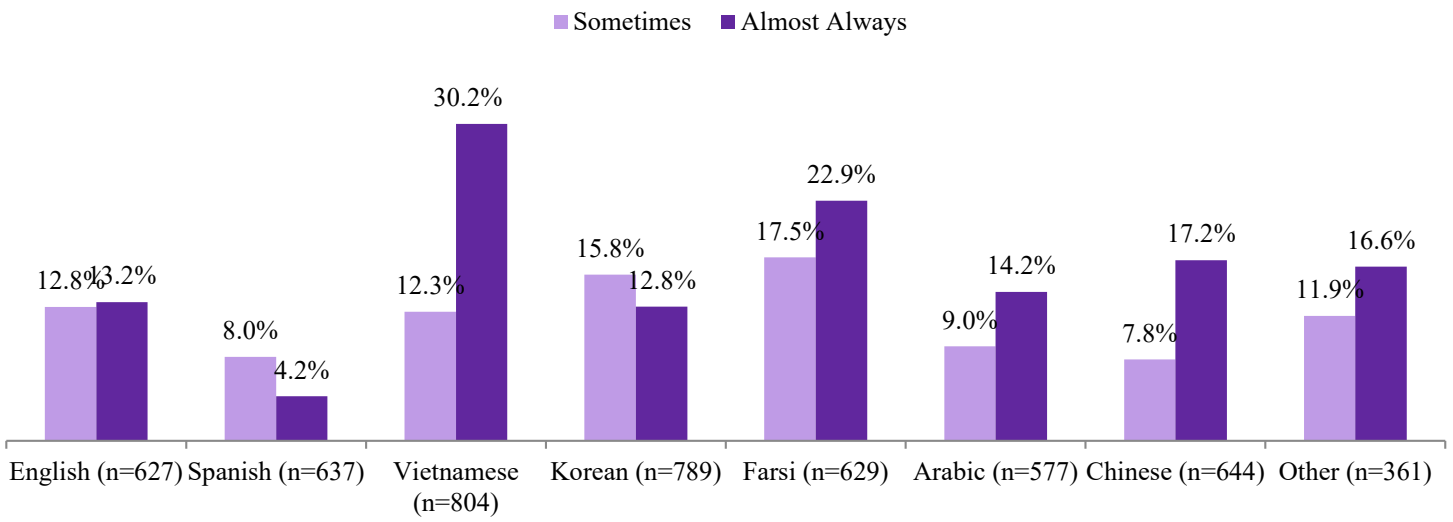


Region:

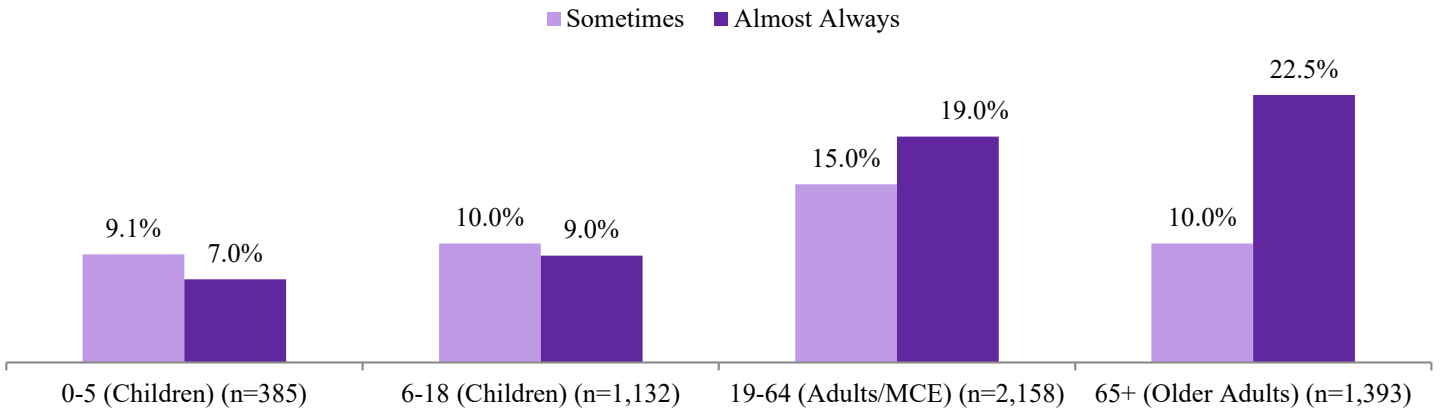


Housing:

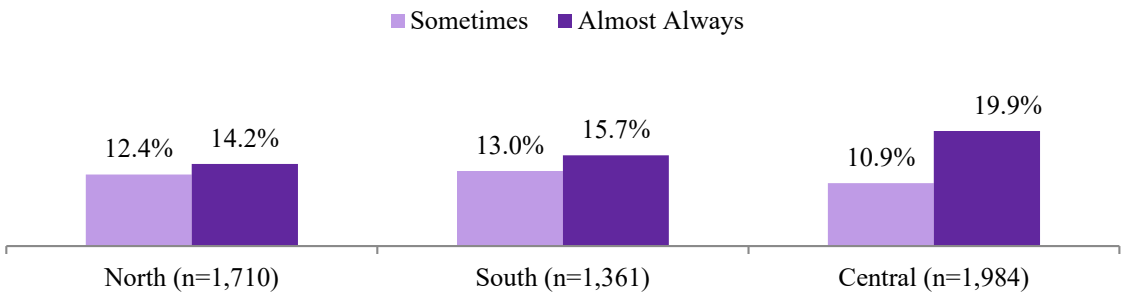
CalOptima language:



Age Category:

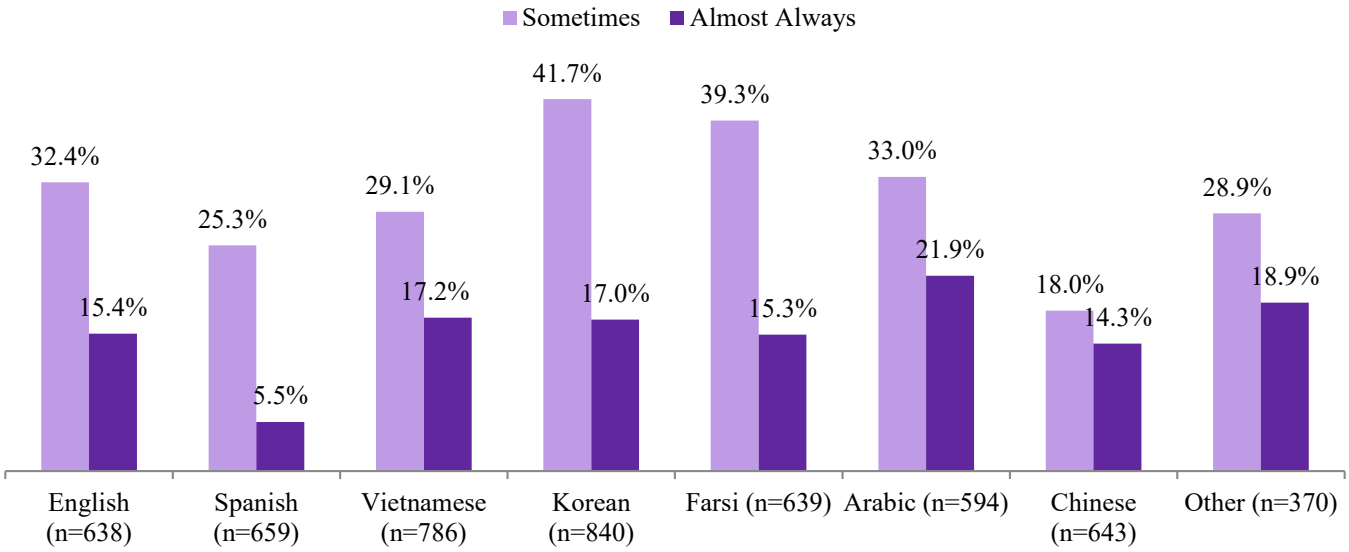


Region:

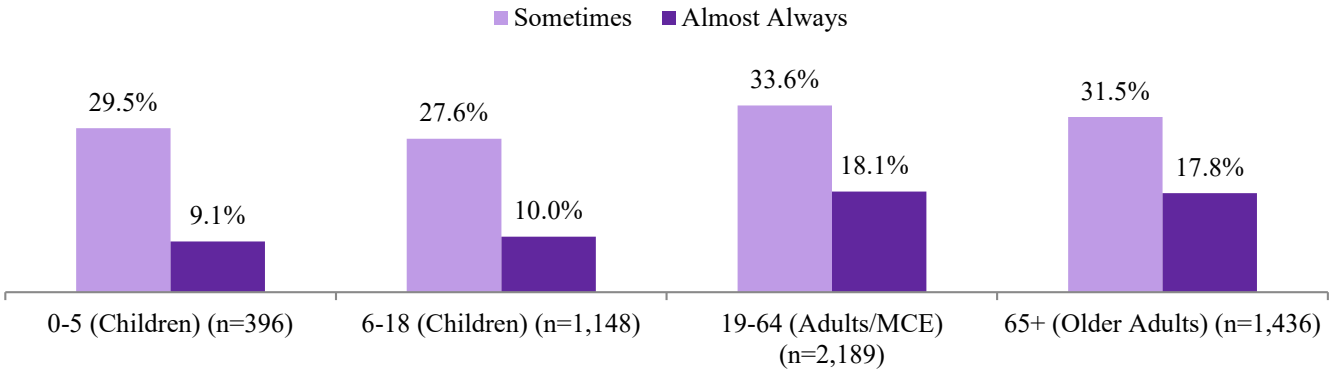


Money to buy things need:

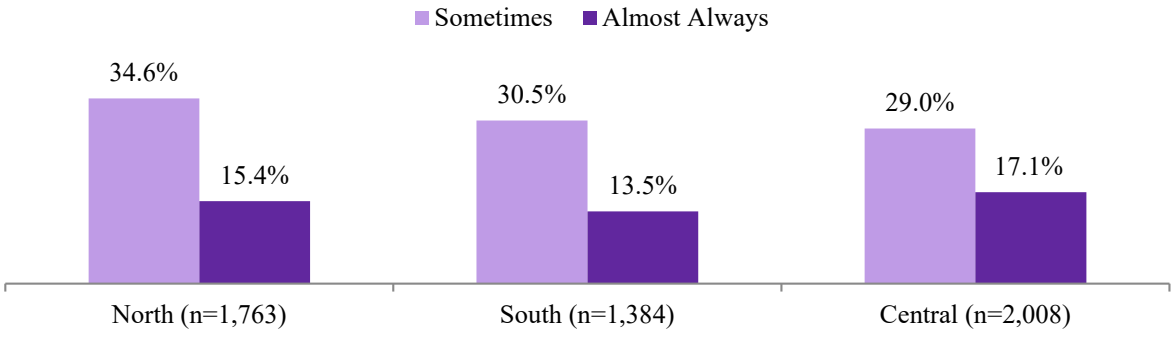
CalOptima language:



Age Category:

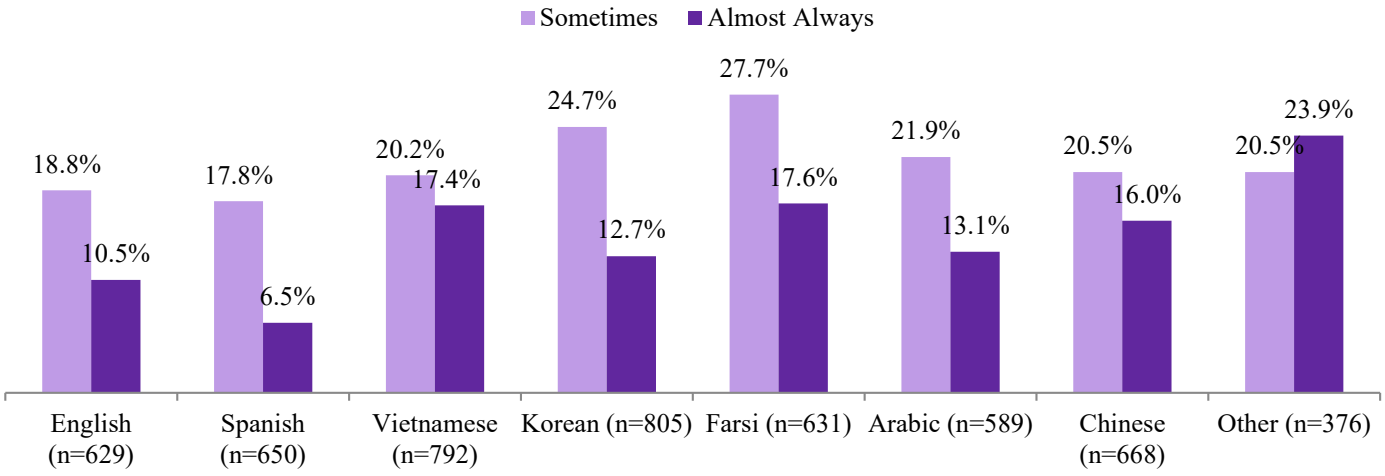


Region:

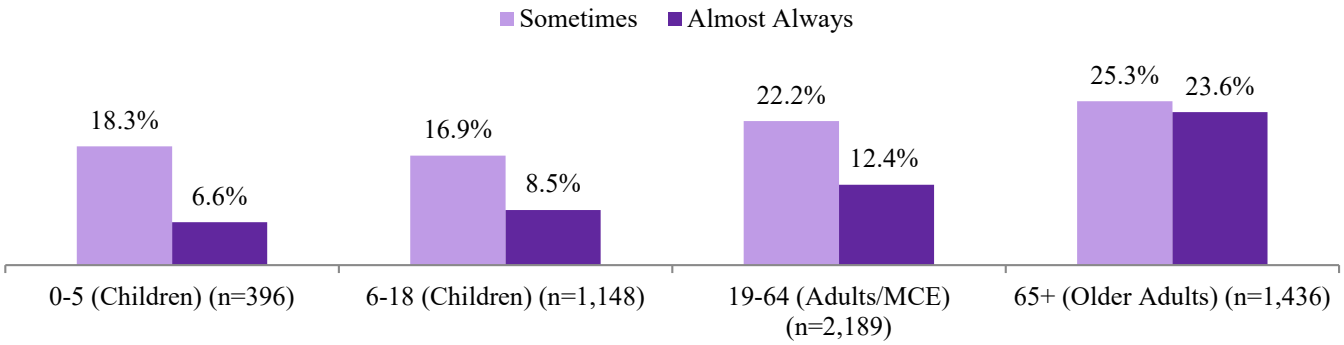


Transportation:

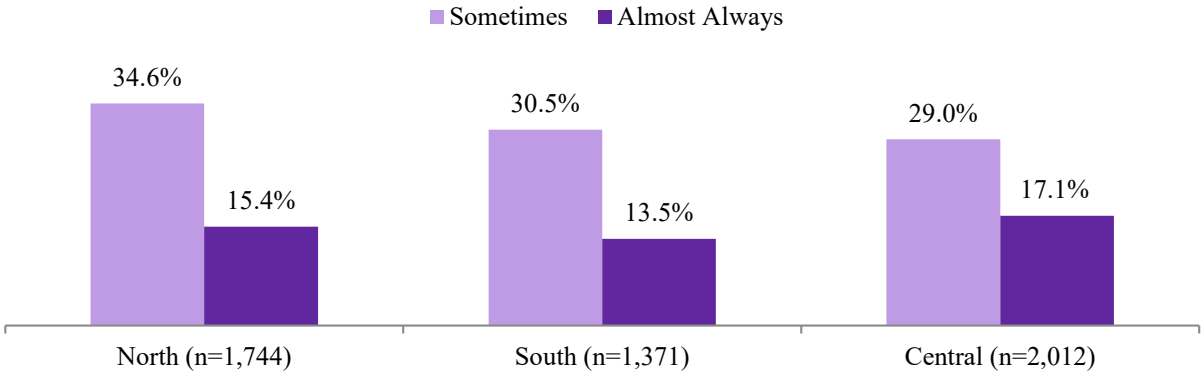
CalOptima language:



Age Category:

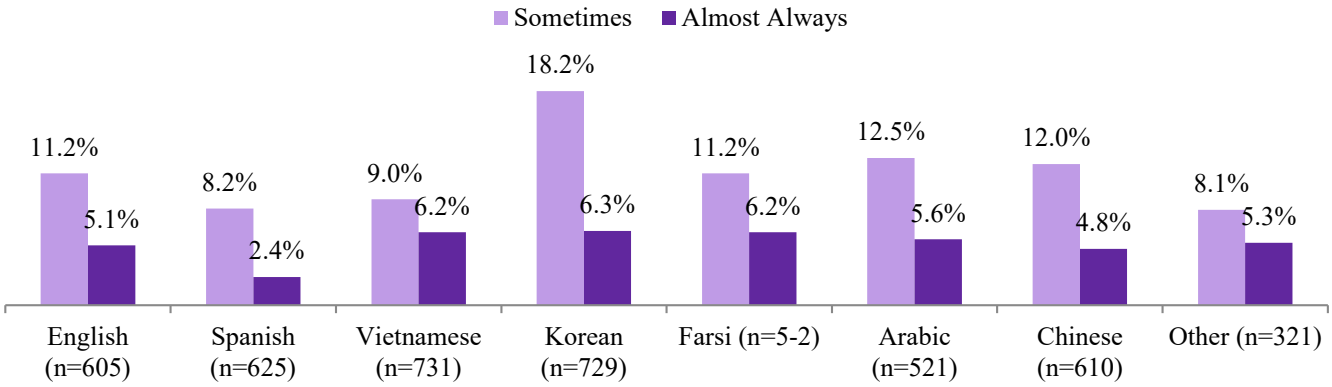


Region:

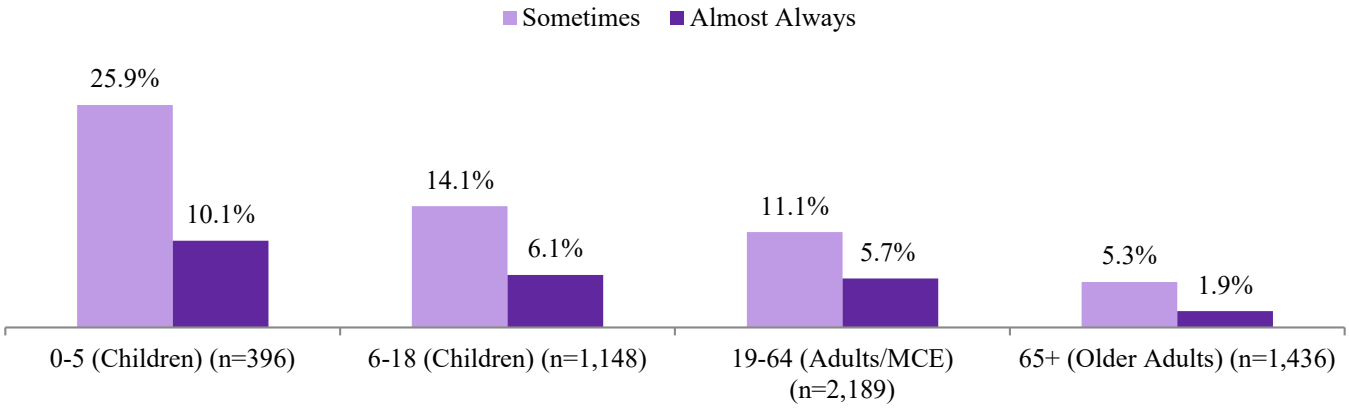


Child care:

CalOptima language:



Age Category:



Region:

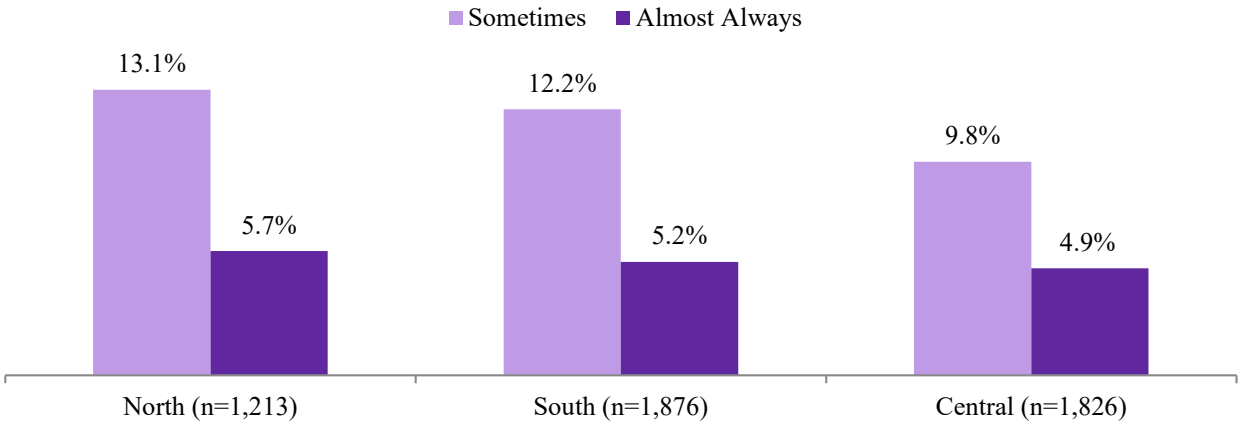
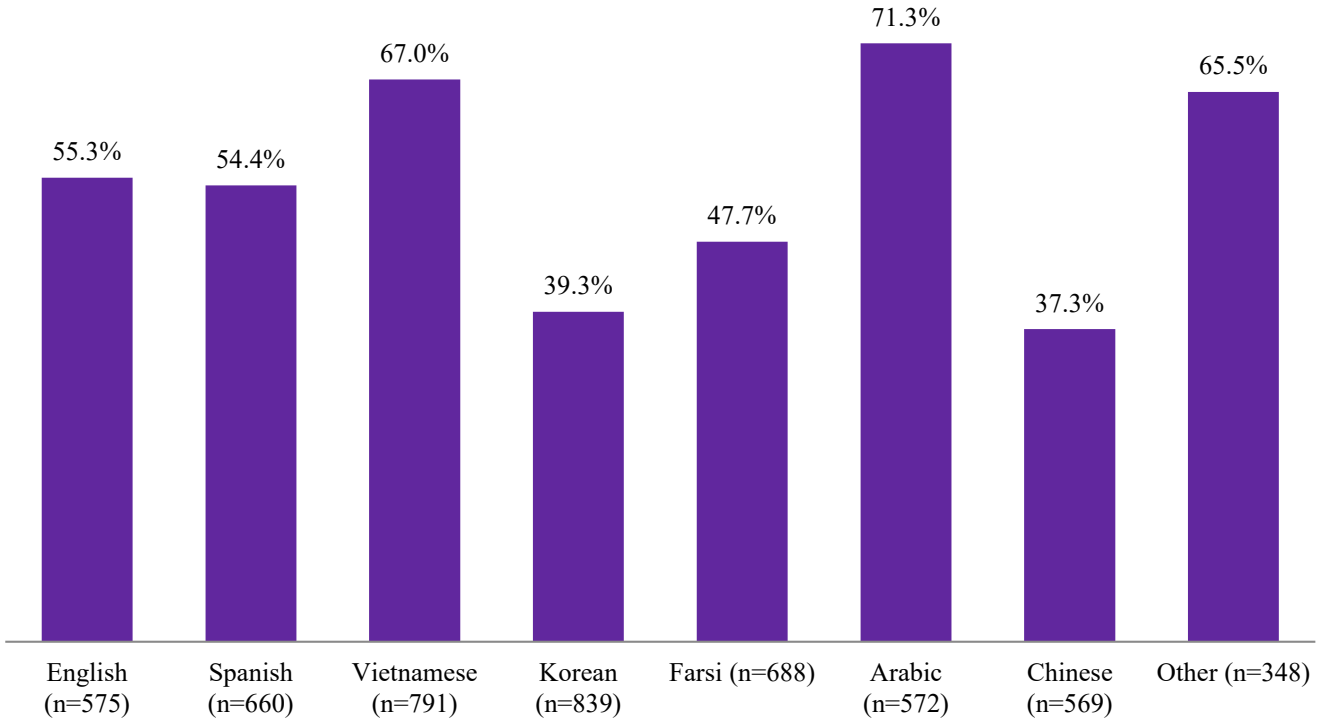


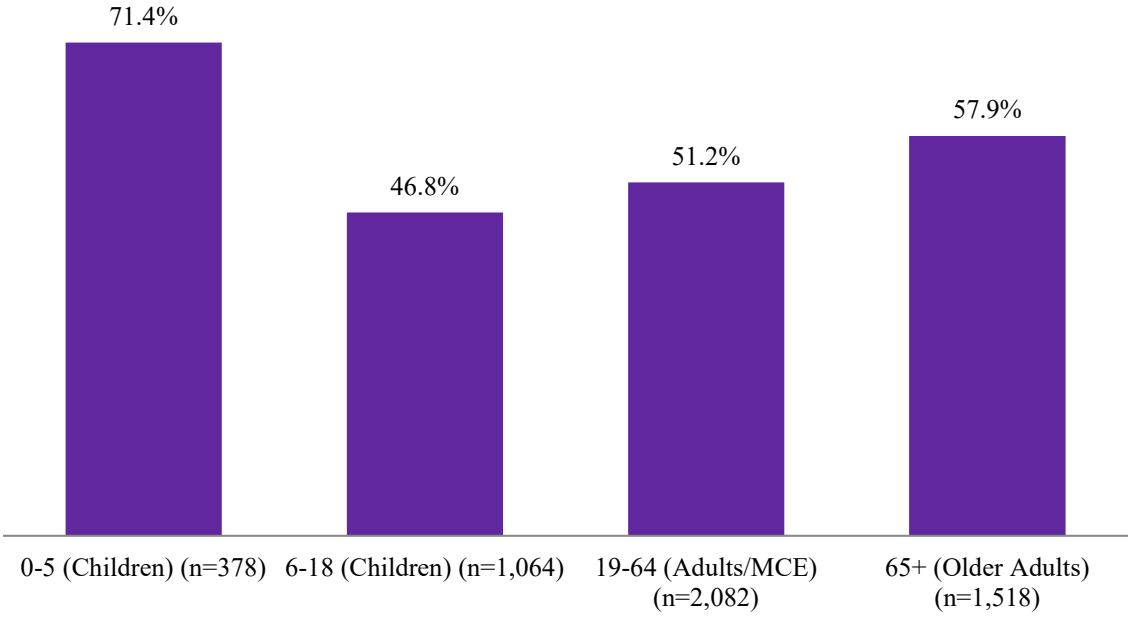
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

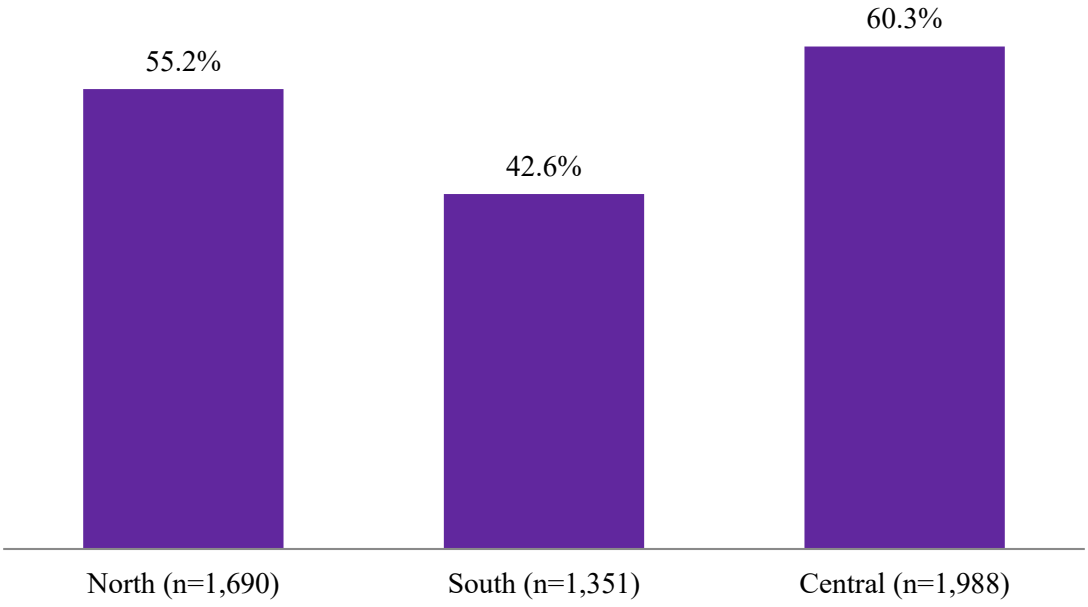
CalOptima language:



Age Category:



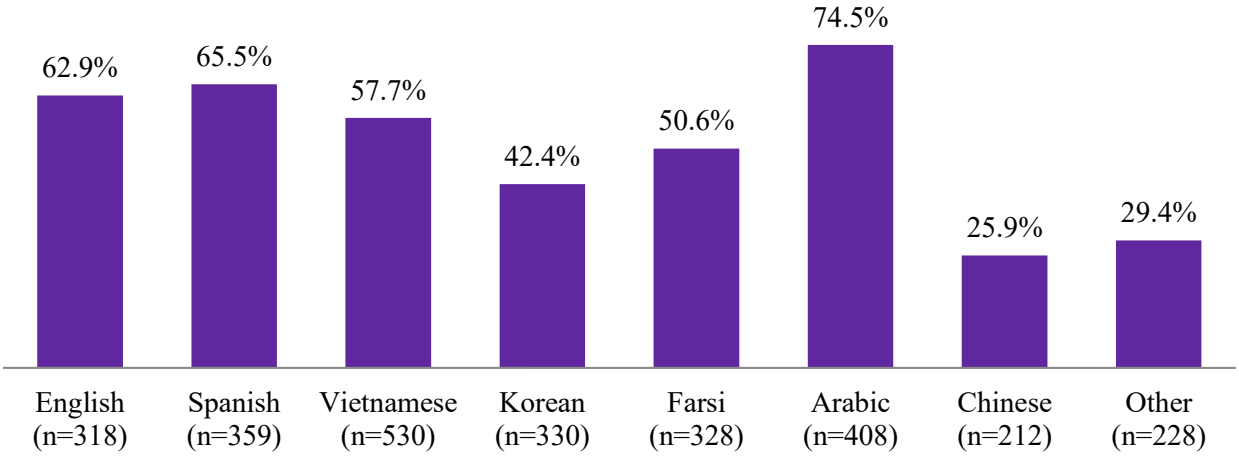
Region:



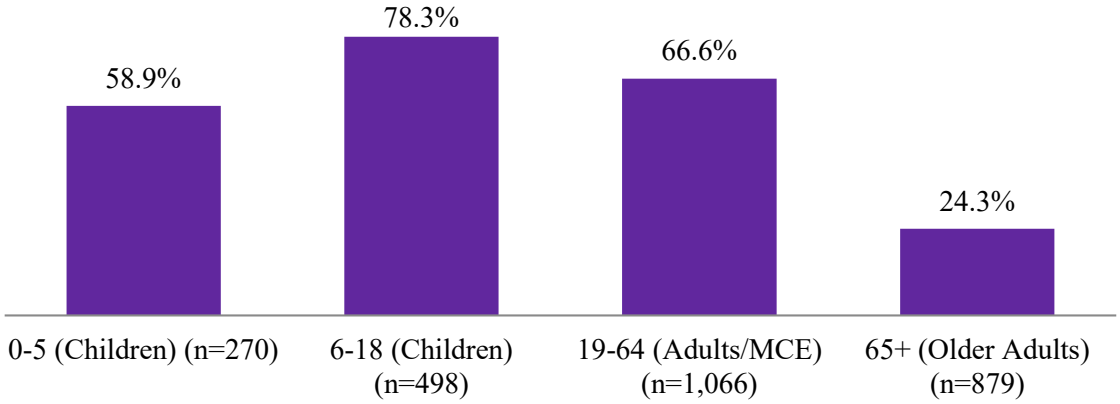
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

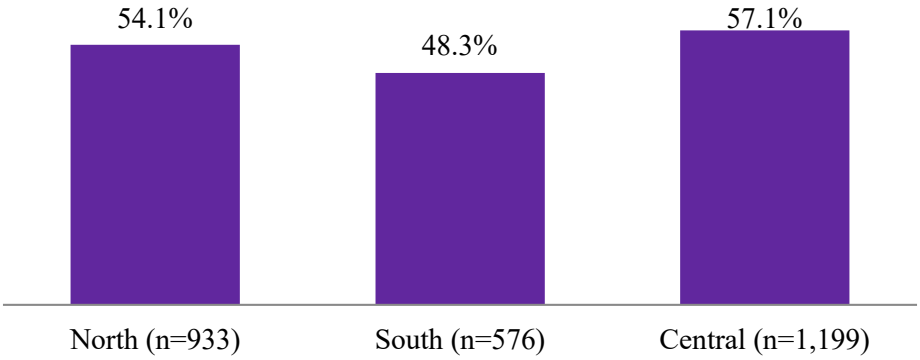
CalOptima language:



Age Category:



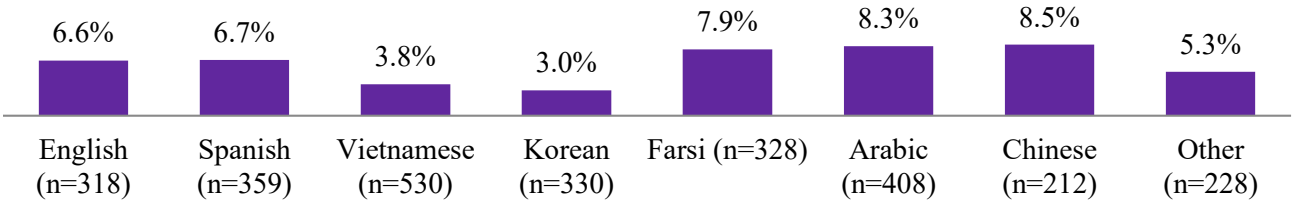
Region:



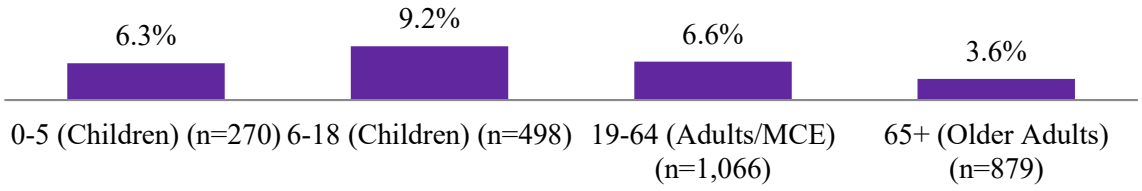
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

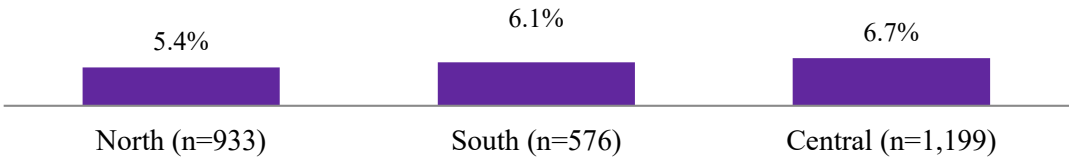
CalOptima language:



Age Category:

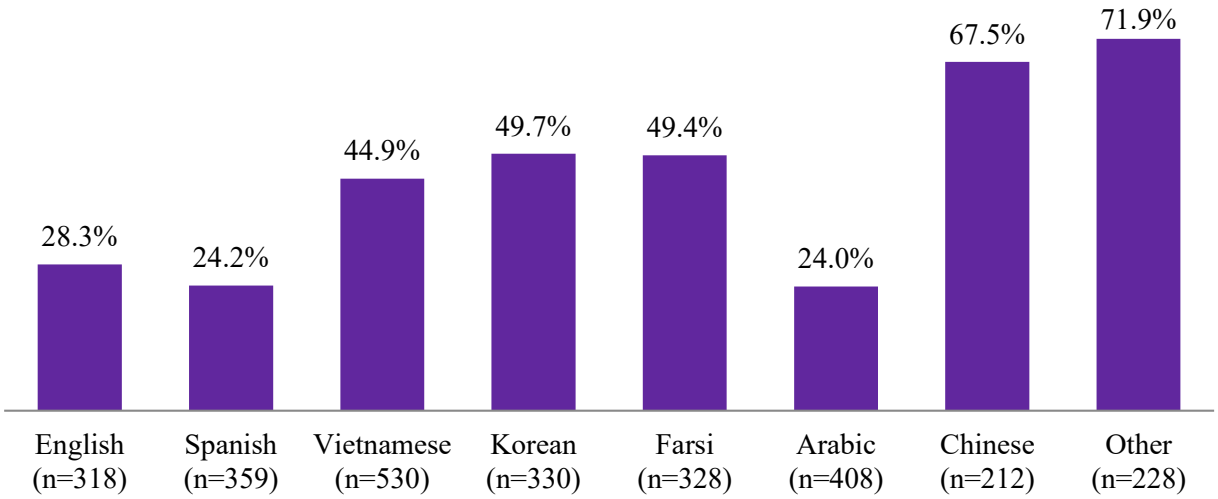


Region:

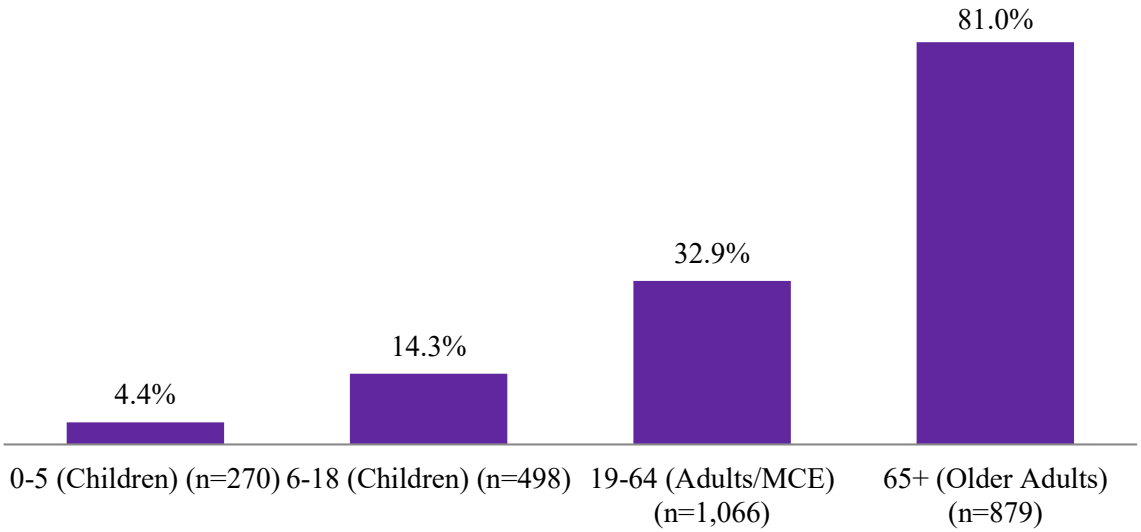


Receive SSI or SSDI as a public benefit:

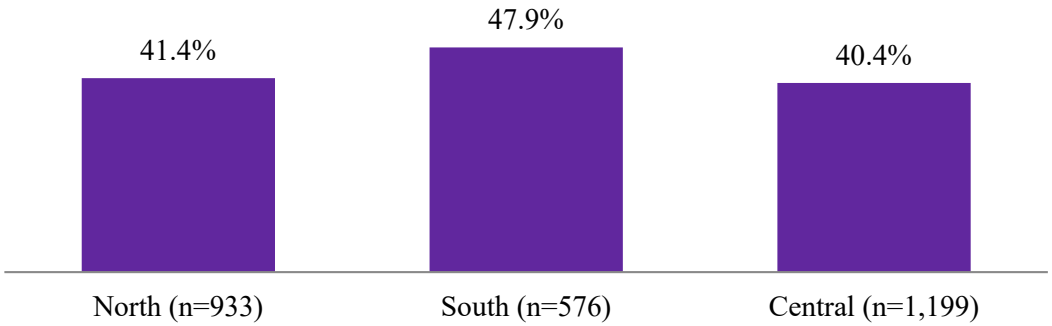
CalOptima language:



Age Category:

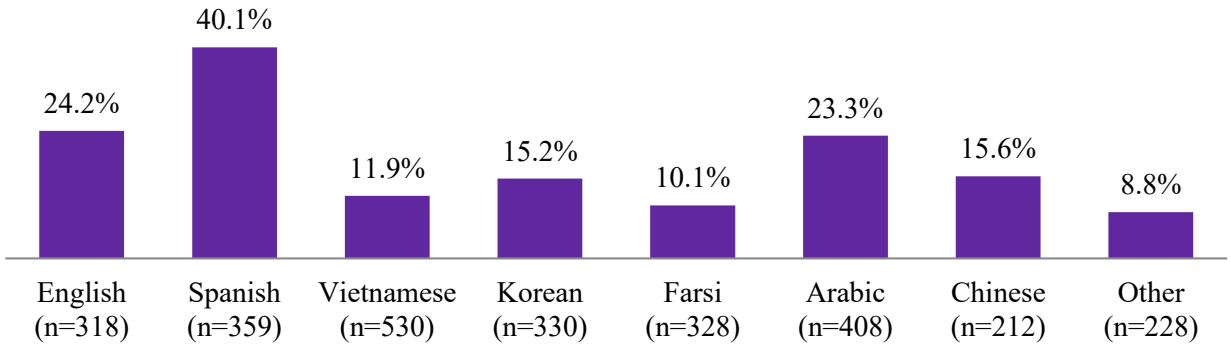


Region:

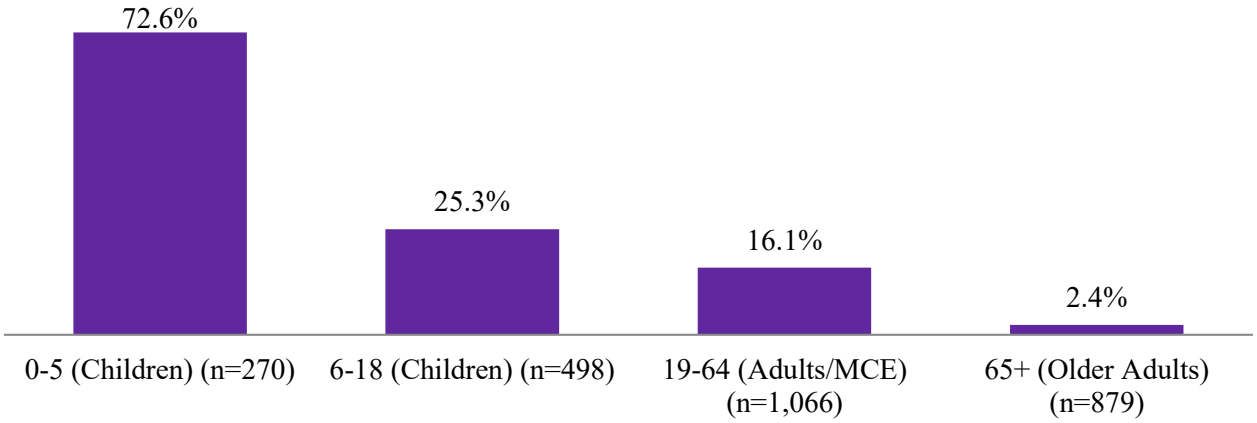


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

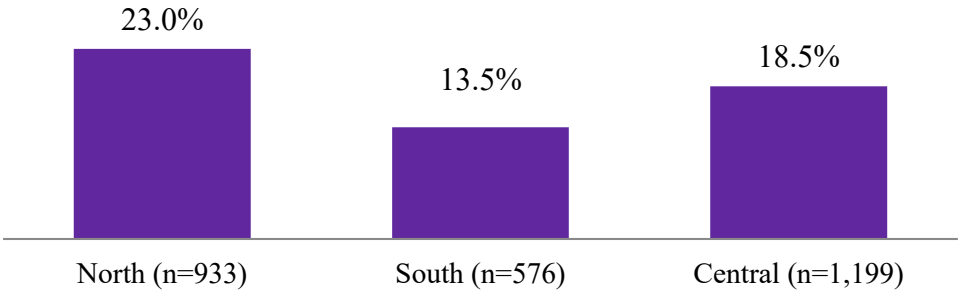


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467
Get enough sleep	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249
Have enough time for self	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

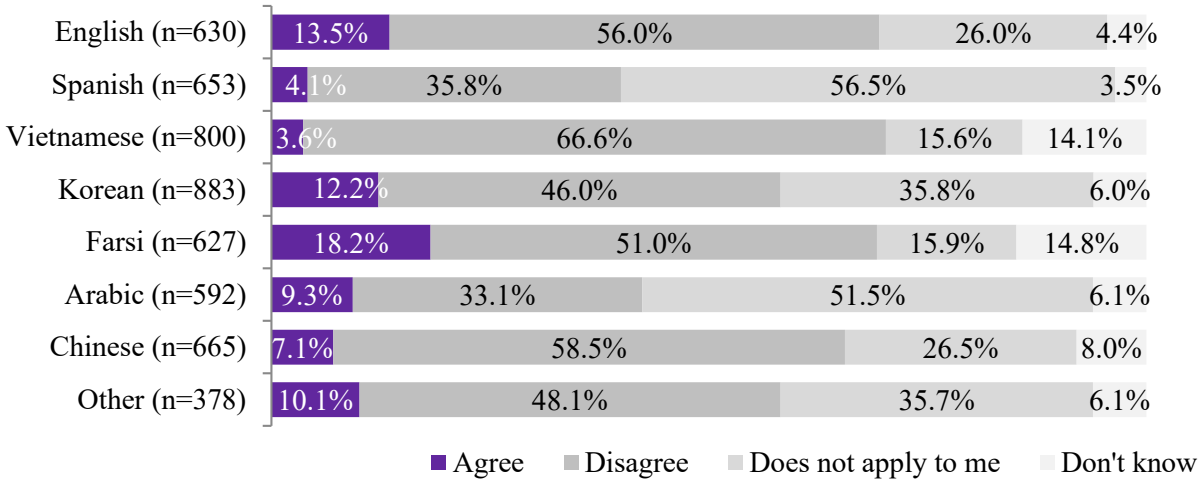
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

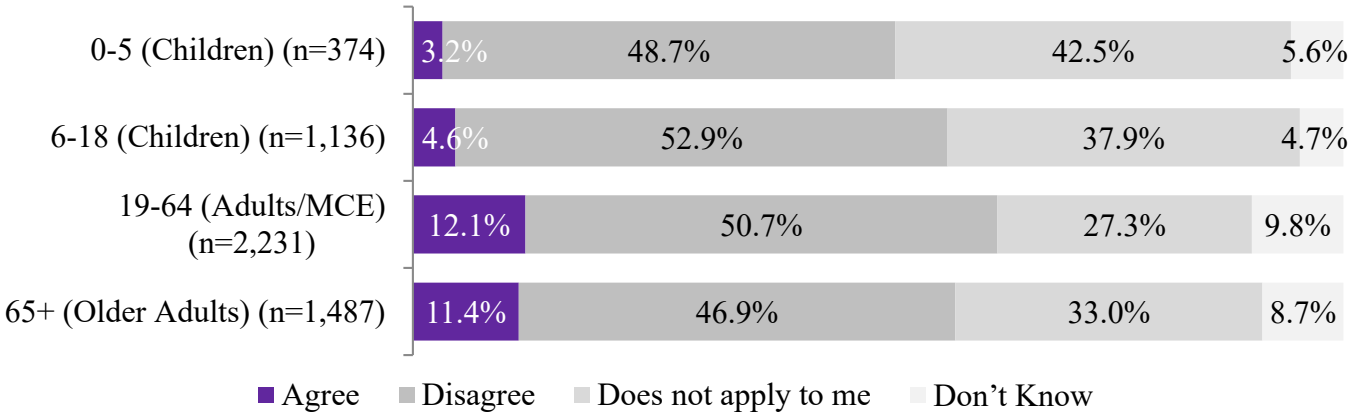
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

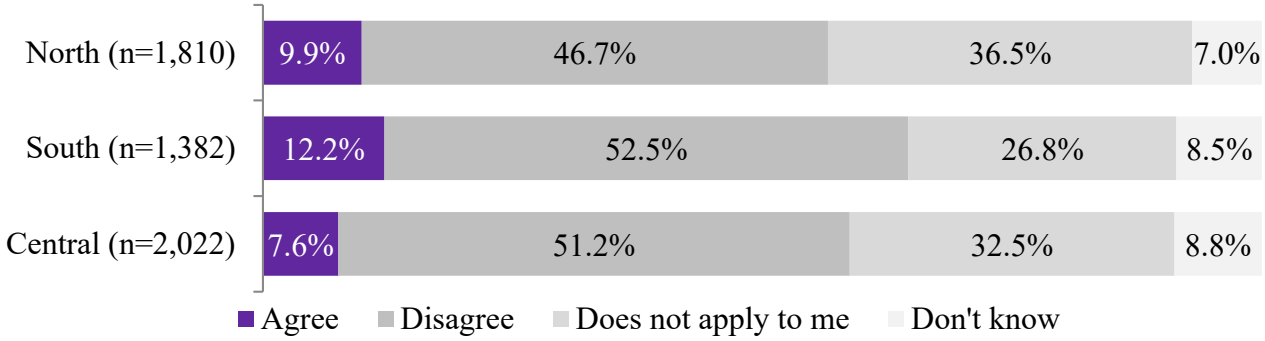
CalOptima language:



Age Category:

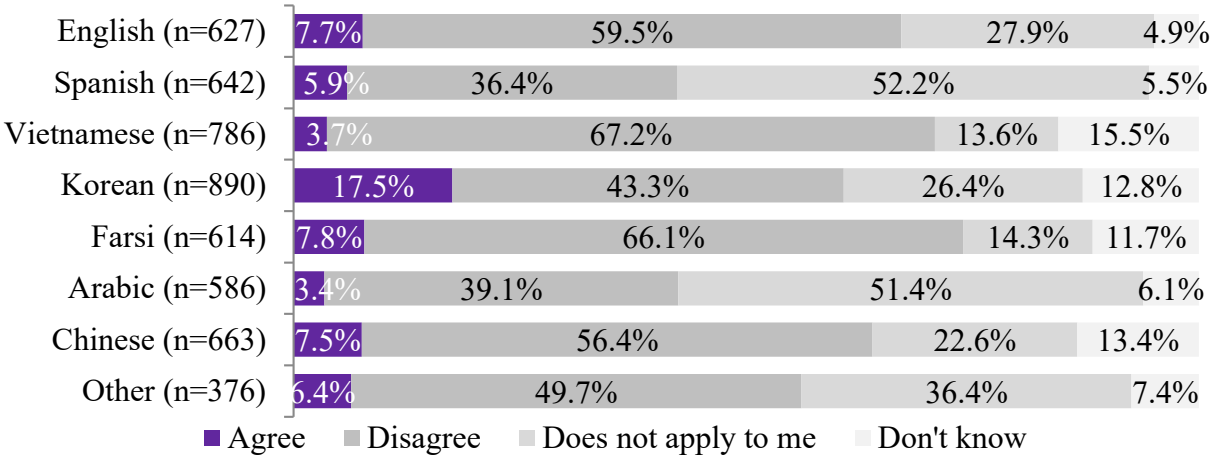


Region:

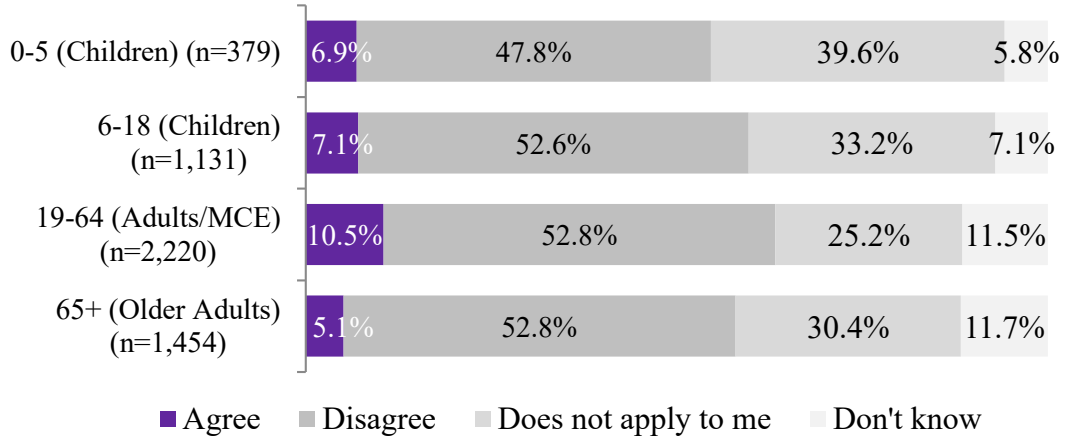


Feel not treated equally because of ethnic and culutral backgrounds:

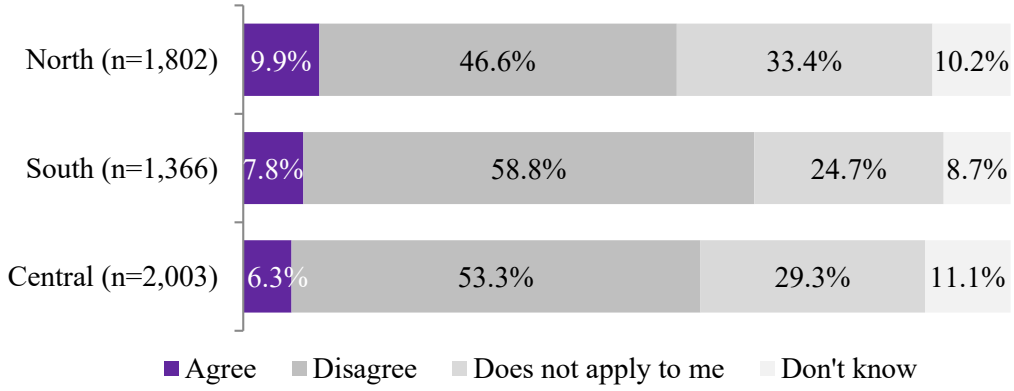
CalOptima language:



Age Category:

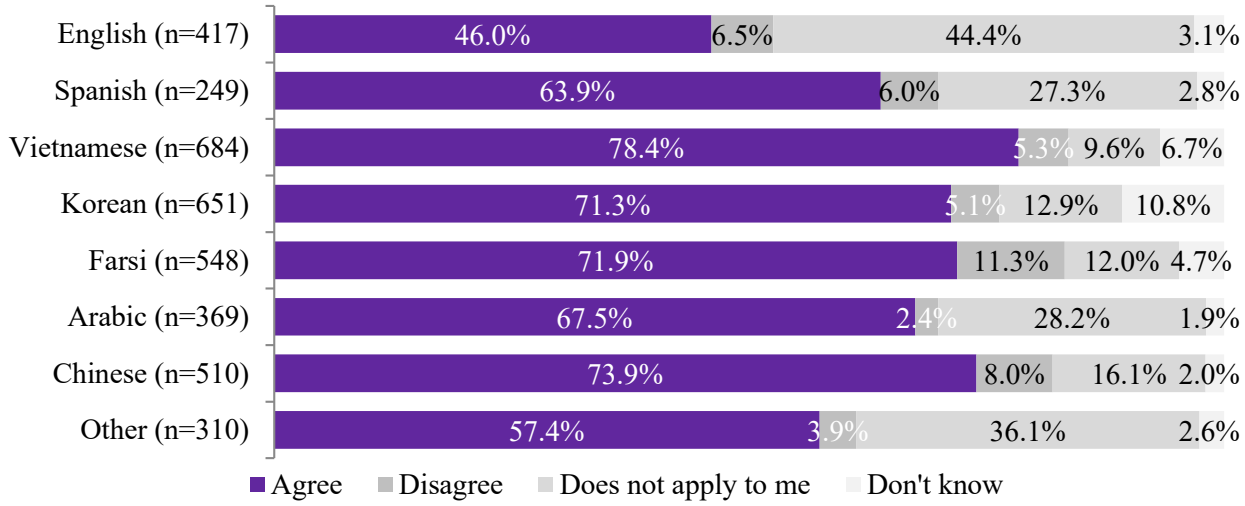


Region:



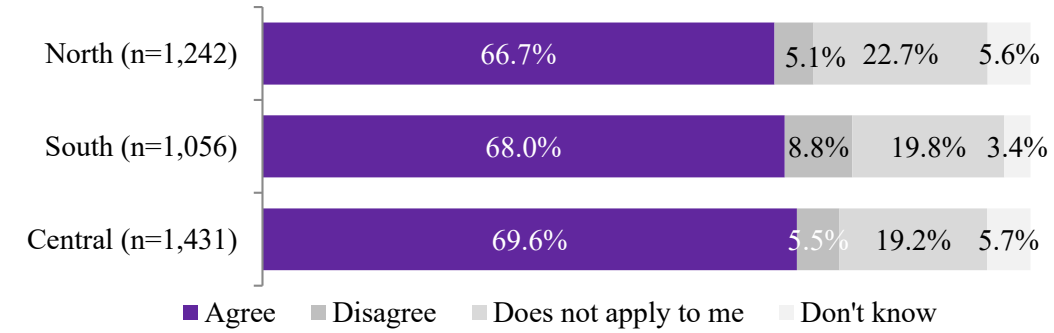
Feel child respects them as a parent[9]:

CalOptima language:



Age Category:

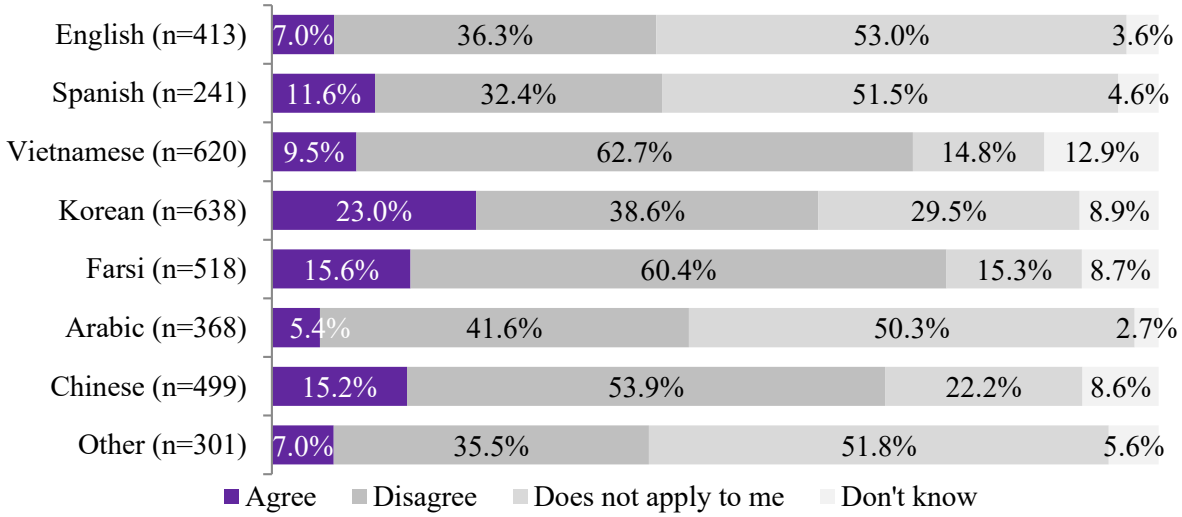
Region:



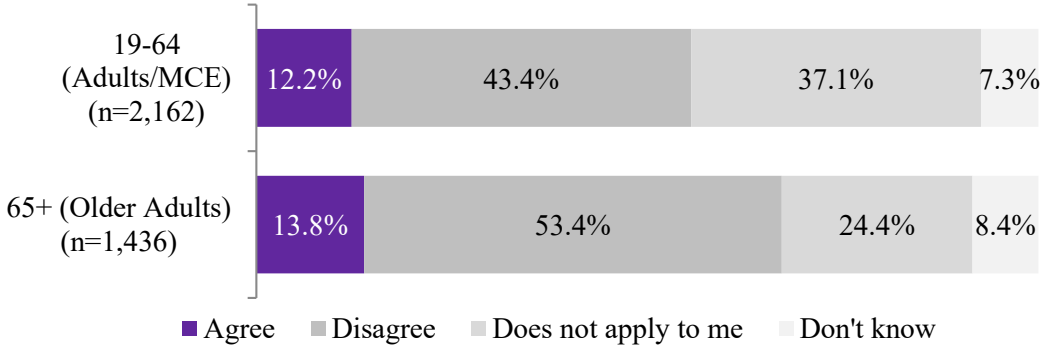
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

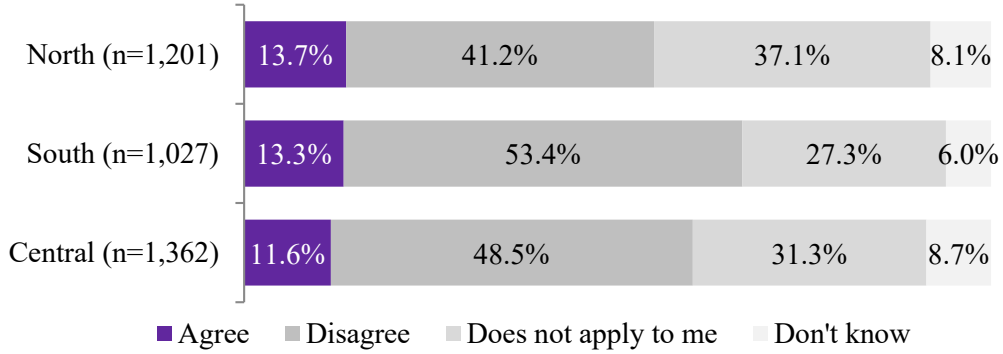
CalOptima language:



Age Category:



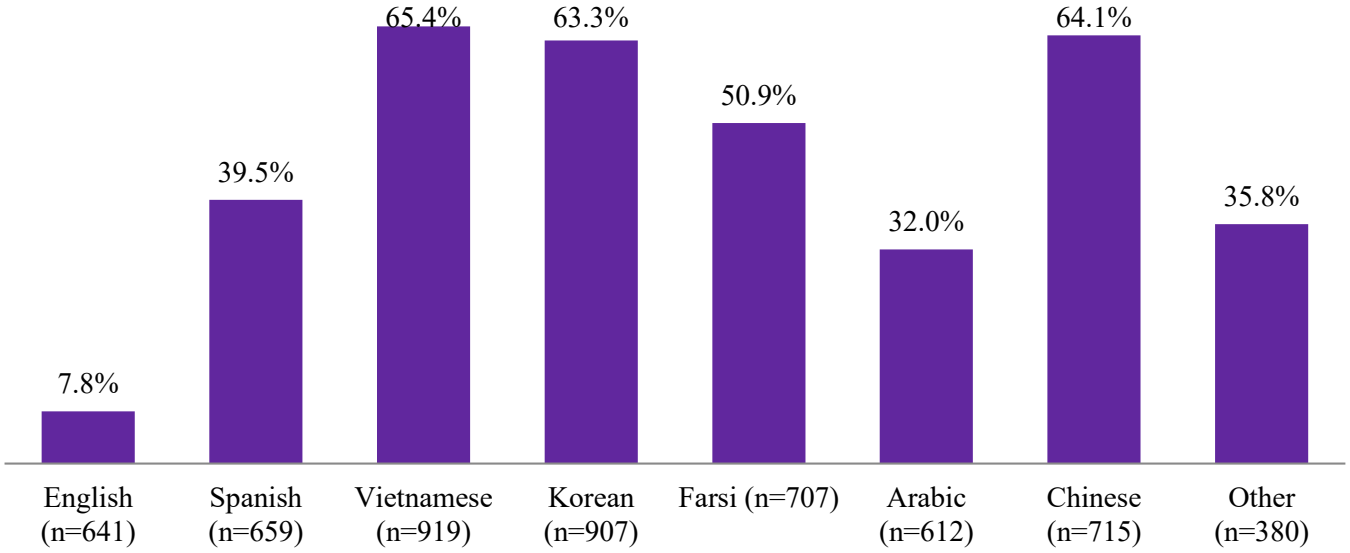
Region:



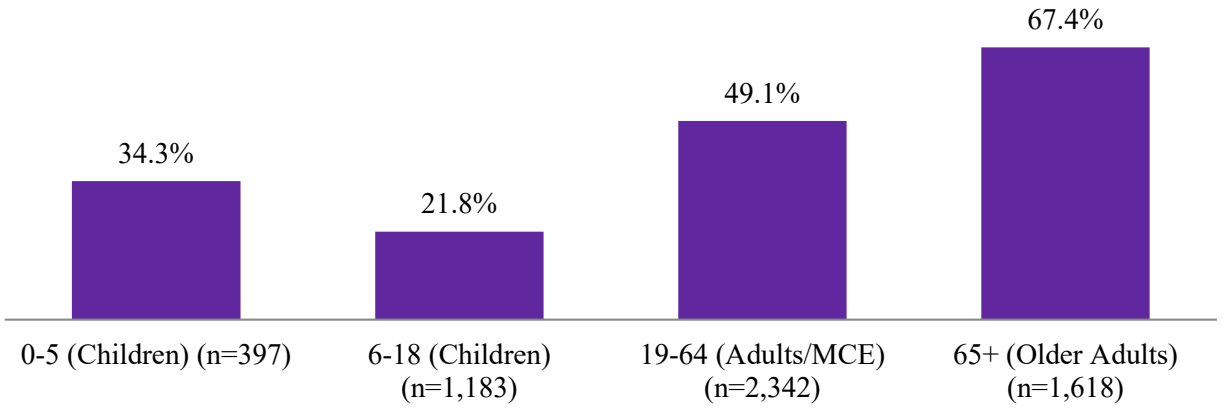
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

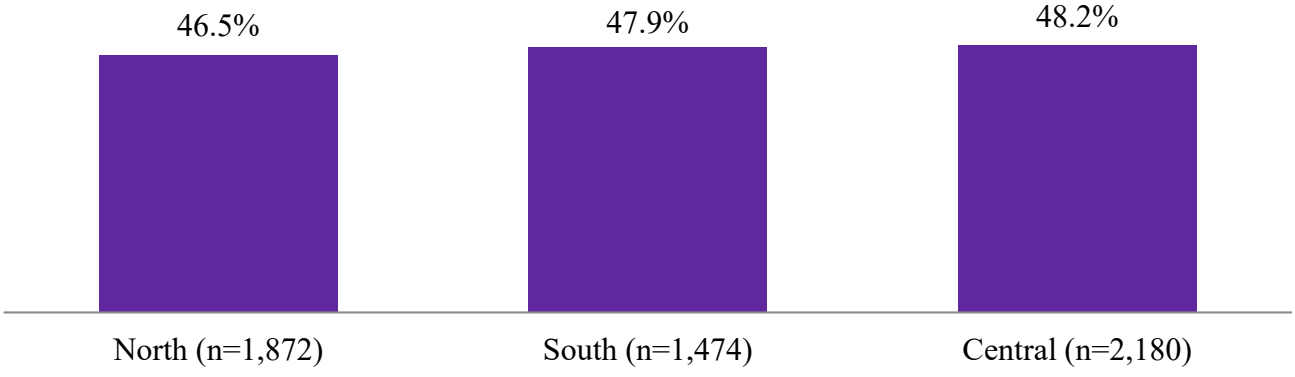


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

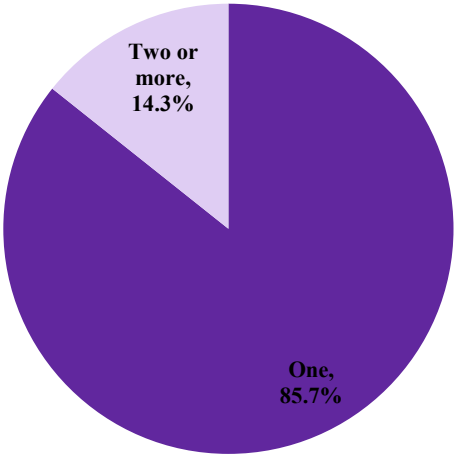
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

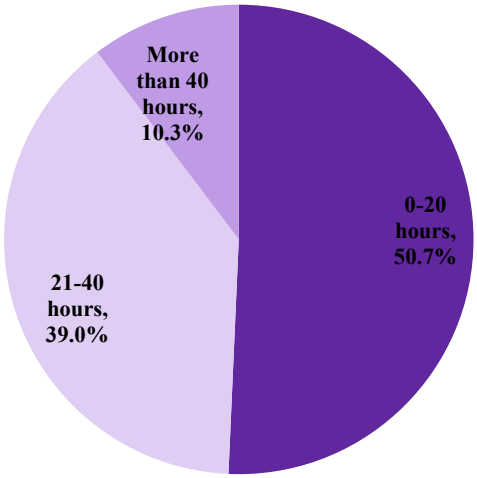
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

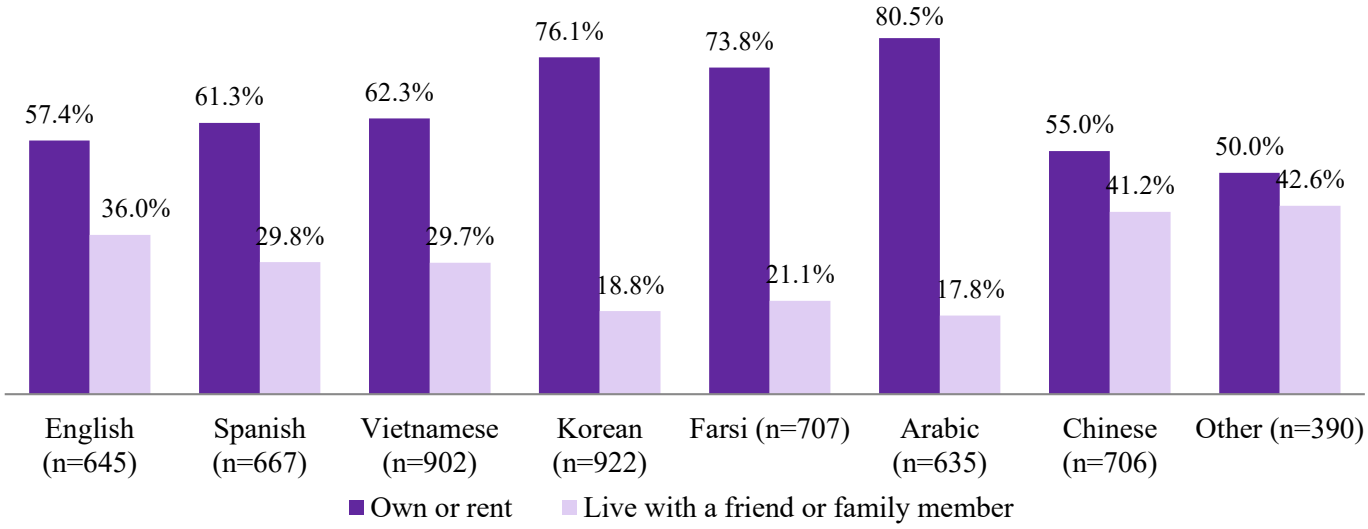


Number of hours that members work each week

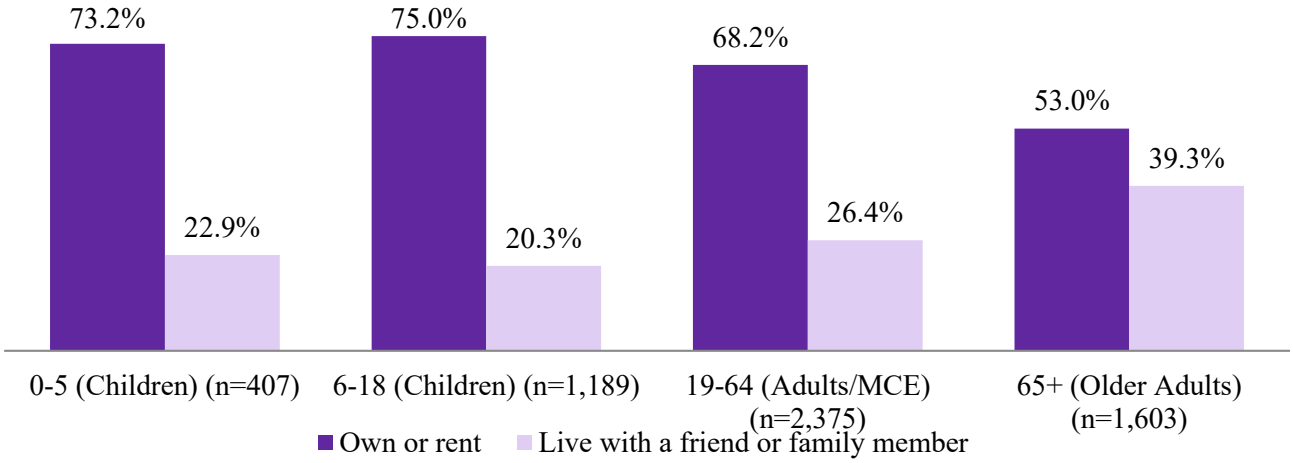


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

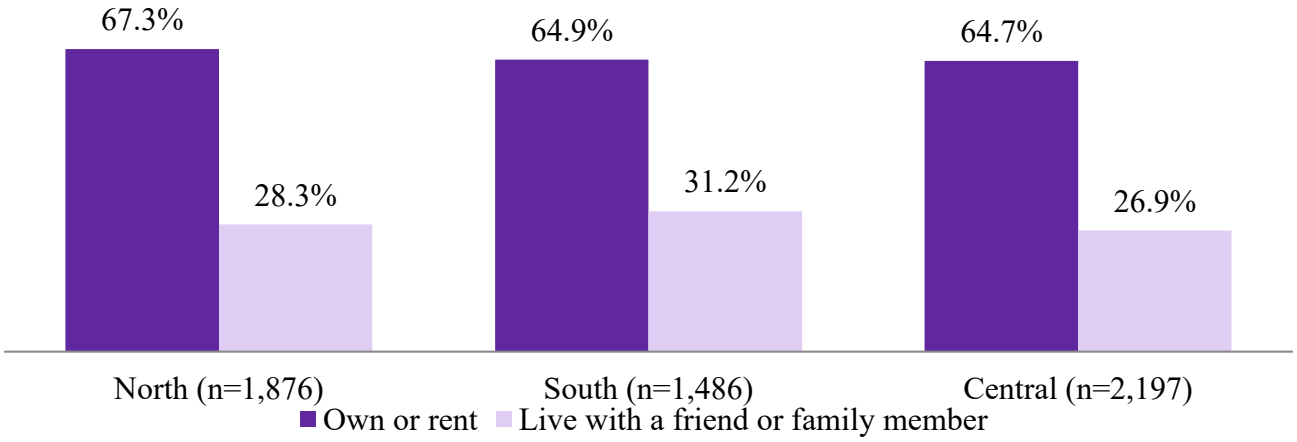
Exhibit 20. Members' living situation[14]



Age Category:



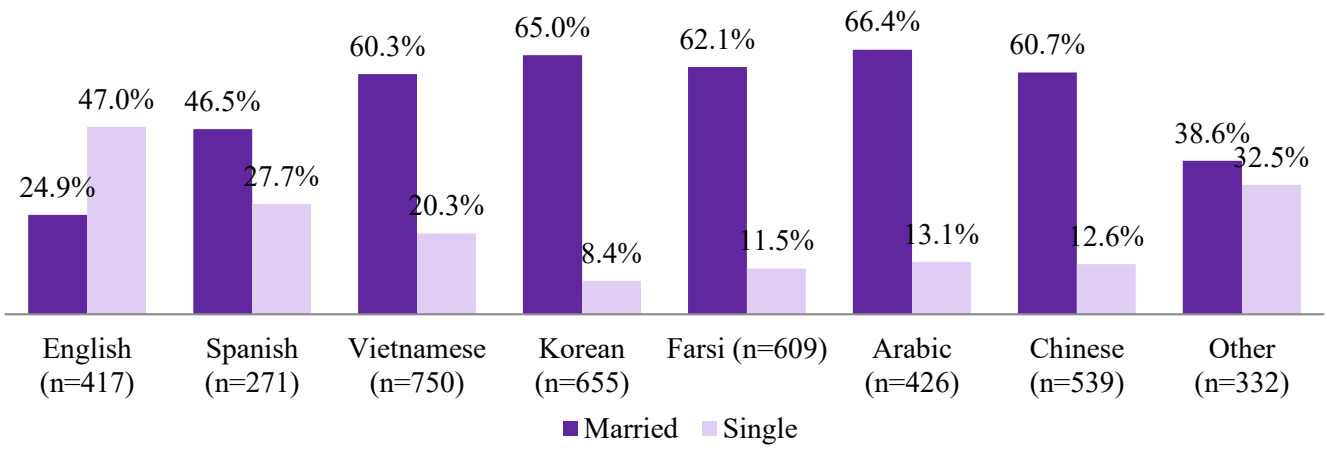
Region:



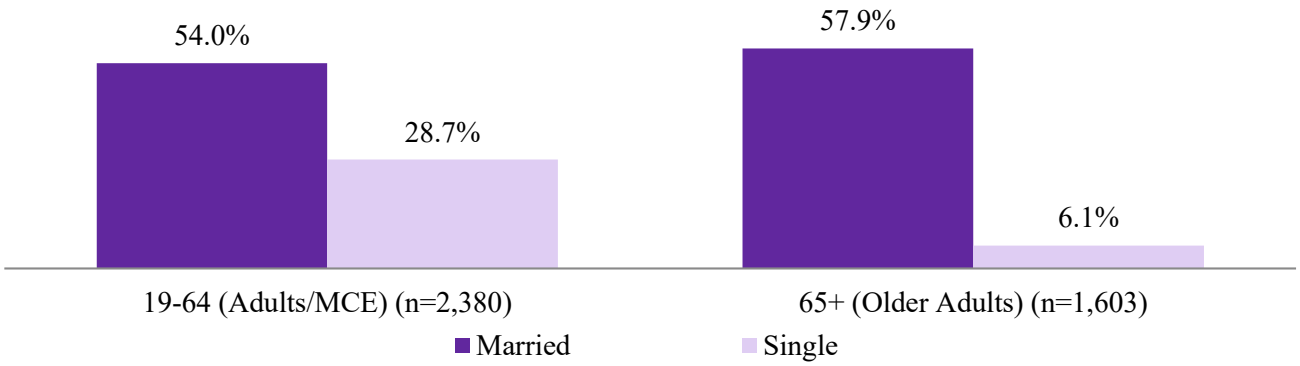
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

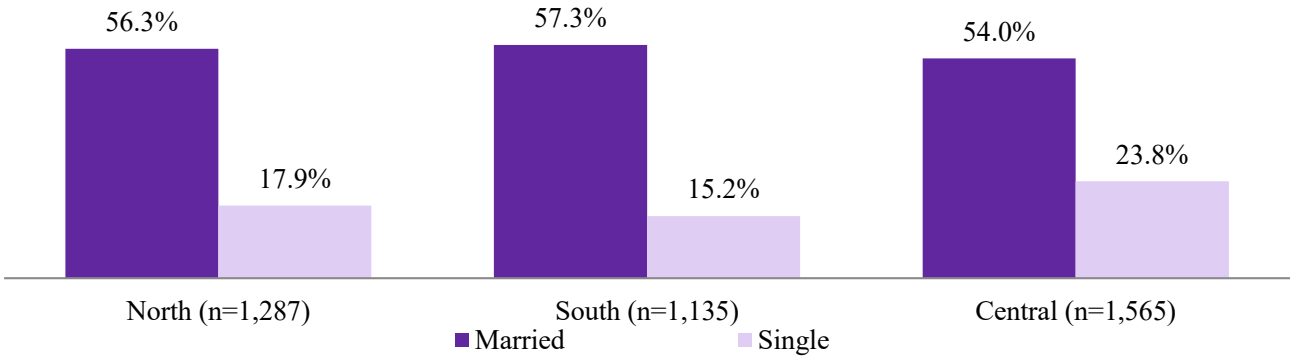
CalOptima language:



Age Category:



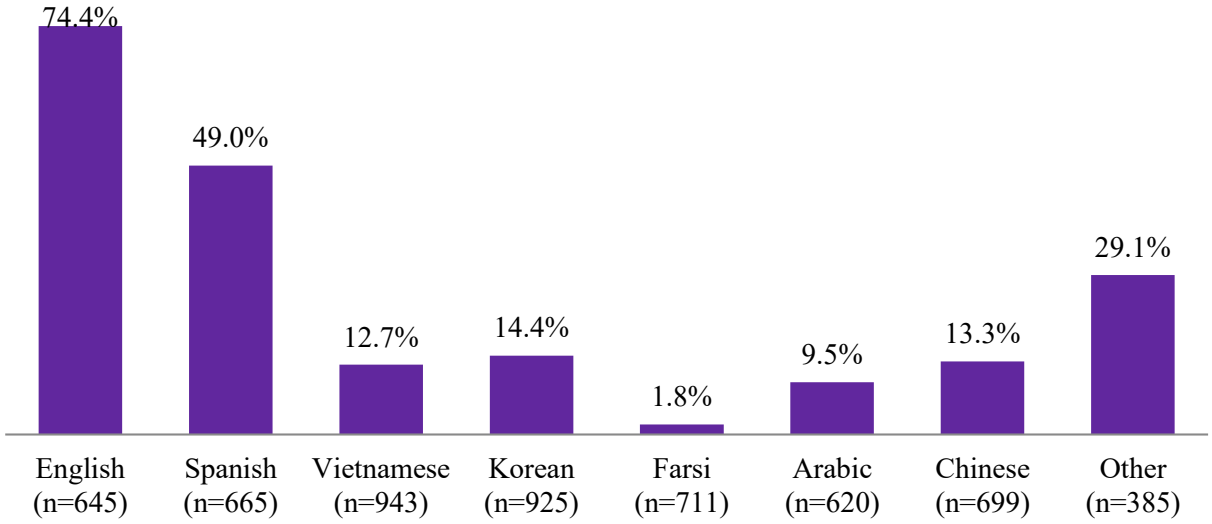
Region:



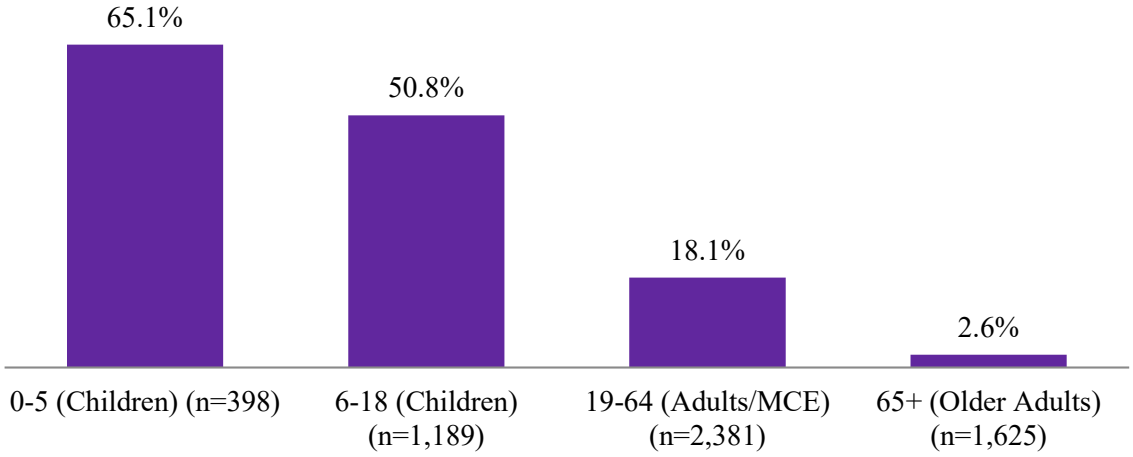
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

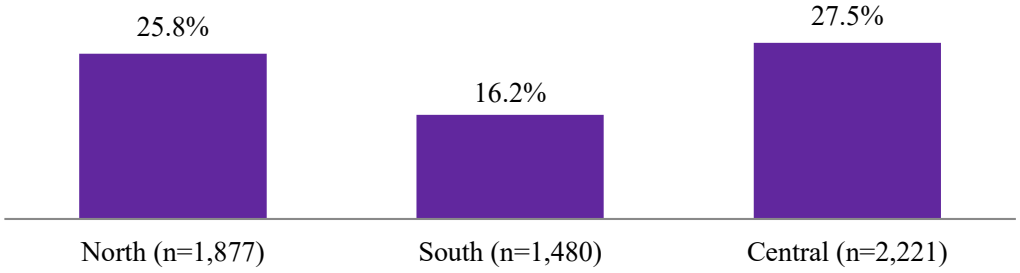
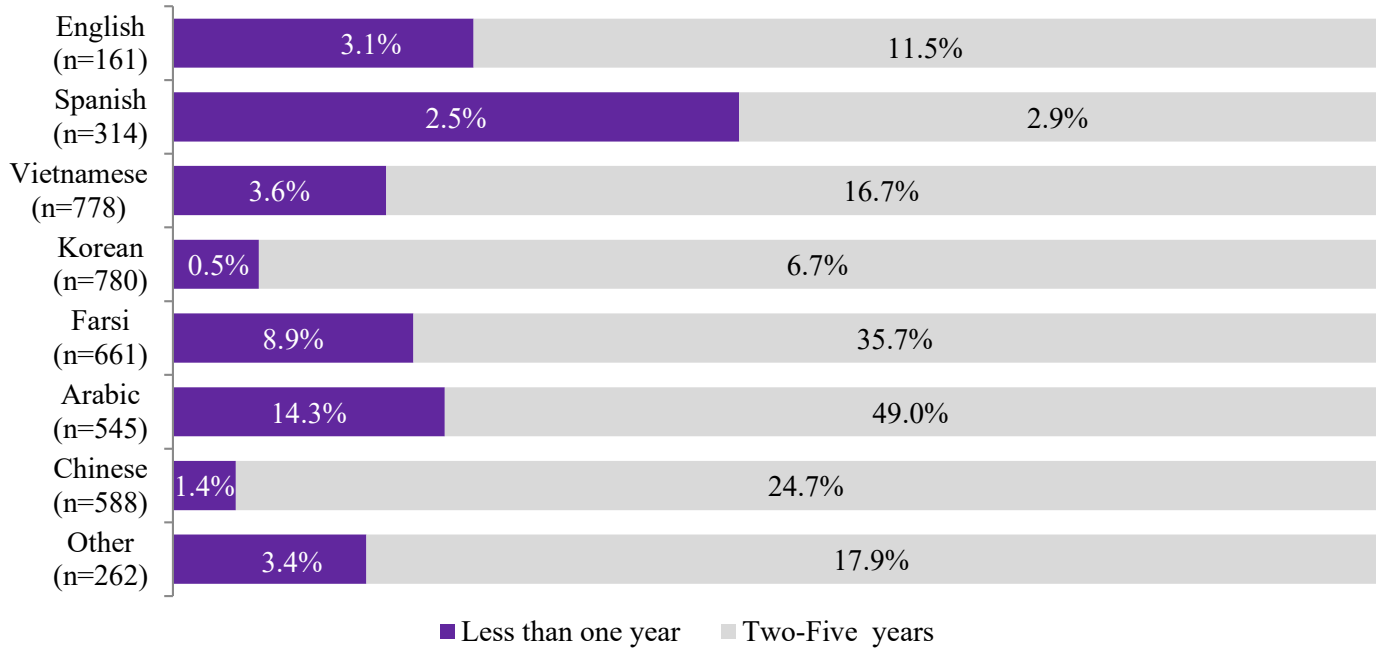
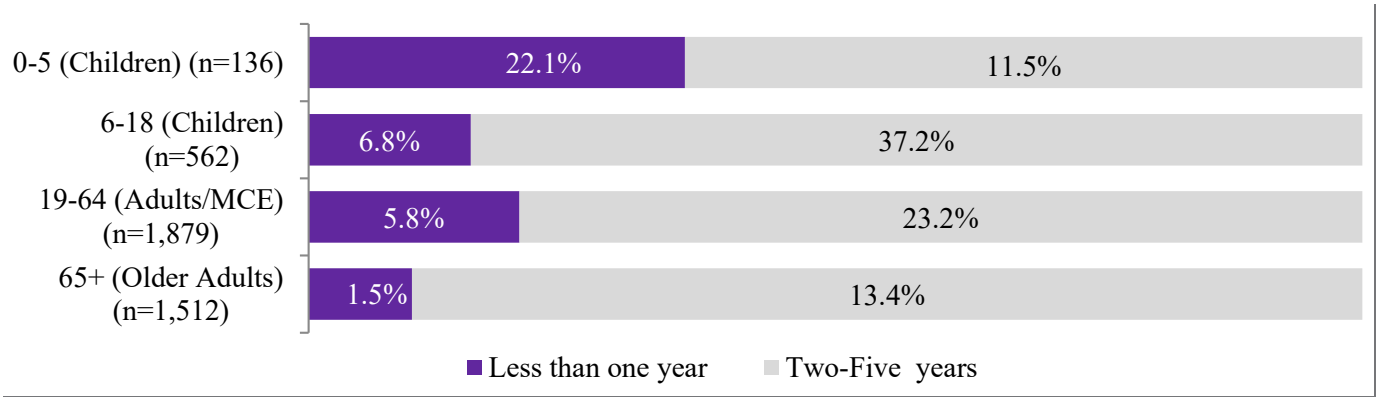


Exhibit 23. Length of time lived in the United States of those not born in the United States

CalOptima language:



Age Category:

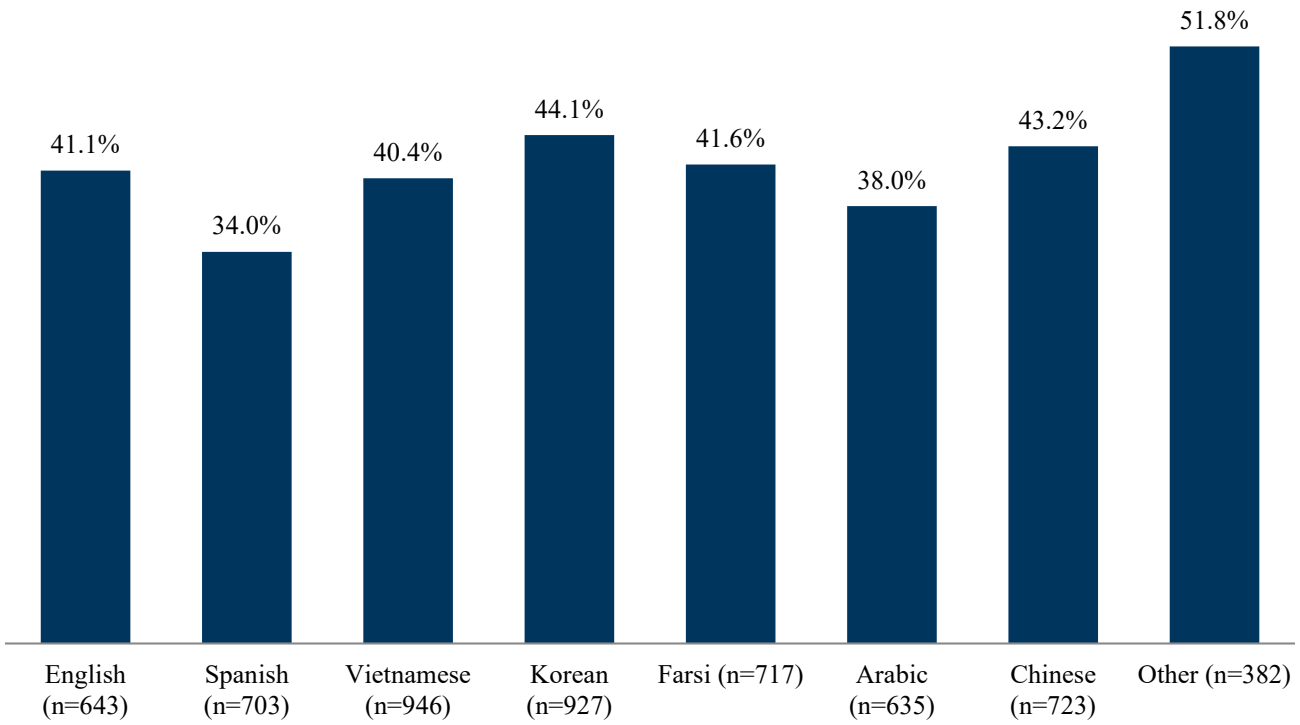


Region:

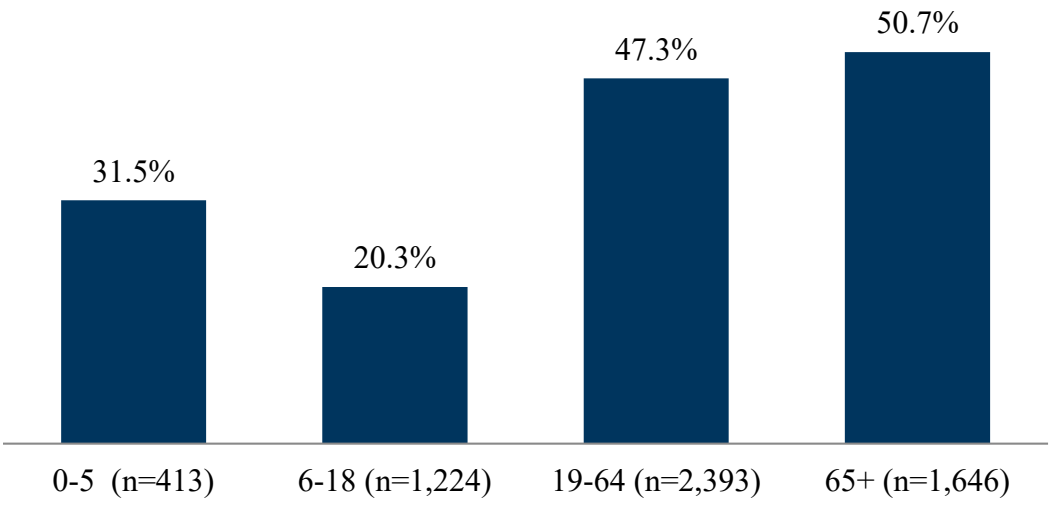
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

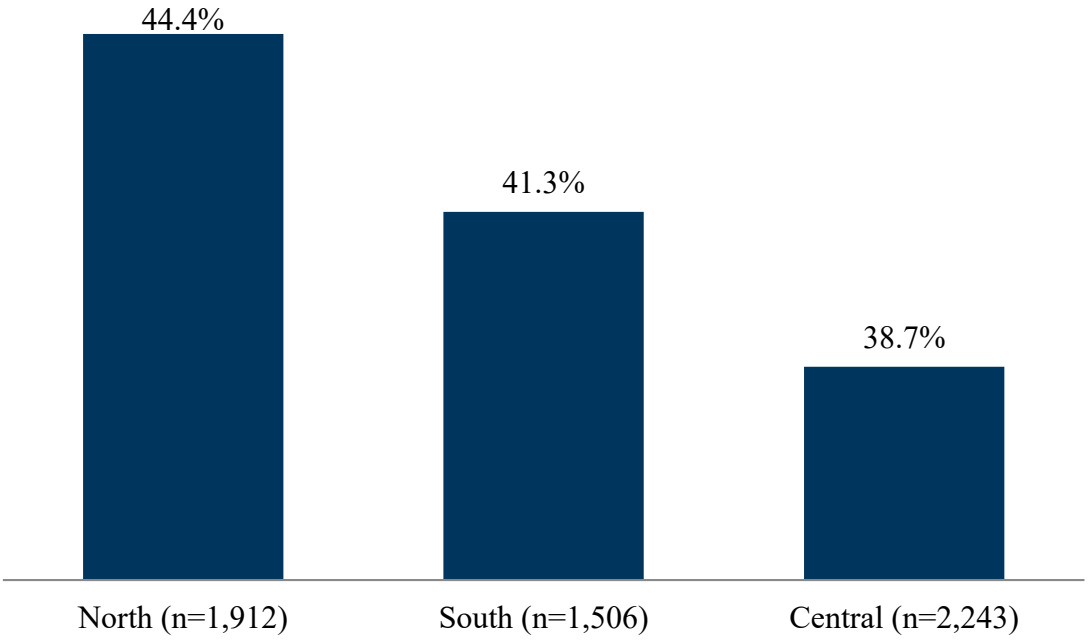


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

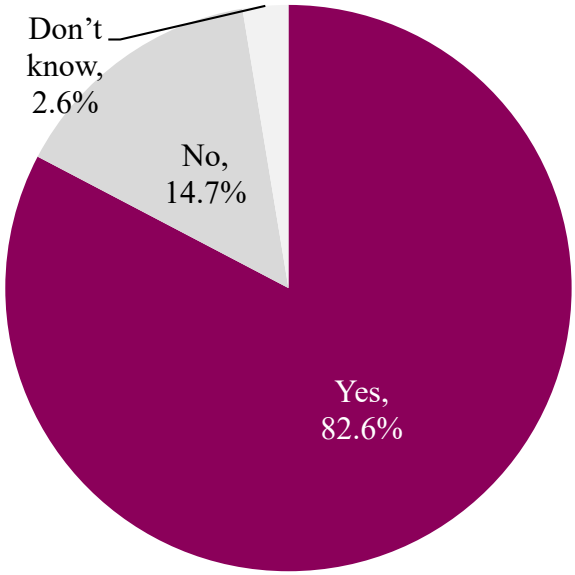


Exhibit 28. Where respondents go to see their doctor (n=5,743)

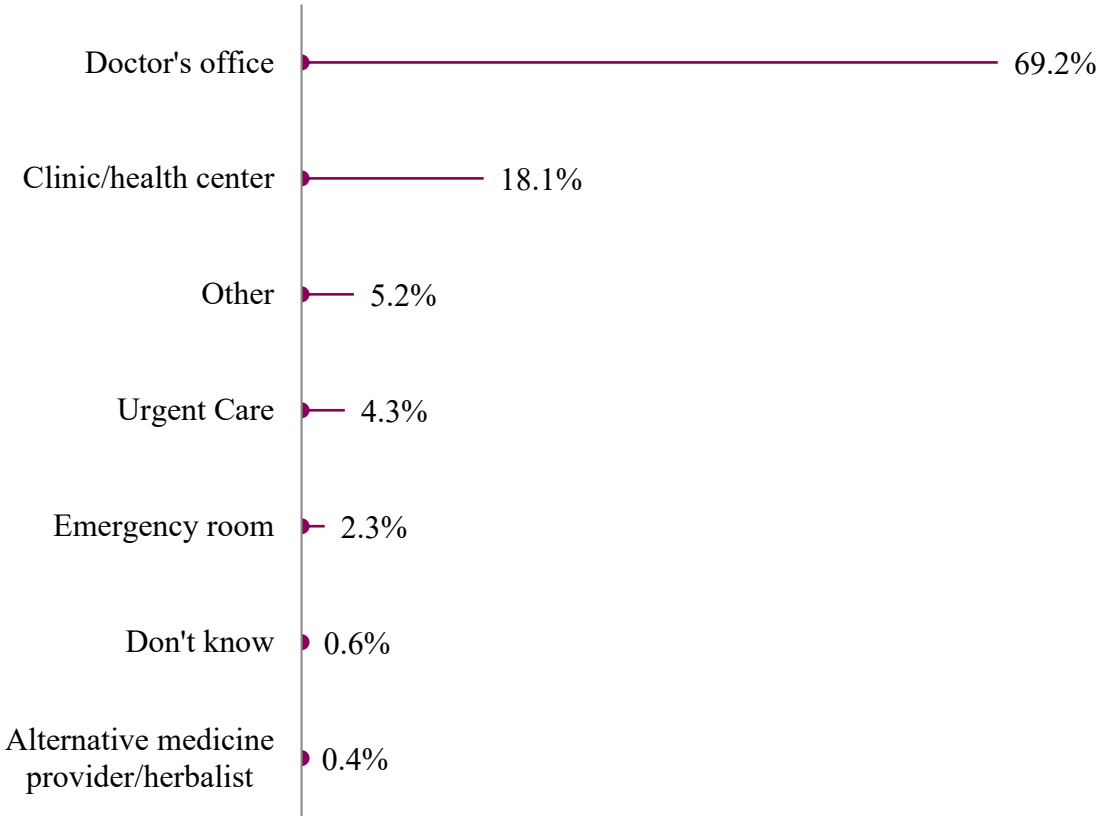


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

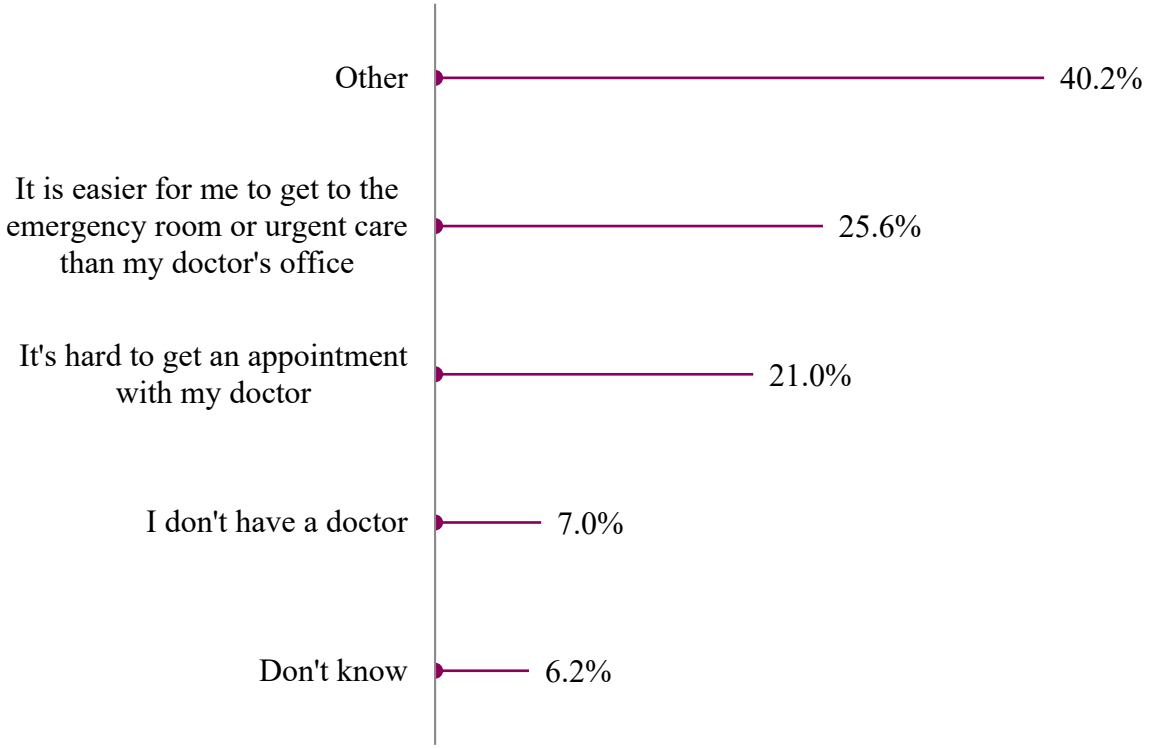


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

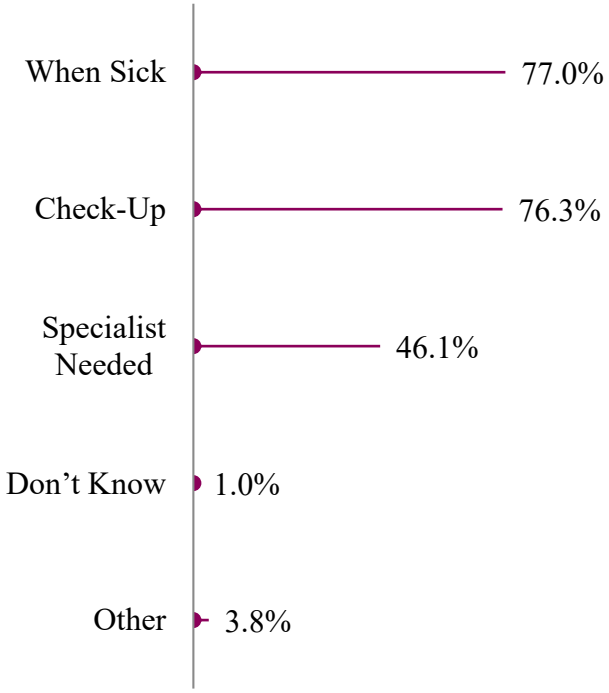
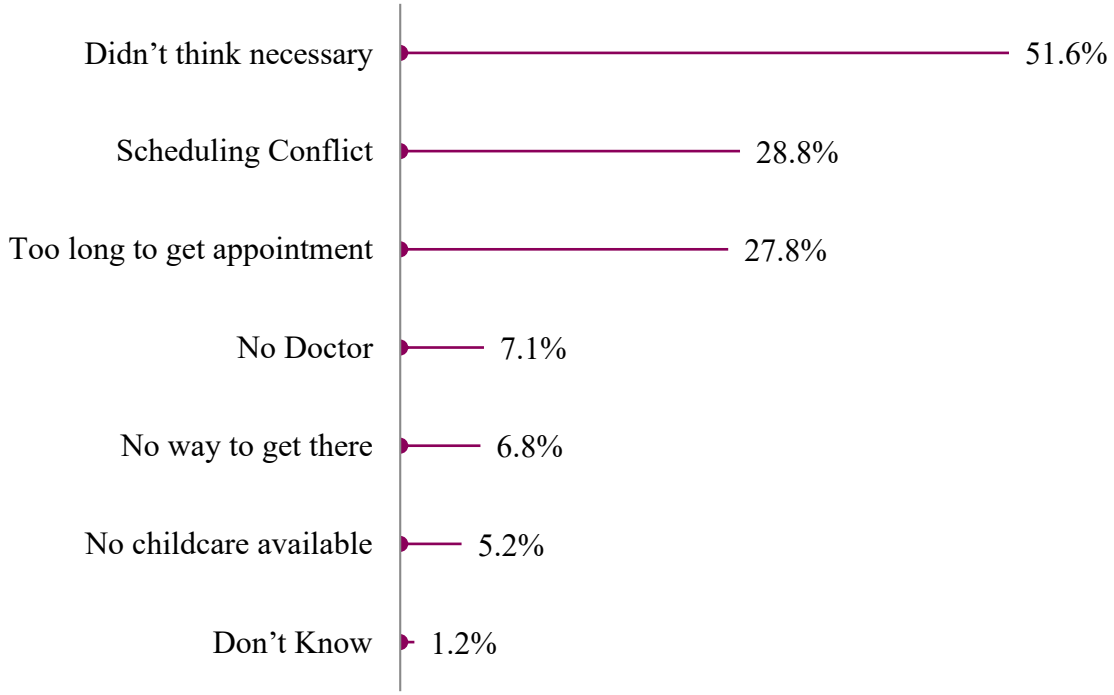


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

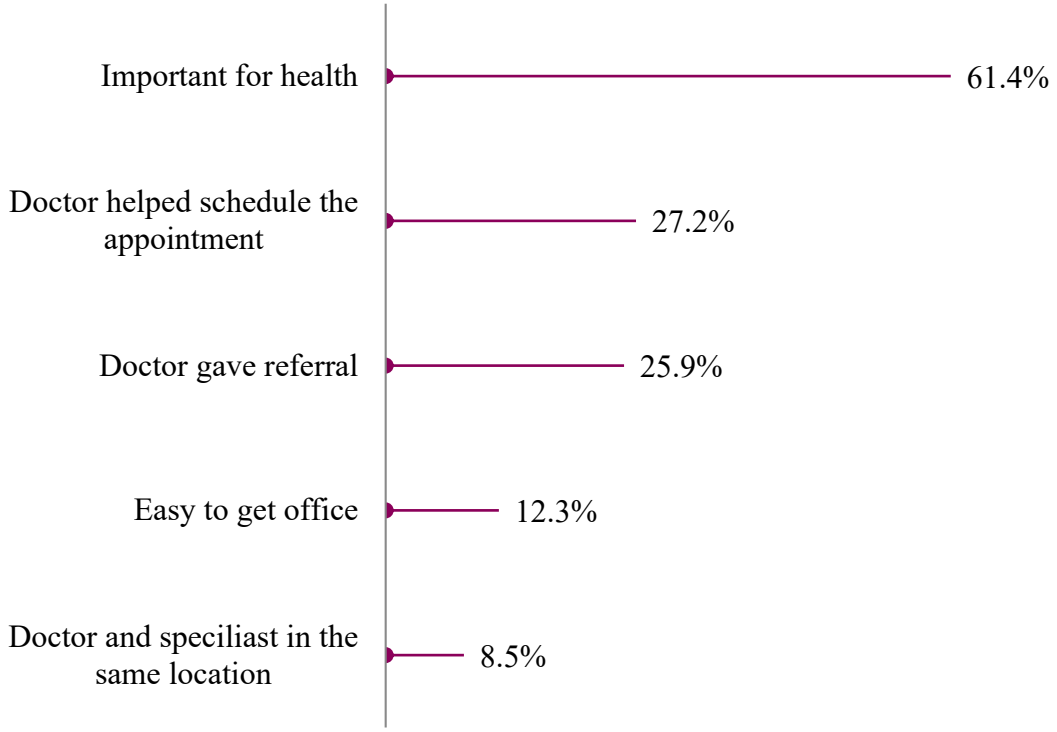
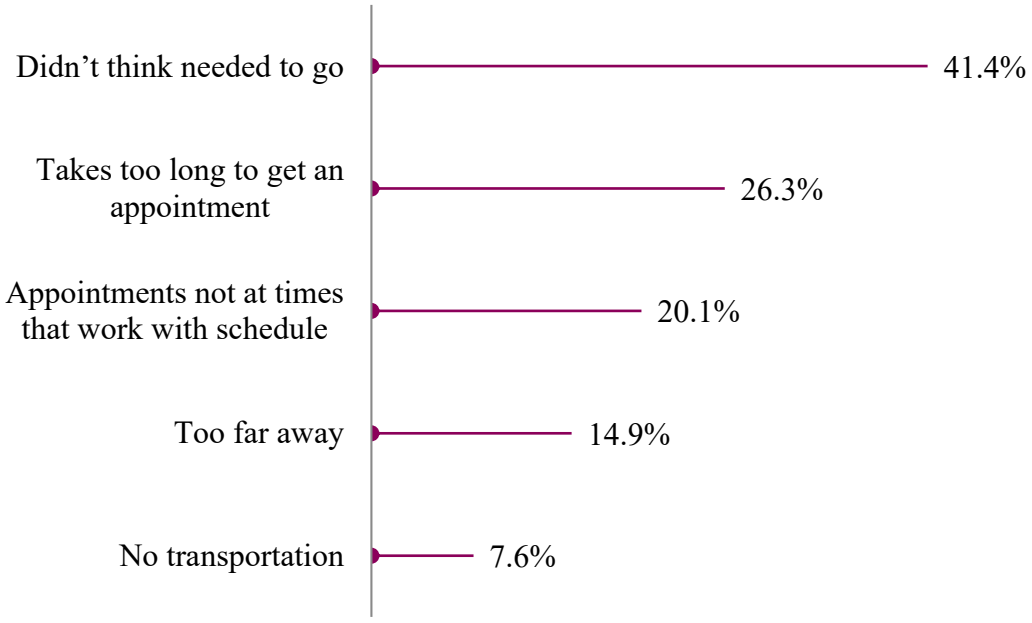
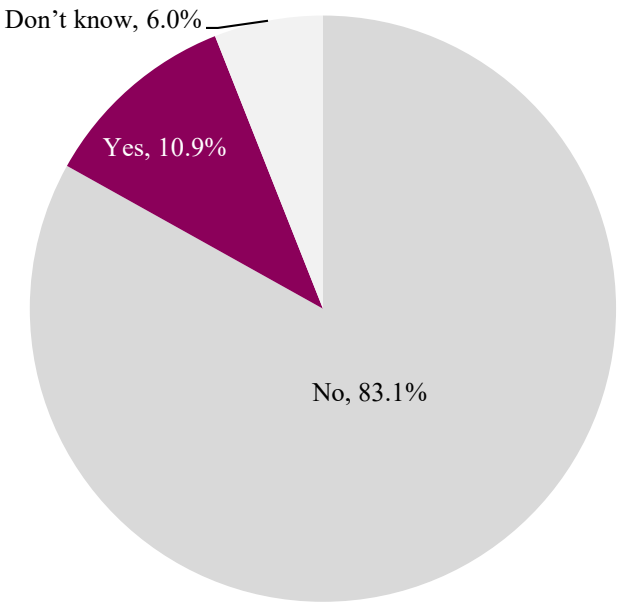


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

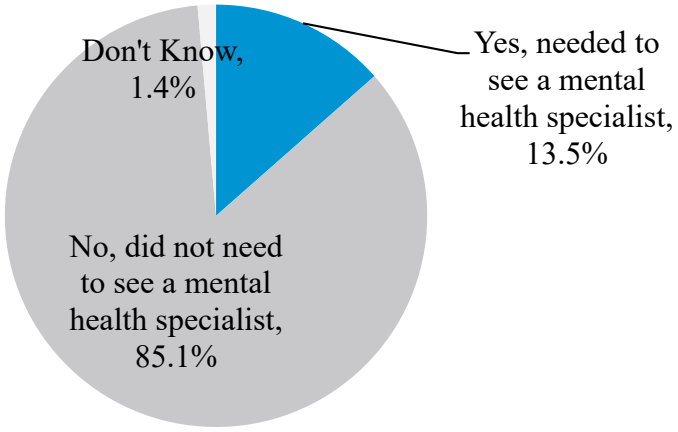


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

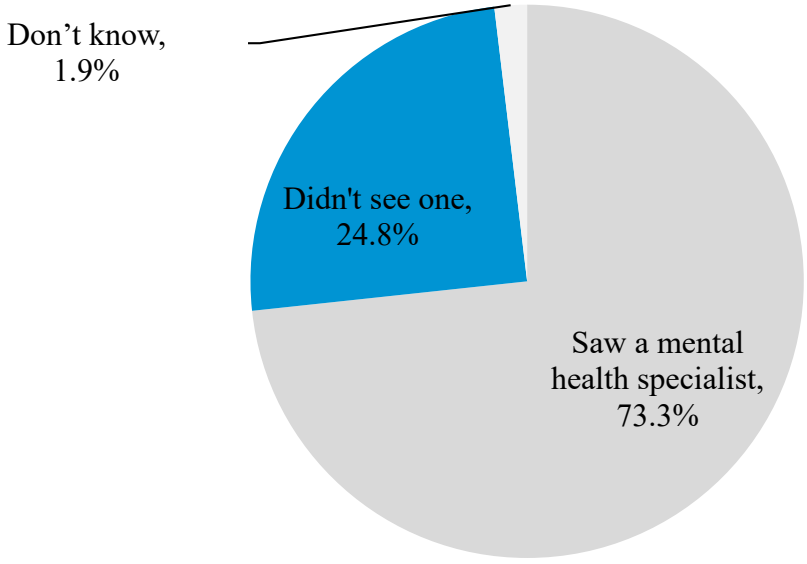


Exhibit 37. Reasons why members didn't see mental health specialist[24]

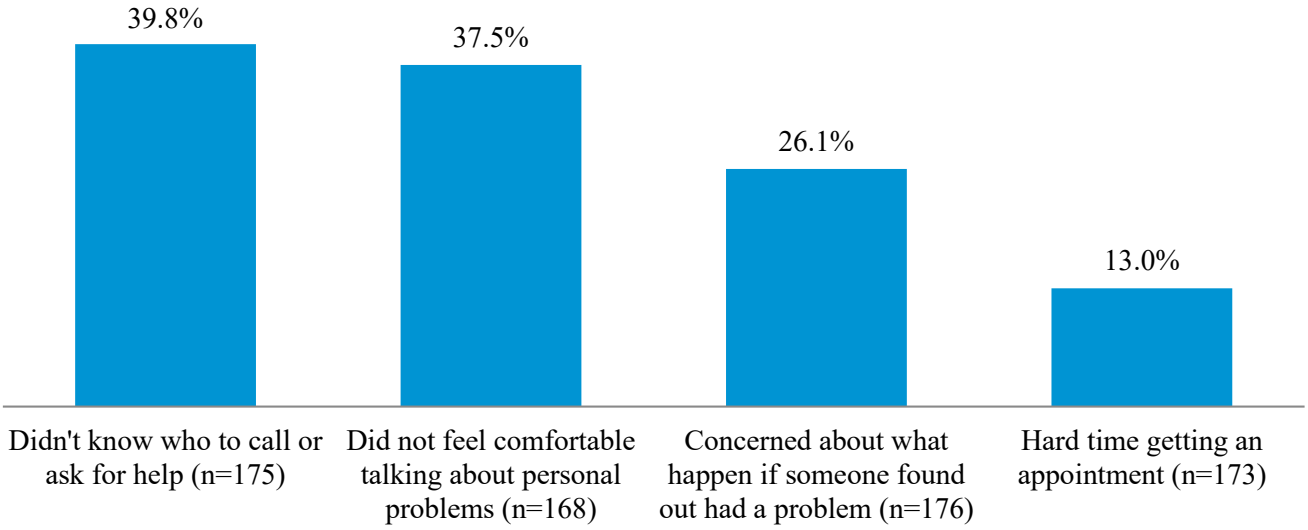
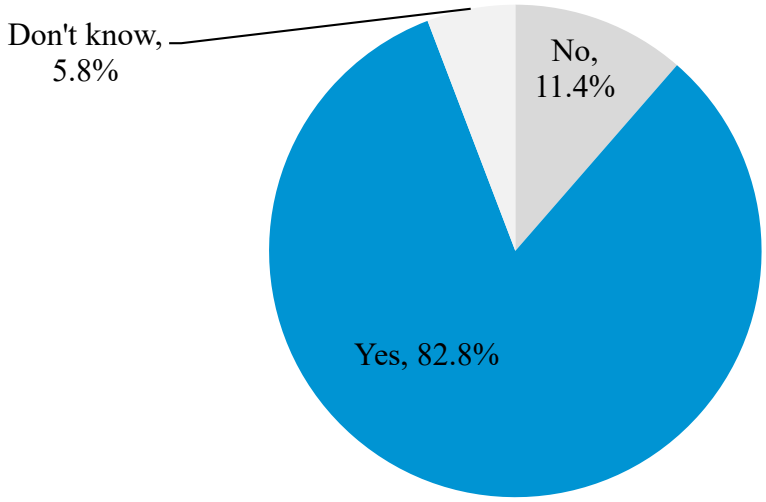


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

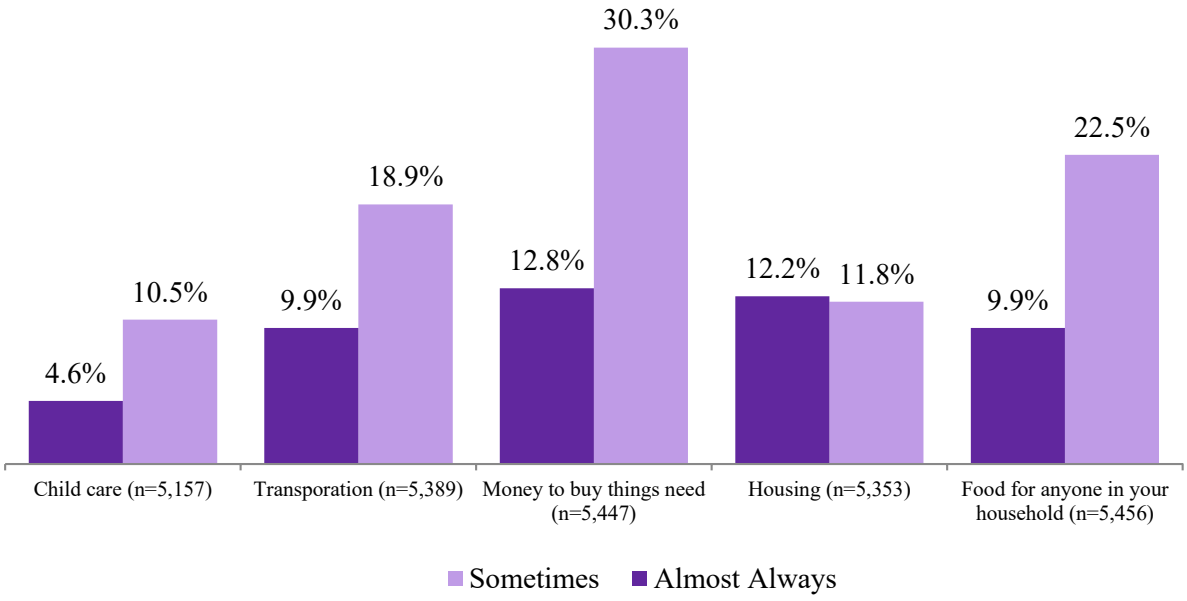


Exhibit 41. Percent of members who receive public benefits (n=5,117):

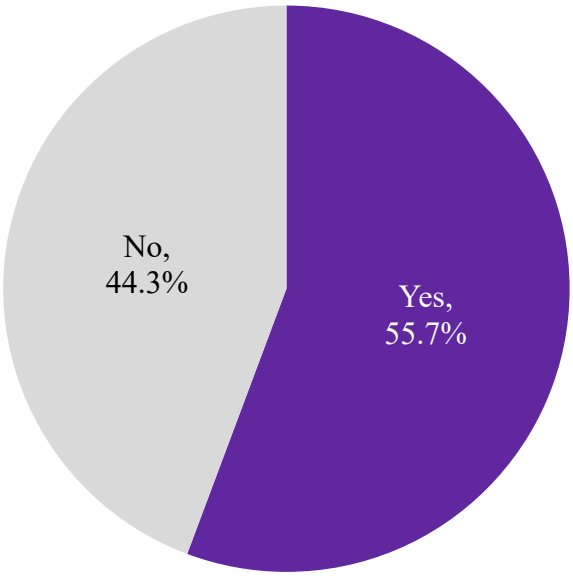
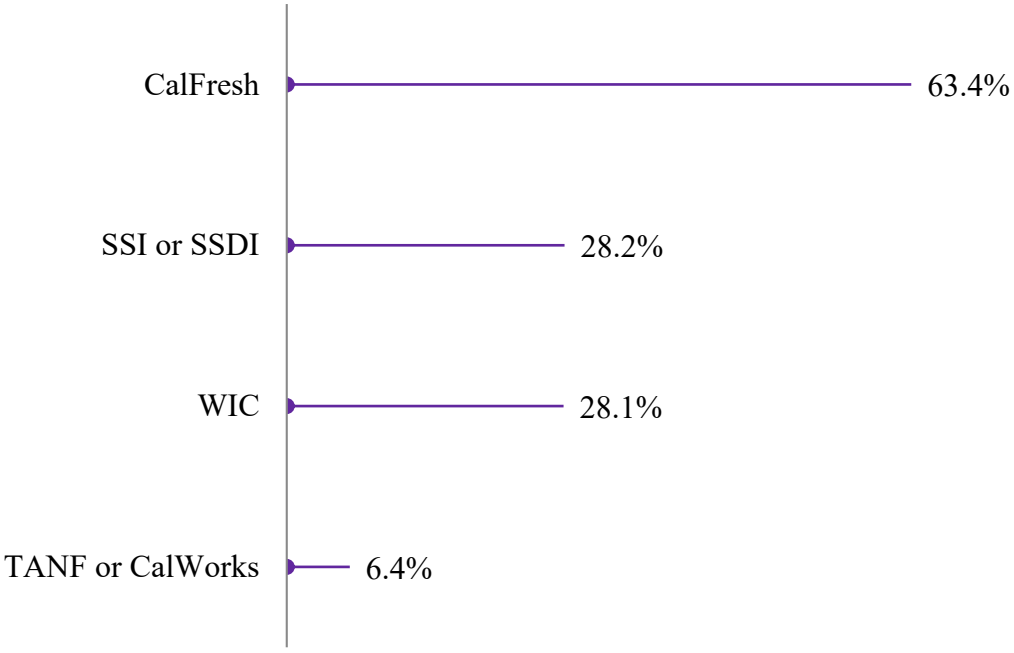


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

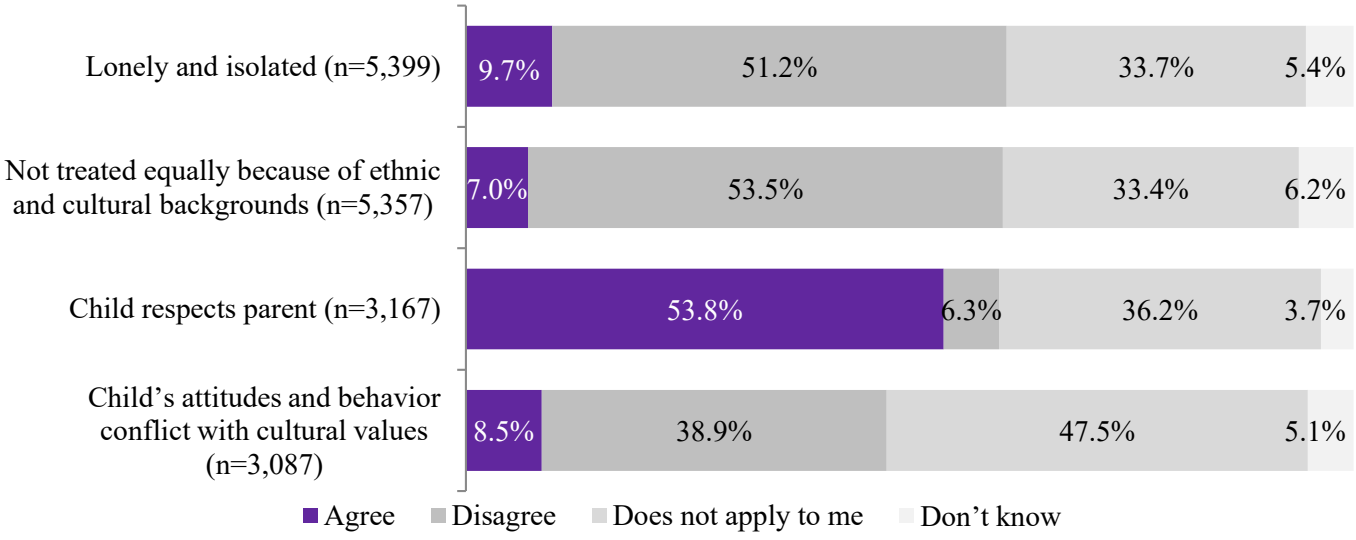


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

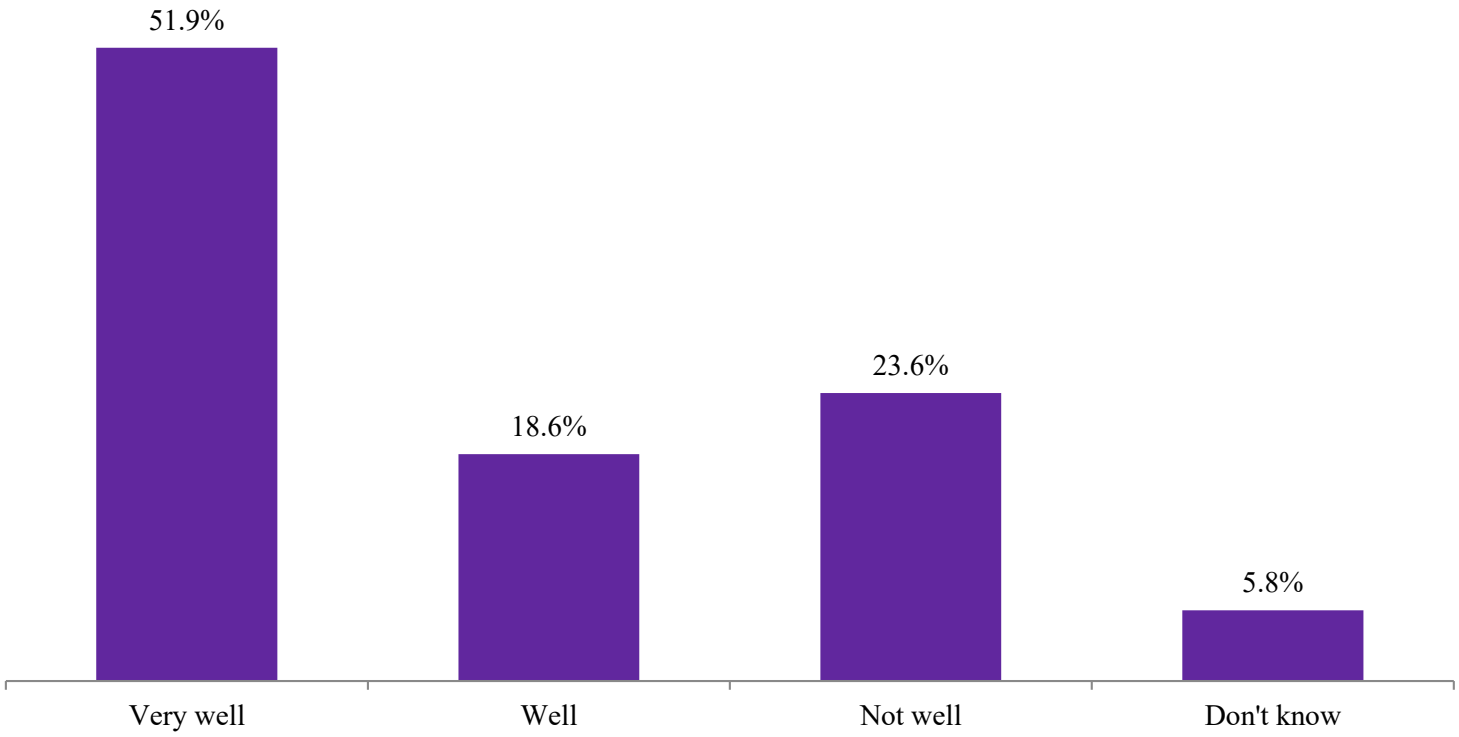


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

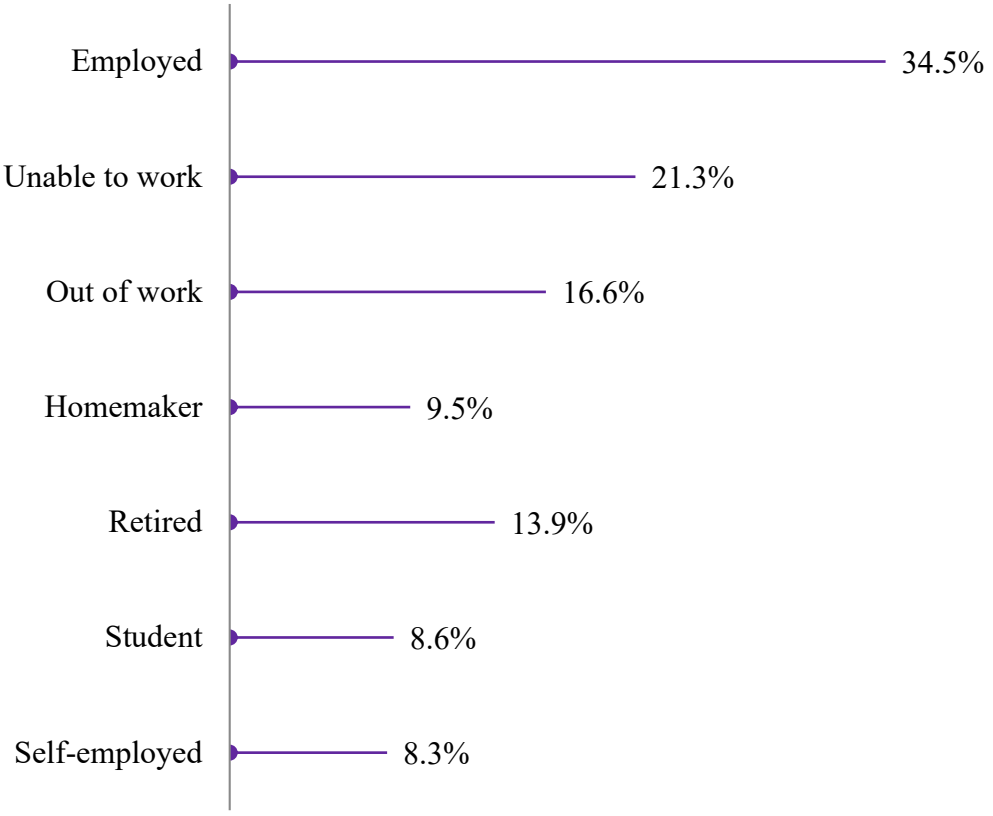
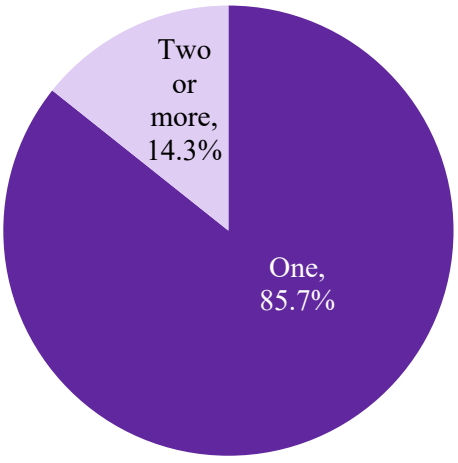
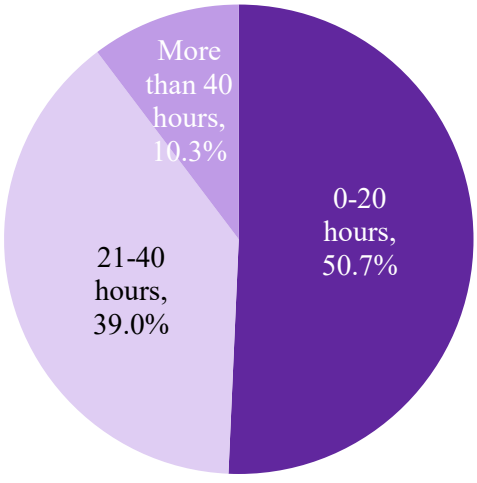


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

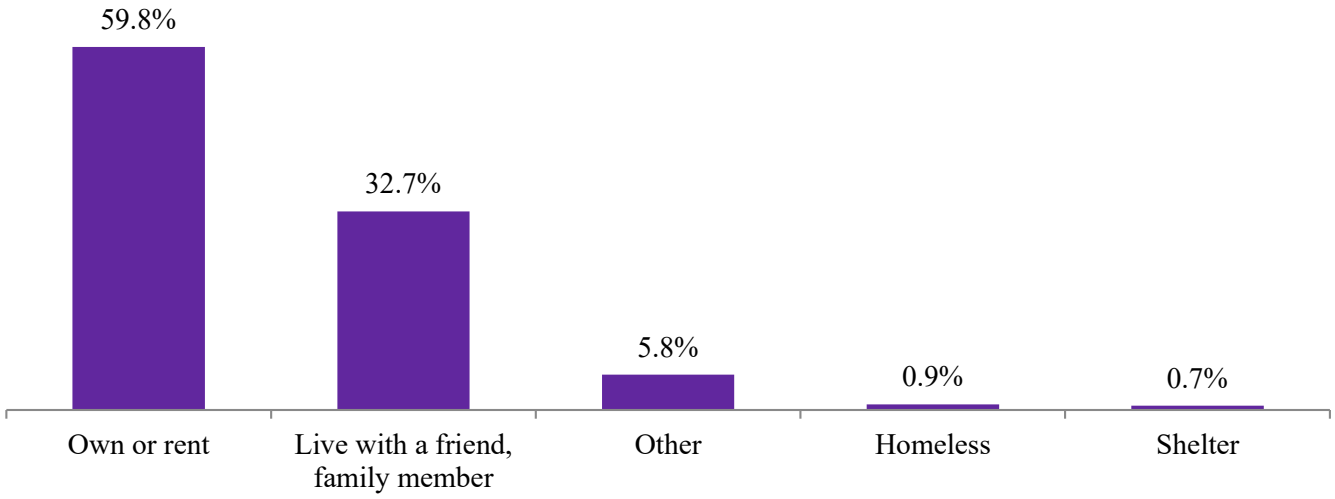
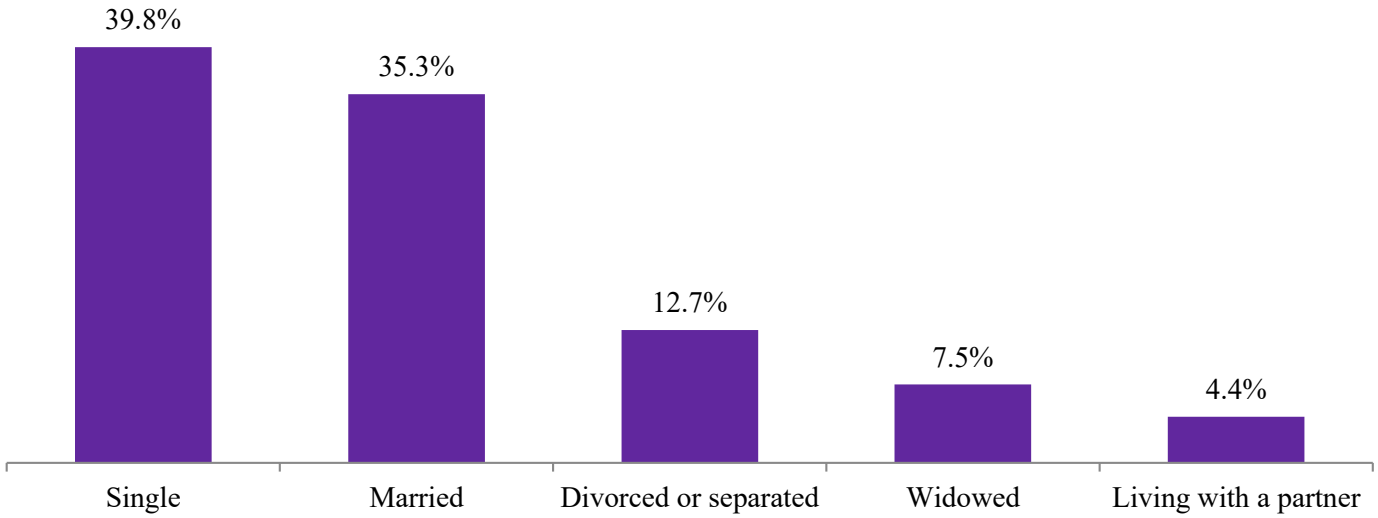


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

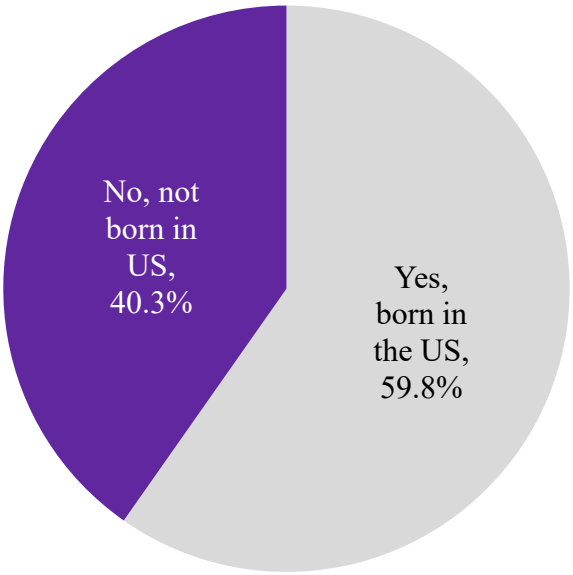
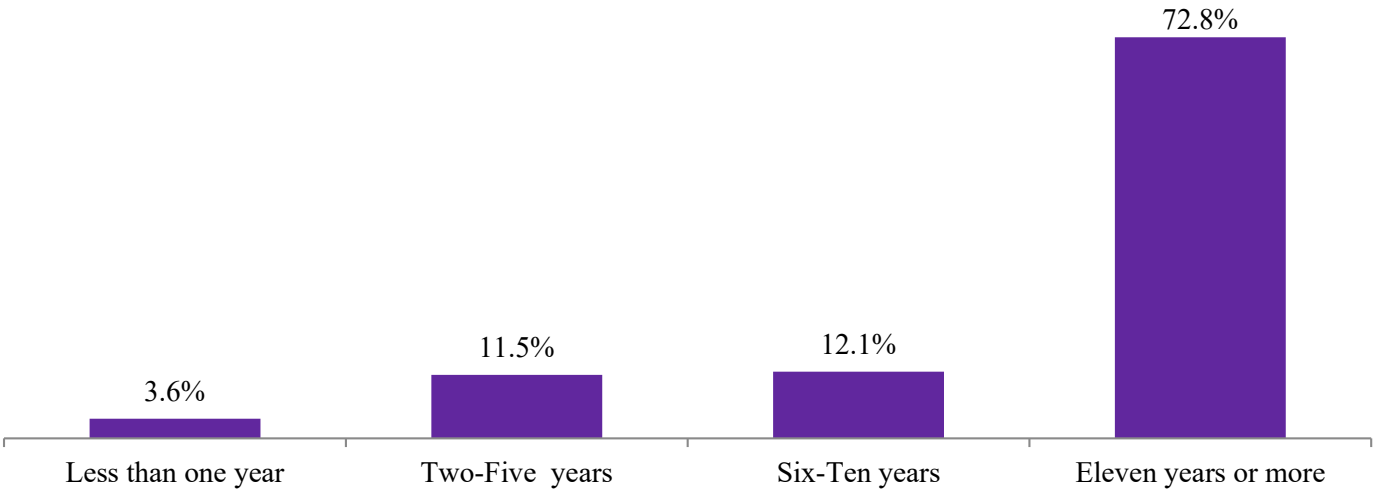


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

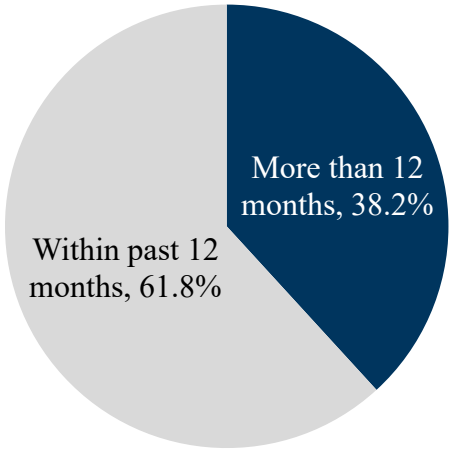
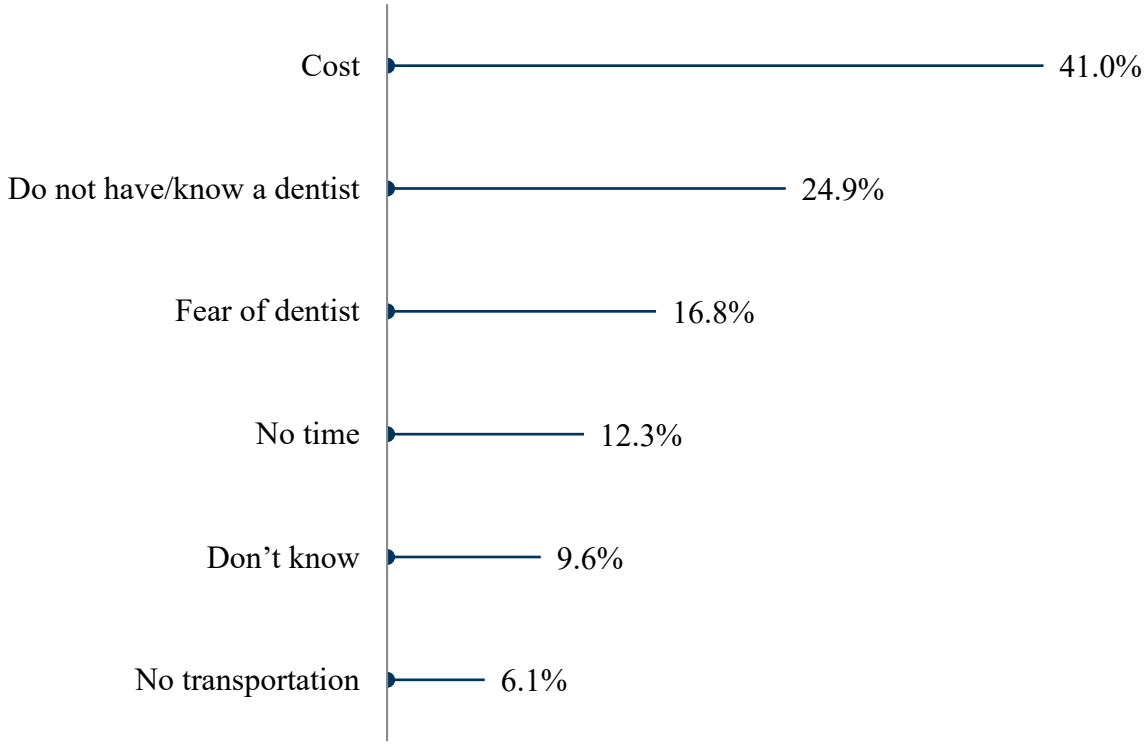
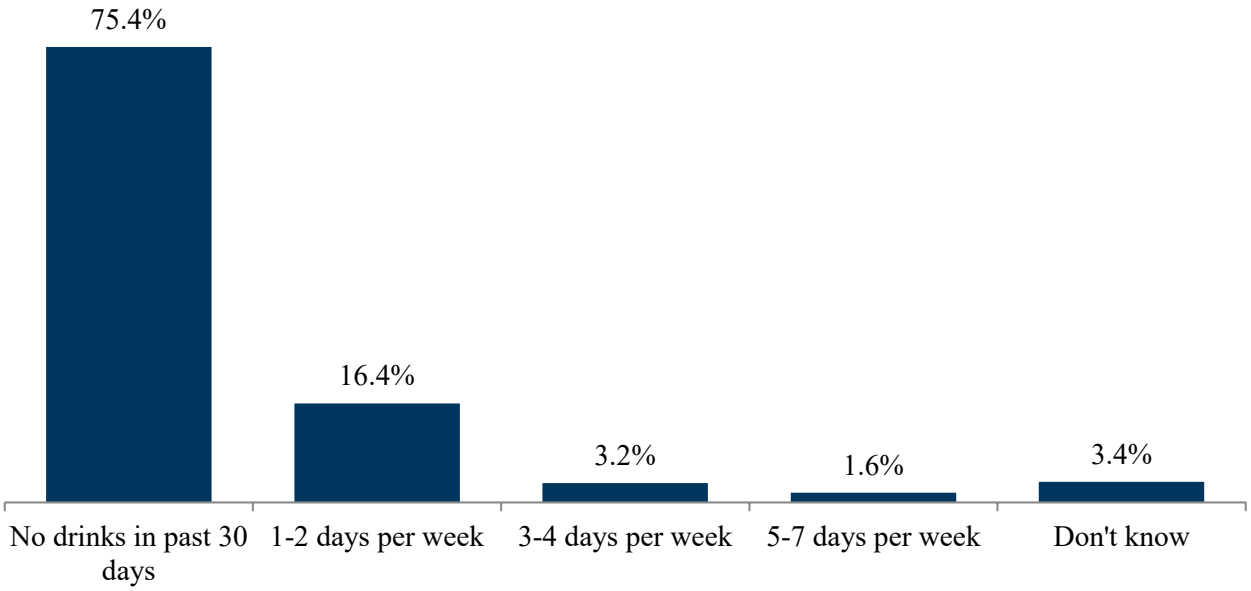


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize the release of Requests for Proposal (RFPs) for community grants with staff returning at a future Board meeting with recommendations for award decisions; and
2. Authorize the reallocation of IGT 2 funds remaining from the Autism Screening project to Community Grants consistent with the state-approved IGT 2 approved funding categories.

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to address the unmet needs identified by the MHNA.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

After the June 7, 2018 Board of Directors meeting, CalOptima released a notice for Requests for Information (RFI) from organizations to better define the scopes of work to address community needs in one or more of the above referenced categories. CalOptima received a total of 93 RFI responses from community-based organizations, hospitals, county agencies and other community interests. The 93 RFI responses are listed as follows:

Back to Agenda

MHNA Categories	# of RFIs
Adult Mental Health	15
Older Adult Mental Health	13
Children's Mental Health	13
Nutrition Education and Physical Activity	12
Children's Dental Services	5
Medi-Cal Benefits Education and Outreach	10
Primary Care Access and Social Determinants of Health	19
Adult Dental Services	6
TOTAL	93

Subject matter experts and grant administrative staff performed an examination of all the responses and evaluated them based on the following criteria:

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

Discussion

The Ad Hoc Committee, comprised of Supervisor Do and Director DiLuigi, met on November 9, 2018 to discuss the results of the 93 RFI responses for the MHNA categories and review the staff-recommended RFPs for consideration.

Following the review of the RFI responses, the staff evaluation process and recommendations, the Ad Hoc committee recommended moving forward with the following Community Grant categories:

Community Grant Requests for Proposal (RFPs)

Grant RFP	Total Grant Award
1. Access to Children's Dental Services	$1,000,000
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1,400,000
3. Access to Adult Dental Services	$1,000,000
TOTAL	**$3,400,000**

Back to Agenda

Staff is also recommending the reallocation of an amount up to $400,000 remaining from the IGT 2 Autism Screening Project to support these community grants. This provider incentive project aimed at increasing the access to autism screenings for CalOptima children members has been discontinued. The program was able to screen a total of 110 children. Support of the grant RFPs fulfills the original Board-approved uses of the IGT 2 funds which were as follows:

1. Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
2. Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventive dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventive health programs.

Funding for the above grant RFPs is derived as follows:

- **$3.0 million**: Remaining from IGT 5 (following anticipated Board action related to other IGT 5 funds)
- **$0.4 million:** Reallocation from IGT 2 Autism Screening Project
- **$3.4 million:** Total available for distribution through Community Grants

Following receipt and review of the RFP responses, evaluation committees consisting of staff and other subject matter experts will evaluate the responses based on a standardized scoring matrix, and will return to the Board with recommendations and proposed funding allocations.

Fiscal Impact

Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations. The recommended action to authorize the release of the Requests for Proposal (RFPs) for community grants has no additional fiscal impact to CalOptima.

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

PowerPoint Presentation: Community Grant RFP Recommendations

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

11/28/2018 — **Date**

Back to Agenda

Community Grant RFP Recommendations

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

IGT 5 Process Summary to Date

Board authorizes Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identifies categories for community grants

Board authorizes Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board Ad Hoc committee meets to consider recommending that the full Board authorize RFPs

Back to Agenda

IGT 5 Expenditure Process

- Subject matter experts and grant administrative staff evaluated/scored all 93 RFI responses by category
  - Evaluation committees met July 30–August 9
  - Provided recommendations on scopes of work to be developed into RFPs

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

Back to Agenda

Grant Funding

- **$14.4M** CalOptima's share of IGT 5
- **-$11.4M** Recommended grant to Be Well OC for first Wellness Hub
- **$ 3.0M** Remaining for recommended distribution for Community Grants
- **$ 400K** Re-allocation from IGT 2 Autism Screening Project
- **$ 3.4M** **Total Available for Community Grants**

Back to Agenda

Three Recommended Grant RFPs

RFP #	RFP Description	Funding Amount
1	Access to Children's Dental Services	$1 million
2	Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1.4 million
3	Adult Dental Services	$1 million
	Total	**$3.4 million**

* Multiple awardees may be selected per RFP

Back to Agenda

RFP 1

Access to Children's Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
  - Assist children/families with establishing a dental home close to their home for emergency and regular dental care
  - Provide or partner with other community dental providers to ensure patients receive restorative and other specialty dental services in addition to exams and screenings as needed

Back to Agenda

RFP 2

Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)

- **Funding Amount:** $1.4 million
- **Description:**
  - Establish and/or operate school-based wellness centers where family, staff and community partners collaborate to align resources
  - Partner with health clinics that allow for school referrals and follow-up care
  - Provide health assessment/screenings on school campuses and community-based education for families

Back to Agenda

RFP 3

Adult Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Expand availability of dental services/treatment at health centers and/or mobile units with medical care integration for comprehensive health care
  - Ensure provider/staff capacity to perform assessment and restorative dental services
  - Expand dental services to nontraditional evening and weekend hours
  - Establish collaboration with community clinics/resources for specialized dental care

Back to Agenda

Next Steps*

Mid-December 2018: CalOptima releases Community Grant RFPs, if approved

January 2019: RFP responses due

March 2019: Ad Hoc reviews recommended grant awards

April 2019: Board considers approval of grant awards

April 2019: grant agreements executed

* Dates are subject to change based on Board approval

Back to Agenda

CalOptima A Public Agency Better. Together.

RFP 1. Access to Children's Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 156,064	Expansion of Portable Oral Health Services and Tele-dentistry in Orange County	Expand access to portable Oral Health Unit services through addition of a Dental Hygienist and introduce a tele-dentistry component into the program.	600
Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000
Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment under general anesthesia) will be referred to traditional clinics in Garden Grove and CHOC Children's Hospital.	13,564
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Children	Educate members on optimal dental health by creating a strong traditional and social media presence. Provide exams and screenings to students in a mobile dental vehicle.	1,000

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Children in North Orange County	Develop a mobile dental care program in conjunction with the school districts and schools to do full dental exams, take x-rays, place sealants, and address problems such as dental caries.	1,310

RFP 2. Primary Care Services & Social Determinats of Health

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
CHOC Children's	$ 1,396,813	The School-based Student Wellness Center: Addressing the Social Determinants of Health Where Children Are	Create three School-based Student Wellness Centers within three Orange County school districts and enhance current mental health OC Department of Education (OCDE) offerings with novel physical health and social determinant services led by a school site Coordinator and staffed by medical, nutrition, fitness, and social services personnel.	3,886
Coalition of Orange County Community Health Centers	$ 1,400,000	Healthy Kids, Healthy Schools	Collaborate with five schools in establishing school-based wellness centers throughout Orange County. These wellness centers will provide immunizations, health screenings, health education, and direct comprehensive health care (medical, dental, vision, and behavioral health) with community clinics. Six letters of support from schools/school districts were submitted.	5,500

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
NAMI Orange County	$ 174,794	Decreasing Stigma Through Mental Health Education, While Increasing Access to Wellness Resources	NAMI-OC will host Ending the Silence (ETS) presentations and conduct outreach at schools to further educate and increase awareness surrounding mental health conditions. Resource Navigation services will also be offered for students and their families.	13,590
Santa Ana Unified School District	$ 1,400,000	Family and Community Engagement (FACE) Wellness Centers	Enhance the Family and Community Engagement (FACE) Wellness Centers at all 57 K-12 school sites across the school district. Service providers, healthcare professionals, and local clinics will conduct services within the centers which are located within walking distance from the homes of families and residents of the entire Santa Ana community. SAUSD collaborates with local stakeholders; business organizations, institutions of higher learning, for-profit and nonprofit organizations in order to provide wrap-around services for students, families and the surrounding community. Several agreements have already been established with service providers to partner with the SAUSD.	50,000

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Serving Kids Hope	$ 1,351,412	School-Based Wellness Program	The project formalizes district-wide wellness assessment based on State Wellness Standards, establishing baseline and measurement of impact. It will be data-driven, with district-wide wellness assessment, documented services, and analysis and reporting of outcomes. Two letters of support from school districts were submitted.	25,975
Wellness & Prevention Center	$ 224,631	Expansion and Integration of South Orange County School-Based Wellness Centers into the CalOptima Primary Care Network	Expand five school-based wellness centers and leverage existing agreement with the Capistrano United School District. Project will increase bilingual staff, expand parental engagement, and create educational materials.	300
RFP 3. Access to Adult Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 150,678	Expanded Access to Adult Dental Services in Orange County	Expand access through the addition of a dental team in the Santa Ana clinic location and expand service hours (evening and weekend). The project also: increases awareness about coverage; promotes timely treatment plan completion; links members to a dental home; and integrates culturally-responsive, language-appropriate dental and medical services.	300

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Camino Health Center	$ 50,000	Adult Dental Services Expansion	Camino Health Center will be using funds to provide additional evening and weekend hours in the current dental clinic. The additional hours will allow more patients in the community access to receive dental services with hours that may be more compatible to their personal schedules. The additional funding for elective dental procedures with lab fees will allow patients to have access to procedures not covered by insurances.	150
Families Together of Orange County	$ 1,000,000	Bridging the Gap: Addressing Orange County's Oral Health Needs	Open a new health center with four dental exam rooms located on the border of Garden Grove and Anaheim, targeting patients who speak Arabic, Spanish, or Vietnamese. Dental care will be integrated into FTOC's comprehensive primary care services with evening and weekend hours.	6,000
KCS Health Center (Korean Community Services)	$ 987,600	Integration of MECCA Community Based Organizations with FQHC Adult Oral Care Access in Mobile and Nontraditional Delivery Modalities	KCS Health Center requests to build mobile sites at each of its six (6) partnering MECCA community-based organizations and extend hours of operation to nontraditional hours at the mobile sites as well as at KCS Health Center and Southland Integrated Services locations. The organizations together serve populations that speak Spanish, Vietnamese, Korean, Farsi, Arabic, and Khmer	8,000

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Adults	Educate members on optimal dental health by creating a strong traditional and social media presence. Add an additional day (on Fridays) for 9 hours to provide more access to care and allow more appointments.	1,000
Livingstone Community Development Corporation	$ 350,000	Finding Your Smile: Expanding Dental Services for Adults Beyond Emergency Care	Expand direct preventive and restorative dental services by increasing dental program staff, extending hours and days of operation and providing improved integration with its primary care program. The dental program will provide exams and x-rays, dental cleaning, cavity fillings, extractions, root canal treatments, and crowns.	2,500
Serve the People	$ 1,000,000	Oral Health for the Homeless	Establish dental care access points with a three-chair dental mobile unit at 10 homeless shelters managed by homeless support service providers. These new dental homes will provide preventative, restorative, and specialized dental care to CalOptima members.	1,500
St. Jeanne de Lestonnac Free Clinic	$ 180,000	Oral Health Program	Increase outreach efforts and purchase equipment and supplies to treat more patients. Dental services include exams, x-rays, fillings, root canals, and tooth extractions. Lab work and/or dental prosthetics will be available to patients at cost with no additional markup.	100

Back to Agenda

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Adults in North Orange County	Develop a mobile dental care program serving adults in La Habra to do full dental exams, x-rays, sealants, and addressing problems such as dental caries. The program will be include an outreach initiative, to helping to raise awareness of safety-net healthcare services, and promoting knowledge of and access to CalOptima's health care services.	1,426

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Actions Related to Homeless Health Care Delivery

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
    a. Reallocate $135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
    b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
    c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background
CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a Clinical Field Team pilot program • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details • Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

Back to Agenda

	• Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
June 27, 2019	Authorized $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

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc's intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately $324,000, or $270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately $320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to $300,000 from the $10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile until for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to $300,000 for claims payments and up to $270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the "Clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

The recommended action to reallocate $135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

Back to Agenda

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurtt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corpration dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

Back to Agenda

Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084

Back to Agenda

Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

Back to Agenda

Agenda

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

Back to Agenda

Current System of Care

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

**For Medi-Cal Members*

Back to Agenda

Current System of Care (Cont.)

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

Back to Agenda

Gaps in the Current System of Care

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

Back to Agenda

Immediate Response

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

Back to Agenda

Strengthened System of Care

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

Back to Agenda

Federal and State Guidance

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

Back to Agenda

Federal and State Guidance (Cont.)

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

Back to Agenda

Activities in Other Counties

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

Back to Agenda

Considerations

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

Back to Agenda

Additional Considerations

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

Back to Agenda

Recommended Actions

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

Back to Agenda

Recommended Actions (Cont.)

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

Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

Back to Agenda

Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

Back to Agenda

Clinical Field Team Pilot

- Board approved up to $1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
  - Partner with up to five interested FQHCs that will:
    - Establish regular hours at high-volume shelters
    - Deploy to community locations on short notice
    - Coordinate to arrange for coverage with extended hours
    - Deliver urgent-care-type services to homeless individuals in need
      - Bill CalOptima for current CalOptima members
      - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

Back to Agenda

Homeless Response Team

- Board authorized CalOptima Homeless Response Team
  - Eight new positions in Case Management department
  - Primary point of contact at CalOptima for homeless health services for CalOptima members
    - Dedicated phone line
    - Extended hours
  - Coordinate scheduling and dispatch of CFTs
  - Work closely with County, shelters and providers
    - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

Back to Agenda

Expanded Service Options Under Consideration

- Embedded clinics at shelters
  - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
  - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
  - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

Back to Agenda

Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
  - Set up a post-WPC recuperative care program
  - Reallocate part of $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
    - From WPC recuperative care funds
    - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
  - Coordinate with County to explore possibilities of:
    - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
    - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Back to Agenda

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
  - CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
    - WPC
      - Link clients to other programs that provide housing supportive services
      - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
    - Health Homes Program
      - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
      - Members must elect to participate
      - Care management includes housing navigation

Back to Agenda

Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
  - Obtaining legal opinion
  - Seeking guidance from the Department of Health Care Services

Back to Agenda

Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
  - WPC hospital navigators
  - Increased access to skilled nursing services
  - Recuperative care beyond 90 days
  - Recuperative care with behavioral health focus
  - Housing supportive services
  - Housing development and rental assistance

Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

Back to Agenda

Impetus for Action in Orange County

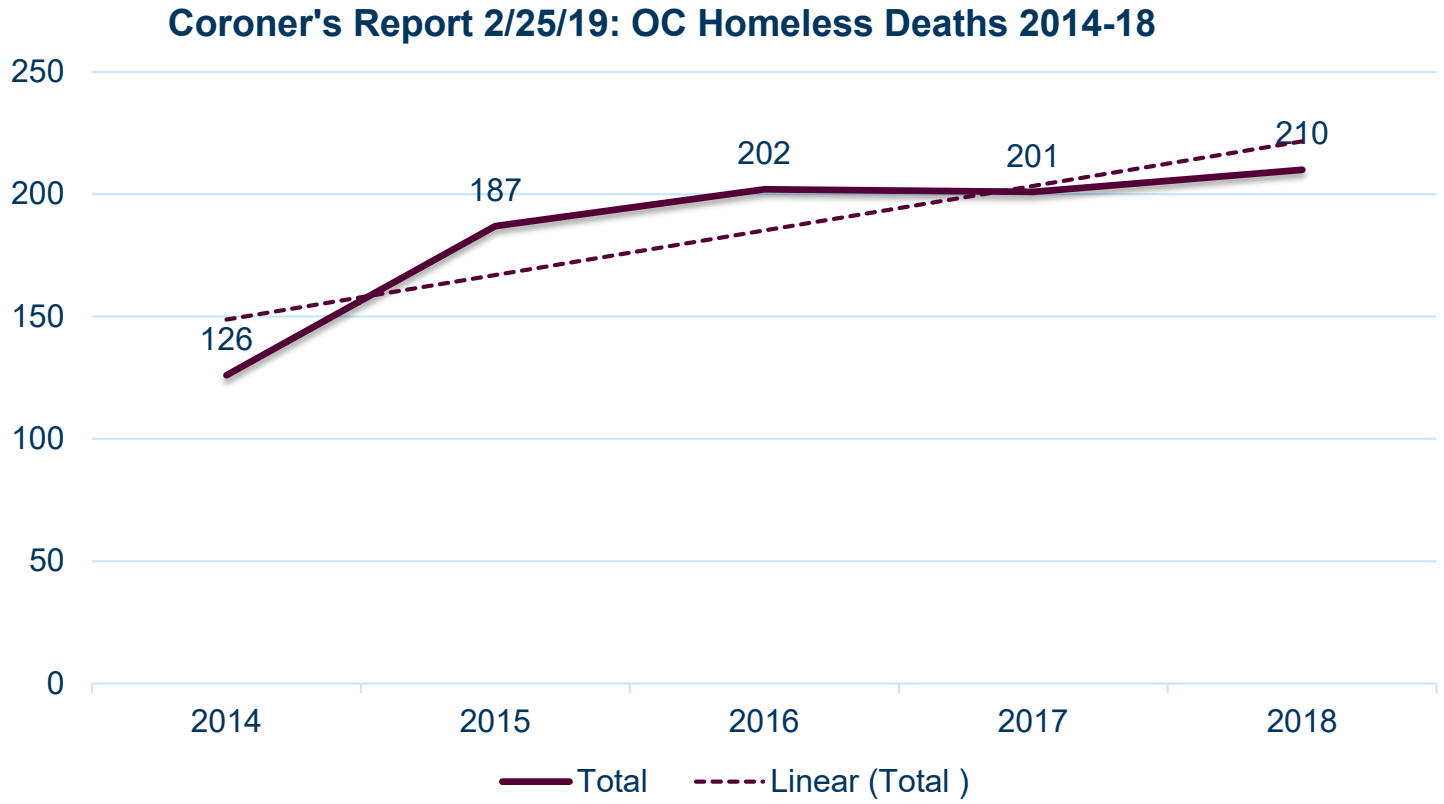
- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Back to Agenda

Homeless Deaths

Back to Agenda

Coroner's Report on Homeless Deaths



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

Back to Agenda

Coroner's Report on Homeless Deaths And Possible Interventions

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

Back to Agenda

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

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

Back to Agenda

Quality Assurance Committee
Further Clinical Analysis

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

Back to Agenda

Better System of Care

Back to Agenda

Ad Hoc Recommendations

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

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

Back to Agenda

Clinical Field Team Structure

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

Back to Agenda

Clinical Field Team Structure (cont.)

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

Back to Agenda

Clinical Field Team Partnerships

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

** Signed contract amendment*

Back to Agenda

CalOptima Homeless Response Team

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

Back to Agenda

Homeless Population in CalOptima Direct

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

Back to Agenda

Homeless Coordination at Hospitals

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

Back to Agenda

Medical Respite Program

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

Back to Agenda

WPC Connect

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

Back to Agenda

WPC Connect (cont.)

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

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

Back to Agenda

Better System of Care: Future Planning

Back to Agenda

Evolving Strategy and Homeless Health Needs

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

Back to Agenda

Recommended Actions

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

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

CalOptima's Mission

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

Back to Agenda

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

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

Back to Agenda

Discussion

Clinical Field Team Pilot Program (CFTPP)

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

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

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

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

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

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

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

Back to Agenda

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

FQHC Contracts

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

Back to Agenda

Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

Back to Agenda

Agenda

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

Back to Agenda

Current System of Care

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

**For Medi-Cal Members*

Back to Agenda

Current System of Care (Cont.)

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

Back to Agenda

Gaps in the Current System of Care

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

Back to Agenda

Immediate Response

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

Back to Agenda

Strengthened System of Care

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

Back to Agenda

Federal and State Guidance

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

Back to Agenda

Federal and State Guidance (Cont.)

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

Back to Agenda

Activities in Other Counties

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

Back to Agenda

Considerations

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

Back to Agenda

Additional Considerations

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

Back to Agenda

Recommended Actions

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

Back to Agenda

Recommended Actions (Cont.)

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

Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

MEMORANDUM

DATE:	May 2, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April

CalOptima moved our $100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- Clinical Field Teams: Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurtt Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- Anaheim Encampment: Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- Use of Funds: Approximately $60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

Back to Agenda

allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- Stakeholder Input: The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- State Programs and Legislation: Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total $36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force $16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DHMC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigette Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OFCA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

Back to Agenda

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

Back to Agenda

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

Back to Agenda

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:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend 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

Back to Agenda

CalOptima
A Public Agency
Better. Together.

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.

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

Back to Agenda

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,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative.

Contact

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

Recommended Actions

1. Authorize modification of the existing "CalOptima Day" Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
2. Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
3. Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

Background

"CalOptima Day" is one of the Quality Improvement and incentive strategies approved by the Board on December 1, 2016 as part Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. CalOptima Day aims to increase access to care, enhance the member experience, and improve quality outcomes in collaboration with health networks and CalOptima Community Network provider offices. CalOptima Days are half- or full-day health and wellness events for high-volume provider offices or clinics chosen by health networks. Staff works with the provider office/clinic to schedule members to receive necessary preventive services on CalOptima Day. The provider office/clinic earns incentives for each completed preventive health visit, as evidenced by billing/encounter reporting using codes in accordance to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The intent of these initiatives is to increase access to care and provide CalOptima members with immunizations, well-care visits and/or other services tied to quality measures. CalOptima Days have proven to be an impactful quality activity since they began in 2016. Due to the many benefits linked to CalOptima Days, they are now part of an ongoing quality strategy to improve access to preventive care and performance on quality measures.

During the February, April and June 2019 CalOptima Board meetings, the Board approved various homeless health initiatives, including an implementation plan for the Clinical Field Team Pilot Program (CFTPP) and contracts with Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes (jointly Community Health Centers) selected to participate in the CFTPP.

Back to Agenda

As part of the CFTPP, CalOptima amended its contracts with five Community Health Centers to provide on-call services at hot spots throughout the county such as parks, encampments and shelters to address urgent clinical needs of individuals experiencing homelessness.

Further, the Board requested that CalOptima staff focus on significantly expanding preventive and primary care services at homeless shelter sites. CalOptima also received stakeholder feedback that such services would also be valuable at other hot spots, such as soup kitchens. CalOptima staff proposes expansion of the CalOptima Day model to provide greater access to preventive and primary care services at these locations in collaboration with interested Community Health Centers, whether they participate in CFTPP or not.

At its June 27, 2019 special meeting, the Board approved funding allocations for $60 million in new Homeless Health Initiatives. As part of this action, the Board allocated $10 million to "Clinic health care services in all homeless shelters."

Discussion

Staff recognizes the need for members experiencing homelessness to have reliable access to preventive and primary care in shelters and at other settings. Many shelters already have established relationships with community providers to provide those services via either an on-site or mobile clinic; however, hours may be limited. These services are sometimes not be billed, even when a provider is rendering services to a CalOptima member. This may occur, for example, if the provider is not contracted with the member's assigned health network or is not the member's assigned primary care provider (PCP). Further, some Community Health Centers have advised that set up and tear down of mobile clinics is time consuming and may not be cost-effective, even if the clinic is able to bill for the visit. These factors may contribute to limited access to care at shelters and other hot spots.

To address these concerns, CalOptima staff proposes partnering with any interested Community Health Centers to provide preventive and primary health care services at shelters and other hot spots. This may include locations that do not have established schedules with community providers, as well as those that may benefit from expanded schedules. These Community Health Centers will be required to create a regular schedule based on input from the shelters/hot spots, and those schedules will be informed by need, which may include bed count, frequency of resident turnover, other individuals served at the location, existing service schedules, and proximity to community providers. Additionally, the Community Health Centers will be expected to encourage CalOptima members to seek services from their assigned CalOptima providers and coordinate services with other medical and behavioral health care providers.

As proposed, and similar to the CalOptima Day tiered incentive payment model, clinics maintaining a presence at the shelter or hot spot will be compensated up to $1 million annually in total for all participating providers, excluding CalOptima staff resources, based on expanded hours and services completed for CalOptima members, as well as claims submission.

CalOptima staff proposes to offer eligible providers with a monetary incentive for participating in the HCAP according to two (2) tiers:

Back to Agenda

- Tier 1: An eligible provider will receive a Tier 1 provider incentive for event participation for a half day (4 hours) or a full day (8 hours).

- Tier 2: An eligible provider may receive a Tier 2 provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
    - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visit.
    - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visit.

Provider Incentive	Half Day (4 hours)	Full Day (8 hours)
Tier 1	$800	$1,600
Tier 2	$400	$800

Staff estimates that CalOptima will schedule a combination of 10 half day or full day HCAP events per week, with an average of 15 appointments completed during each event.

CalOptima staff will leverage the coordination and incentive mechanisms already established by the current CalOptima Day strategy. The effectiveness of CalOptima Days is measured by lead measures such as numbers of members accessing services, numbers of CalOptima Days with expanded hours, and lag measures such as HEDIS. A similar program measurement and evaluation discipline will apply to the HCAP.

In addition, management requests additional staffing to coordinate HCAP. Staff recommends the addition of two full-time equivalent positions: a Program Manager and a Quality Analyst. The total estimated annual impact of the addition of the two staff positions is approximately $231,087.

Fiscal Impact

The recommended action to develop HCAP by modifying the existing CalOptima Day Quality Improvement and incentive strategy is a Homeless Health Initiative budgeted item. Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures are budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget approved by the Board on June 6, 2019 and will be funded from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the care they need. By partnering with shelters, other hot spots and Community Health Centers to implement the HCAP will help provide members with access to preventive and primary health services that this population segment may not otherwise seek. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Homeless Clinic Access Program Presentation
2. Board approval of Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. on December 1, 2016
3. CalOptima Day Fact Sheet

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

CalOptima Homeless Clinic Access Program

David Ramirez, M.D.
Chief Medical Officer

Betsy Ha, R.N., M.S., LSSMBB
Executive Director, Quality & Population Health Management

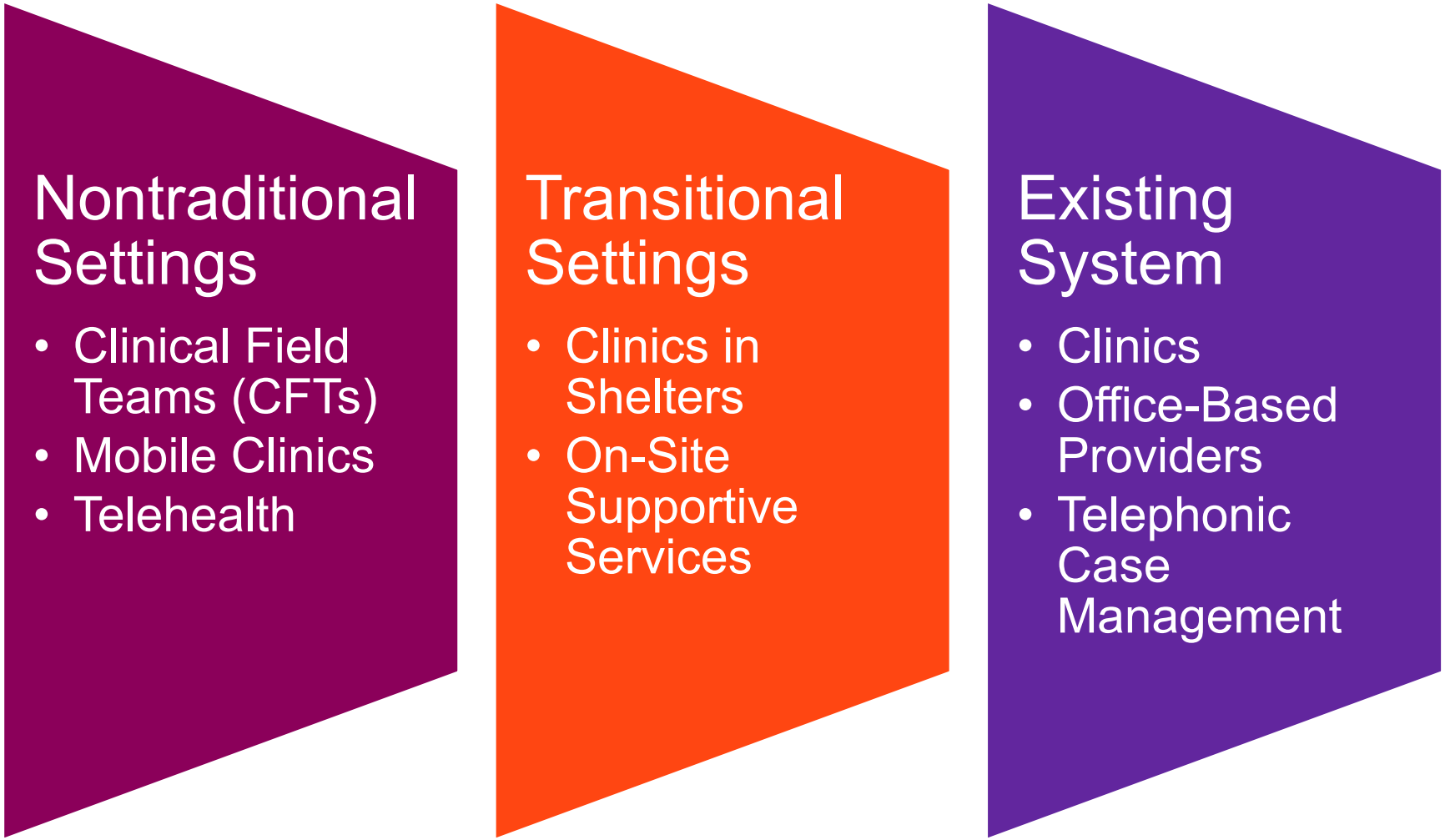
Back to Agenda

Building a Better System of Care

- In response to the homelessness crisis in Orange County, CalOptima has approved the following:
  - Homeless Response Team to coordinate care
  - Deployed the Clinical Field Team in collaboration with Federally Qualified Health Centers (FQHC) to provide urgent care for those unable or unwilling to access the traditional care system
  - Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination
  - Increased Recuperative Care funding and creation of a Medical Respite Program
- These initiatives focus on the urgent and clinical needs of members unsheltered.

Back to Agenda

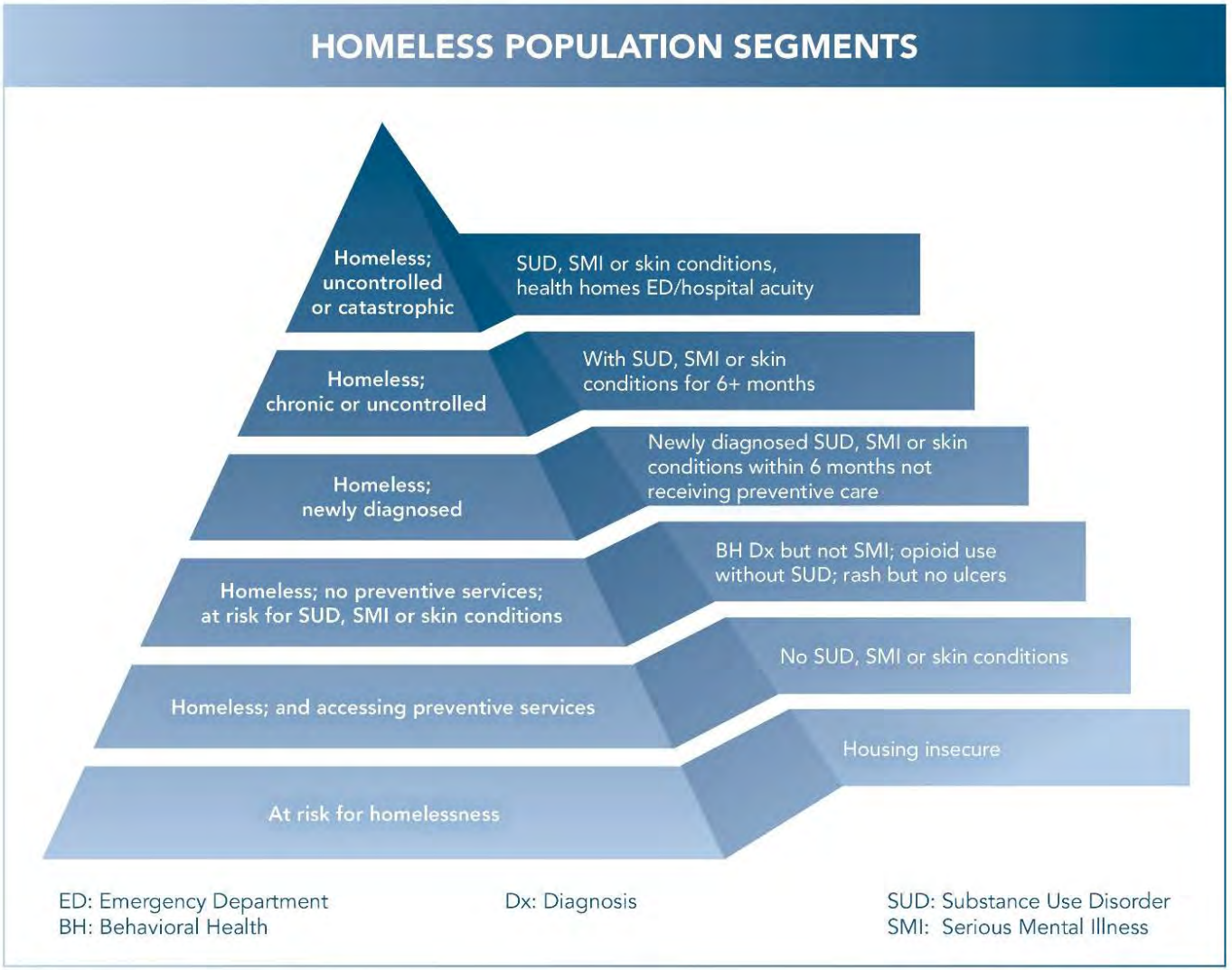
Bridging to Existing System



Back to Agenda

CalOptima A Public Agency Better. Together.

A Population Health Approach



Back to Agenda

Clinic Health Care Services

- In response to the June 27, 2019, special meeting, the Board approved funding allocations of $60 million for new homeless health initiatives.
- As part of this action, the Board allocated $10 million to “Clinic health care services in all homeless shelters.”
- Staff recognizes the need to establish reliable, recurring, preventive and primary care schedules for members experiencing homelessness who are staying in shelters.
- Currently, most shelters in Orange County have inadequate physical health services available either on-site or through mobile clinics

Back to Agenda

Leveraging Quality Incentives

Modify the “CalOptima Day” Quality Improvement and incentive strategy for Homeless Health Initiative

Develop a CalOptima Homeless Clinic Access Program (HCAP)

Provide CalOptima Homeless Clinic Access Program (HCAP) at Orange County homeless shelters and other appropriate locations

Back to Agenda

What is CalOptima Day?

- A practice site-based Quality Improvement and incentive strategy used by CalOptima since 2016 to improve member access to care and HEDIS performance results
  - A half or full-day health and wellness event that is co-hosted by CalOptima, a health network, and a clinic or provider office, offering immunizations and well-care visits to our Medi-Cal members.
  - Clinic/providers offices' to only schedule appointments for CalOptima members assigned to the participating health network and clinic/provider office designated CalOptima Days.
  - Providers are incentivized to host the event and can receive up to $2,400 per CalOptima Day.
  - Members are incentivized with a $25 gift card for completing a visit.

Back to Agenda

2018 CalOptima Day Focused Measures

- Well-Care Measures
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
  - Adolescent Well-Care Visits (AWC)
- Immunization Measures
  - Childhood Immunization Status (CIS)
    - Combo 10
  - Immunizations for Adolescents (AWC)
    - Combo 2

Back to Agenda

CalOptima Homeless Clinic Access Program (HCAP)

- Increase the availability of preventive and routine health care services at Orange County shelters to create regular clinic schedules informed by need.
- Provide care transition support and encourage CalOptima members to seek services from their assigned CalOptima providers.
- Coordinate services with other medical and behavioral health care providers when needed.

Back to Agenda

Proposed Quality Measures

- Preventive services, screenings and chronic care HEDIS measures may include but not be limited to:
  - Access to Ambulatory and Preventive Care Services (AAP)
  - Adult BMI Assessment (ABA)
  - Chlamydia Screening (CHL)
  - Cervical Cancer Screening (CCS)
  - Adult Immunization Status (AIS)
  - Comprehensive Diabetes Care (CDC)
    - HbA1C
    - Retinal Eye Exam
    - Blood Pressure

Back to Agenda

Proposed Provider Incentives

- CalOptima will offer eligible providers a monetary incentive for participating in the CalOptima Homeless Clinic Access Program (HCAP) events according to two (2) tiers:
  - Tier 1: Eligible provider receives a Tier 1 incentive for event participation for a half (4 hours) or full day (8 hours)
  - Tier 2: Eligible provider may receive a Tier 2 provider incentive, in addition to Tier 1, if the following levels or service are provided;
    - Eligible provider completes 10 appointments during half day (4 hours)
    - Eligible provider completes 20 appointments during a full day (8 hours)

Provider Incentive	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Incentive	$800	$1,600
Tier 2 Incentive	$400	$800

Back to Agenda

Fiscal Impact

- Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures
- Budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget
- Approved by the Board on June 6, 2019
- Will fund from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019

Staffing Expenditure

- Hire Program Manager and Quality Analyst
- Perform incentive program management
- Facilitate scheduling
- Provide care transition support
- Monitor quality and access to primary care
- Coordination with internal and external partners
- Quality performance measurement, analysis and reporting

Back to Agenda

Recommended Action

- Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
- Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
- Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

Contact

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

Recommended Actions

1. With respect to the Grant application submitted by AFH Casa Paloma LP and by other developer applicants under Article I of the Department of Housing and Community Development Housing for Healthy California (HHC) Program, authorize the Chief Executive Officer (CEO) to provide such applicants whose target populations include CalOptima Medi-Cal Members with a letter of commitment for Medi-Cal supportive services in conjunction with their proposed participation for the program;
2. With respect to the Grant application submitted by the Orange County Health Care Agency (HCA) under Article II of the Department of Housing and Community Development Housing for Healthy California (HHC) Program:
   A. Authorize the CEO to provide HCA with a letter of commitment for Medi-Cal supportive services participation for the program; and,
   B. Authorize the CEO, with the assistance of Legal Counsel, to enter into a Memorandum of Understanding (MOU) with HCA to coordinate Supportive Services and information exchange activities.

Rev. 8/1/19

Background

In September 2017, AB 74 was signed into law authorizing the California Department of Housing and Community Development (HCD) to develop the Housing for Healthy California (HHC) Program to create supportive housing opportunities through competitive grants to counties and developers. The goal of the HHC Program is to reduce the financial burden of emergency room visits, inpatient care and nursing home stays and use of corrections systems and law enforcement resources as the point of health care for people who are chronically homeless or are homeless and high-cost health care users.

On May 13, 2019, HCD released final guidance and Notice of Funding Availability (NOFA), including application requirements for two funding opportunities under:

- Article I: for property owners or developers for operating reserve grants and capital loans using National Housing Trust Fund allocations; and

- Article II: for counties to acquire, newly construct, or reconstruct and rehabilitate homes, as well as for rental subsidies and rental assistance for existing and new supportive

Back to Agenda

housing opportunities. For this purpose, "county" means a county, city and county or a city collaborating with a county to secure services funding.

The target population to be served under both Articles I and II is a person who is:

- Chronically homeless or is homeless and high-cost health care users upon initial eligibility;
- A Medi-Cal beneficiary;
- Eligible for Supplemental Security Income;
- Eligible to receive services under a program providing services promoting housing stability; and,
- Likely to improve his or her health conditions with Supportive housing.

A Supportive Services Plan (the Plan) must be submitted with applications under Articles I and II. The Plan describes the supportive services provided for those eligible for HHC Program and identifies the Lead Service Provider (LSP) with overall responsibility for provision of the supportive services and for implementation of the Plan. Supportive Services are defined as social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits. The LSP may provide services directly or through agreement with other agencies. The LSP must have at least three or more years of experience serving members in the target population, including comprehensive case management in supportive housing.

The application under Article I must also include a Memorandum of Understanding (MOU) or commitment letter from the Lead Service Provider or county department to make available to the project's HHC tenants case management and supportive services from one of the following:

- County's Whole Person Care (WPC) Pilot;
- Health Homes Program (HHP);
- Managed care organization (MCO); or,
- Other community-based health care services.

The Application under Article II requires identified funding sources for providing intensive services promoting housing sustainability including, for example:

- County general funds;
- WPC pilot program funds, to the extent those funds are available, or the WPC program has been renewed;
- HHP;
- MHSA program;
- MCO; or,
- Other County-controlled funding to provide these services to eligible participants.

The application under Articles I and II require budget and staffing information for service delivery, including from subcontractors, which may include in-kind services that might be

Back to Agenda

provided, for example, by an MCO and HHP programs. The applications are due August 13, 2019.

Discussion

Orange County Community Resources and HCA (jointly the County) have taken a leadership role for planning and supporting development of applications by an owner or developer under Article I, and by HCA under Article II, as well as for Supportive Services Plan development under Article II. Collaboration between CalOptima and County on the HHC Program began in March 2019.

Article I

AFH Casa Paloma LP is expected to submit an application under Article I for development of a 49-unit complex of which will 24 will be supportive housing units (Development). AFH Casa Loma LP has advised that its affiliate, American Family Housing, Inc. a 501(c) (3) organization, will be the LSP for the Development. The application will include the Supportive Services Plan outlining the roles and responsibilities of the LSP, HCA, and CalOptima; CalOptima's responsibility will include services that are required of it under its DHCS contracts, such as providing access to primary, preventive and specialty care for all tenants who are CalOptima members and, for HHP enrolled members, housing navigation services and tenancy support services. Thus, CalOptima's participation will be limited to CalOptima Medi-Cal Members, including those in HHP and to Medi-Cal covered services. AFC Casa Loma LP has requested CalOptima provide a letter of commitment to satisfy the application requirements. CalOptima anticipates that any other applicant under Article I would make a similar request. Additionally, AFS Casa Loma has requested that CalOptima enter into a Memorandum of Understanding (MOU) with its LSP prior to the first tenancy if it is awarded an HHC grant; the first tenancy is not expected until at least 2021. CalOptima staff will return to the Board at a future meeting to seek authority to enter the MOU, if needed.

Article II

The HCA has advised that it intends, subject to Board of Supervisors approval, to submit an application under Article II for funding for housing subsidies for 214 individuals. CalOptima staff and the County have reviewed the application requirements, as well as their respective experience with the target population. They also discussed the HCA led Whole Person Care pilot, under the Department of Health Care Services (DHCS) Medi-Cal 2020 waiver program; discussions included CalOptima's on-going participation in WPC, the current December 31, 2020 waiver expiration date and HCA's planned development of a sustainability plan to continue services following termination of the WPC pilot.

CalOptima staff has shared information about the anticipated implementation of HHP on January 1, 2020, subject to DHCS approval. CalOptima staff and the County have also reviewed the overlapping target populations and services under their various respective programs. It has been noted that some potential tenants may not be CalOptima Medi-Cal members (either initially or during their tenancy), and that many of the specific services (e.g., peer support, recreational and

Back to Agenda

social activities) are not covered services under CalOptima's Medi-Cal Agreement with DHCS, and some services will be covered only for members enrolled in HHP (e.g., housing navigation and tenancy support services). Thus, CalOptima's participation will be limited to CalOptima Medi-Cal Members, including those in HHP and to Medi-Cal covered services.

CalOptima staff and the County additionally reviewed the application requirements, particularly related scoring based on experience in providing supportive housing services. In order to provide the strongest possible application, HCA is expected to be the LSP under Article II. The application will include the Supportive Services Plan outlining the roles and responsibilities of the LSP and CalOptima. HCA has requested CalOptima provide a letter of commitment to satisfy the application requirements. Additionally, HCA has asked that CalOptima enter into an MOU, should HCA be awarded an HHC grant. Similar to Article I, CalOptima's responsibility will be consistent with its responsibilities under its DHCS Medi-Cal contract.

Fiscal Impact

Management does not anticipate an additional fiscal impact for the proposed participation in the HHC Program. Services provided under the HHC Program will be limited to Covered Services for CalOptima enrolled Medi-Cal Members. To the extent there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

CalOptima, County and American Family Housing share common goals of improving care and health outcomes for residents of Orange County, including members experiencing homelessness. HHC provides increased opportunities for CalOptima members who are chronically homeless or high-cost health utilizers, including those who may be eligible or enrolled in HHP and/or WPC.

Concurrence

Gary Crockett, Chief Counsel

Attachments

California Department of Housing and Community Development Housing for Healthy California Final Guidelines amended May 13, 2019

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

Housing for a Healthy California (Chapter 777, Statutes of 2017)
Final Guidelines Amended

State of California
Gavin Newsom, Governor

Alexis Podesta, Secretary
Business, Consumer Services and Housing Agency

Ben Metcalf, Director
Department of Housing and Community Development

2020 West El Camino Avenue, Suite 500
Sacramento, CA 95833

Telephone: (916) 263-2771
Website: http://www.hcd.ca.gov
HHC email: HousingforHealthyCA@hcd.ca.gov

January 25, 2019
Amended May 13, 2019

Back to Agenda

The matters set forth herein are regulatory mandates, and are adopted in accordance with the authorities set forth below:

> Quasi-legislative regulations … have the dignity of statutes … [and]… delegation of legislative authority includes the power to elaborate the meaning of key statutory terms…
>
> *Ramirez v. Yosemite Water Co.*, 20 Cal. 4th 785, 800 (1999)
>
> Any regulations or guidelines that are adopted, amended, or repealed to implement this part shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
>
> Health and Safety Code Section 53598, subdivision (b).

INTRODUCTION

The Housing for a Healthy California (HHC) Program provides funding that allows the California Department of Housing and Community Development (Department) to provide Supportive housing opportunities through grants to Counties for capital and operating assistance, or operating reserve grants and capital loans to developers on a competitive basis. The guidelines for the Program are organized into two Articles as follows:

Article I. National Housing Trust Fund Allocation. This section includes Program definitions and requirements pursuant to the federal National Housing Trust Fund (NHTF) allocations. The Department will allocate these NHTF funds competitively to developers for operating reserve grants and capital loans.

Article II. Building Homes and Jobs Trust Fund Allocation. This section includes Program definitions and requirements pursuant to SB 2 Building Homes and Jobs Act. The Department will utilize a portion of monies collected in calendar year 2018 and deposited into the Building Homes and Jobs Trust Fund for the HHC program. The Department will allocate these funds competitively to counties for acquisition, new construction, reconstruction, rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and rental subsidies and rental assistance for existing and new Supportive housing opportunities to assist the HHC program's Target Population.

A Notice of Funding Availability (NOFA) will be released for each Article as funds are available.

Back to Agenda

Housing for a Healthy California Program Final Guidelines

Article I. National Housing Trust Fund Allocation

Back to Agenda

Article II. Building Homes and Jobs Trust Fund Allocation

Back to Agenda

Article I. National Housing Trust Fund Allocation

Section 100. Purpose and Scope

(a) In September of 2017, AB 74 was signed into law. This legislation authorizes the California Department of Housing and Community Development (Department) to develop the Housing for a Healthy California (HHC) Program to create Supportive housing for individuals who are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program. The goal of the HHC program is to reduce the financial burden on local and state resources due to the overutilization of emergency departments, inpatient care, nursing home stays and use of corrections systems and law enforcement resources as the point of health care provision for people who are Chronically homeless or Homeless and a High-cost health user. The Department shall coordinate with the DHCS, consistent with state and federal privacy laws, to match program participant data to Medi-Cal data to identify outcomes among participants as well as changes in health care costs and utilization associated with housing and services provided under HHC.

(b) AB 74 directs the Department to utilize federal National Housing Trust Fund (NHTF) allocations for years 2018 - 2021 for the HHC program. Starting in August 2018, and for the next three years, the Department must submit a federal NHTF allocation plan that aligns with federal NHTF and AB 74 requirements. The Department will allocate these NHTF funds competitively to developers for operating reserve grants and capital loans.

In addition to applicable state and federal laws and regulations, these guidelines (hereinafter “Guidelines”) implement, interpret, and make specific the HHC authorized by Part 14.2 (commencing with Section 53590) of Division 31 of the Health and Safety Code.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 101. Definitions

All terms not defined below shall, unless their context suggests otherwise, be interpreted in accordance with the meaning of terms described in Part 14.2 of Division 31 of the Health and Safety Code (commencing with Section 53590).

(a) “Applicant” means an organization, agency, or other entity (including a public housing agency, a for-profit entity, or a nonprofit entity) that is an owner or developer as defined by 24 CFR 93.2.

(b) “Area Median Income” or “AMI” means the most recent applicable county median family income published by the U.S. Department of Housing and Urban Development (HUD).

(c) “Assisted Unit” means a housing unit that is subject to the NHTF rent and/or occupancy restrictions as a result of the financial assistance provided under the program.

(d) “Case Manager” means a social worker or other qualified individual who works with a tenant to offer individualized service planning that is flexible and creative to help the tenant gain housing stability. It includes working in collaboration with the tenant to plan, assess, coordinate, and reassess the tenant’s needs, as well as providing referrals and advocacy, and connecting to community support to meet tenants’ supportive service needs. Services include, but are not limited to: tenancy support services, coordination of medical and behavioral health, and substance use disorder treatment, employment services, life skills training, peer support, and crisis management interventions. Resident service coordinators are not Case Managers.

(e) “Chronically homeless” has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

(f) “Continuum of Care” has the same meaning as 24 CFR Section 578.3.

(g) “Coordinated Entry System” or “CES” means a centralized or coordinated process developed pursuant to 24 CFR Section 578.7(a)(8) designed to coordinate program participant intake, assessment, and referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

(h) “Department” means the California Department of Housing and Community Development.

(i) Development Sponsor or “Sponsor”, as defined in Section 50675.2 of the Health and Safety Code and subdivision (c) of Section 50669 of the Health and Safety Code, means any individual, joint venture, partnership, limited partnership, trust, corporation, cooperative, local public entity, duly constituted governing body of an Indian Reservation or Rancheria, or other legal entity, or any combination thereof, certified by the Department as qualified to own, manage, and rehabilitate a rental housing development. A Development Sponsor may be organized for profit, limited profit or be nonprofit, and includes a limited partnership in which the Development Sponsor or an affiliate of the Development Sponsor is a general partner.

(j) “Distributions” has the same meaning as under 25 CCR Section 8301.

(k) “Extremely Low Income” or “ELI” has the same meaning as in 24 CFR 93.2.

(l) “Federal Housing Trust Fund” has the same meaning as the National Housing Trust Fund (NHTF) established pursuant to the Housing and Economic Recovery Act of 2008 (Public Law 110-289) and implementing federal regulations.

(m)"Fiscal Integrity" means, for any project for any given period of time during the term specified in the Program's regulatory agreement, that the total Operating Income for such project for such period of time, plus funds released pursuant to the Program documents from the project's operating reserve account(s) during such period of time is sufficient to: (1) pay all current Operating Expenses for such project for such period of time; (2) pay all current mandatory debt service (excluding deferred interest) coming due with respect to such project for such period of time; (3) fully fund all reserve accounts established pursuant to the Program documents for such project for such period of time; and (4) pay other costs permitted by the Program documents for such project for such period of time. The ability to pay any or all the permitted annual distributions for a project shall not be considered in determining the Fiscal Integrity of a project.

(n) "HHC" means the Housing for a Healthy California Program administered by the Department.

(o) "High-cost health users" mean people who have had either at least three emergency department visits or one hospital inpatient stay over the last year.

(p) "Homeless" has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

(q) "Housing First" has the same meaning as in Welfare and Institutions Code Section 8255.

(r) "HUD" means the federal U.S. Department of Housing and Urban Development.

(s) "Lead Service Provider" or "LSP" means the organization that has the overall responsibility for the provisions of Supportive Services and implementation of the Supportive Services plan. The LSP may directly provide comprehensive case management services or contract with other agencies that provide services.

(t) "NOFA" means a Notice of Funding Availability.

(u) "Operating Expense" has the same meaning as in 25 CCR Section 8301.

(v) "Operating Income" has the same meaning as in 25 CCR Section 8301.

(w) "Operating Cost Assistance Reserves" has the same meaning as in 24 CFR Section 93.201(e).

(x) "Permanent housing" means a housing unit where the landlord does not limit length of stay in the housing unit, the landlord does not restrict the movements of the tenant, and the tenant has a lease and is subject to the rights and responsibilities of tenancy, pursuant to Chapter 2 (commencing with Section 1940) of Title 5 of Part 4 of Division 3 of the Civil Code.

(y) "Point in Time Count" or "PIT" refers to an annual count of sheltered and unsheltered homeless persons on a single night in January.

(z) “Program” means the Housing for a Healthy California Program.

(aa) “Project Team” consists of the Applicant, the Lead Service Provider, and the property manager.

(bb) “Recipient” means an Applicant who has been awarded NHTF funds and has the same meaning as in 24 CFR 93.2. A Recipient must:

(1) Make acceptable assurances that it will comply with all NHTF requirements during the entire affordability period;

(2) Demonstrate ability and financial capacity to undertake, comply, and manage the eligible activity;

(3) Demonstrate familiarity with requirements of state, federal, and any other housing programs used in conjunction with NHTF funds to ensure compliance; and

(4) Demonstrate experience and capacity to conduct the eligible NHTF activity in question as evidenced by relevant history.

(cc) “Rural Area” has the same meaning as in Section 50199.21 of the California Health and Safety Code.

(dd) “Supportive housing” means housing with no limit on length of stay, that is occupied by the Target Population and that is linked to onsite or offsite services that assist the Supportive housing resident in retaining the housing, improving his/her health status, and maximize his/her ability to live, and when possible, work in the community.

(ee) “Supportive Services” means social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

(ff) “Target Population” means a person who is Chronically homeless or is Homeless and a High-cost health user upon initial eligibility, is a Medi-Cal beneficiary, is eligible for Supplemental Security Income, is eligible to receive services under a program providing services promoting housing stability, and is likely to improve his or her health conditions with Supportive housing.

(gg) “TCAC” means California Tax Credit Allocation Committee.

(hh) “UMR” means the Uniform Multifamily Regulations commencing with 25 CCR Section 8300.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53590 and 53595.

Section 102. Minimum Requirements

The Applicant shall comply with the requirements of HHC and all applicable federal and state laws. To be eligible to receive funding, projects must meet all the following minimum requirements:

(a) Eligible Applicants.

(1) Owners or developers that meet the Recipient definition in 24 CFR 93.2.

(2) Applicant with no members of the development team currently federally debarred or suspended.

(b) Financial Feasibility. The project shall meet the requirements of Sections 105 and 106 and must prove Fiscal Integrity.

(c) Experience. Collectively, among the members of the Project Team, all the following minimum experience requirements must be met:

(1) Development, ownership, or operation of at least two permanent Supportive housing projects or at least two affordable rental housing projects in the last five years.

(2) The Lead Service Provider, which may be the county, or a qualified contracted agency, shall have three or more years of experience serving persons who qualify as members of the Target Population and includes comprehensive case management in Supportive housing, and can include scattered site housing.

(3) The property manager shall have three or more years of experience serving persons who qualify as members of the Target Population in Supportive housing.

(4) Experience must be documented through contracts with public agencies, housing owners, or foundations for services provided to at least 10 households at any one time in either housing projects subject to agreements with public agencies restricting rent and occupancy or through tenant-based housing assistance programs. If the Lead Service Provider is not part of the ownership entity, the Applicant must have a written agreement with the Lead Service Provider to implement the Supportive Services plan and submit this agreement along with the application for funding. Only the Lead Service Provider may enter into written agreements for services under the provisions of the Supportive Services plan. All service providers must have a written agreement with the Lead Service Provider prior to commencement of services.

(d) Site Control. The Applicant must have site control of the proposed project that meets the requirements of the UMR 25 CCR Section 8303, which requires the Applicant to have site control of the proposed project property, in the name of the Applicant or an entity controlled by the Applicant. The ownership interest may be demonstrated by fee title, a leasehold interest, an enforceable option to purchase, a disposition and

development agreement, an agreement giving the Applicant exclusive rights to negotiate for acquisition, or a land sales contract. This includes compliance (if applicable) with UMR 25 CCR Section 8316 for a leasehold interest in the property.

(e) Integration. Proposed projects must demonstrate integration of the Target Population with the general public. In order to demonstrate compliance with this requirement, the following conditions must all be met:

(1) Assisted Units must be integrated with other units in the project and not separated onto separate floors or areas of the building;

(2) To promote integration of the Target Population with other project tenants, in projects of greater than 20 units, the Department will fund no more than 49 percent of the project's total units as Assisted Units. This limitation shall not be interpreted to preclude occupancy of any project units by persons with disabilities or restrictions by other funding sources, including but not limited to TCAC, that result in more than 49 percent of the total project units being restricted to the Target Population. It shall also not apply to projects complying with alternative requirements for demonstrating Olmstead compliance adopted by local jurisdictions and approved by the Department;

(3) Applicants must certify that they will facilitate or provide regular community building activities and architectural design features that promote tenant interaction. For example, indoor and outdoor community space within the project, and wide hallways as feasible, depending on the scope of the construction activity; and

(4) The Supportive Services plan and property management plan, submitted with the application, must document policies that promote participation by tenants in community activities and impose no restriction on guests that are not otherwise required by other project funding sources or would not be common in other unsubsidized rental housing in the community.

(f) Article XXXIV. All projects shall comply with Article XXXIV Section 1 of the California Constitution, as clarified by Public Housing Election Implementation Law (H&S Code Section 37000 et seq). Article XXXIV documentation for loans underwritten by the Department shall be subject to review and approval by the Department prior to the execution of the Department's Standard Agreement.

(g) Scattered Site Housing. Projects are permitted to be on scattered sites provided that all of the below conditions are satisfied prior to the closing of the loan. The requirements of this section shall be interpreted in a manner consistent with the requirements of 25 CCR Section 8303(b) pertaining to scattered site housing.

(1) All project sites in the rental housing development must have a single owner and property manager;

(2) All project sites shall be governed by one set of Program documents, which among other things, shall include similar tenant selection criteria, serve similar

tenant populations, and have similar rent and income restrictions;

(3) If the rental housing development has an operating reserve, there shall only be one operating reserve for all sites in the project;

(4) There may be at most one lender with required payments senior to the Department's loan;

(5) There must be a single audit and annual report that covers all project sites;

(6) The Sponsor's obligations under the Department's Program documents must be secured by all project sites, with lien priority relative to local public agency lenders determined in accordance with 25 CCR Section 8315, and use of cash flow available for residual receipts loan payments determined in accordance with 25 CCR Section 8314; and

(7) The Department must be named on insurance policies covering all project sites, with coverage meeting Department requirements.

(h) Environmental Conditions. All project sites must be free from severe adverse environmental conditions, such as the presence of toxic waste that is economically infeasible to remove and that cannot be mitigated. See 24 CFR 93.301(f).

(i) Federal, State and Local Requirements. All Assisted Units and other units of the project must be on a permanent foundation and must meet all applicable federal, state, and local requirements pertaining to rental housing, including, but not limited to, requirements for minimum square footage and requirements related to maintaining the property in a safe and sanitary condition.

(j) Amenities. All project sites must involve a development site that has reasonable accessibility to public transit, public schools, public parks or other public recreational facilities, and is of reasonable proximity to services and amenities for the purposed tenant population as is typically available in that county. The development site must also be within reasonable proximity to employment opportunities available to the tenant population. The development must consider the hours that the services and amenities are available and the frequency, travel time, and cost of transportation to the tenants. The criteria used to establish reasonable accessibility and reasonable proximity are specified in Section 111(h) of the Guidelines.

(k) Stacking Unit-Based Subsidies.

(1) The Department does not allow stacking of multiple Department Development Funding Sources on an HHC Assisted Unit. Capitalized operating subsidy reserves or operating assistance is allowed for all units. The prohibition of subsidy stacking in HHC refers to the use of multiple funding sources on a single HHC-assisted unit. "Department Development Funding Sources" shall mean loan or grant funds awarded for permanent funding of development costs under the following programs:

a. Multifamily Housing Program
b. Supportive Housing Multifamily Housing Program

c. Veterans Housing and Homelessness Prevention Program
d. No Place Like Home Program, including funds awarded either by the Department or an Alternative Process County
e. Affordable Housing and Sustainable Communities Program Affordable Housing
f. Development loan, except for grants for infrastructure, transportation-related amenities and program costs
g. Transit Oriented Development Program rental housing development loan, except for grants for infrastructure
h. Joe Serna, Junior Farmworker Housing Grant Program
i. SB 2 Farmworker Housing Program
j. National Housing Trust Fund Program

(2) As an exception to this Subsection (k)(1), a previously Department-assisted unit is eligible for funding assistance from other Department programs upon re syndication, or 14 years from the Placed in Service date noted on the TCAC form 8609 (Placed in Service Package).

(l) Relocation. The Applicant of any project resulting in displacement of tenants shall be solely responsible for providing the assistance and benefits set forth in this subsection and in applicable federal, state, and local law, whichever is more stringent.

(1) All tenants of a property who are displaced as a direct result of the development of an HHC project shall be entitled to relocation benefits and assistance as provided in 24 CFR 93.352.

(2) The Applicant shall prepare a relocation plan conforming with the provisions of 24 CFR 93.352. For loans underwritten by the Department, the relocation plan or other relocation documentation shall be subject to the review and approval by the Department prior to the beginning of construction.

(m) Applicant must comply with 2 CFR Part 200.

(n) Application shall be on forms made available by the Department. In addition, applications must contain:

(1) A resolution from the Applicant's governing board to apply for NHTF funds for a requested amount that does not exceed the amount authorized.

(2) A memorandum of understanding or commitment letter from either the Lead Services Provider or a county department to make available to the project's HHC tenants case management and Supportive Services from one of the following:
a. County's Whole Person Care Pilot,
b. Health Homes Program,
c. Managed care organization, or
d. Other community-based health care services.

(3) A certification that residents of the housing development will be authorized to own or otherwise maintain one or more common household pets pursuant to the Pet Friendly Housing Act of 2017 (California Health & Safety Code, Section 50466).

(4) An initial plan for providing Supportive Services based on the anticipated needs of the Target Population proposed to be served by the project must meet the requirements outlined in Section 112.

(5) A property management plan that:
   a. Utilizes a low-barrier tenant selection process;
   b. Accepts referrals of those with the highest needs for available housing;
   c. Implements Housing First practices, consistent with the core components set forth in Welfare and Institutions Code Section 8255(b);
   d. Implements policies and practices to prevent evictions and to facilitate the implementation of reasonable accommodation policies;
   e. Implements policies and practices of trauma-informed care and harm reduction to prevent evictions; and
   f. Implements policies and practices that comply with the Violence Against Women Act (Title VI-Safe Homes for Victims of Domestic Violence, Dating Violence, Sexual Assault, and Stalking – Section 601 – 603 and 81 CFR 80724).

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 103. Uses and Terms

(a) NHTF funds will be limited to the eligible uses described in 24 CFR 93.200 and 93.201.

(1) Loans for acquisition and/or new construction.
   a. NHTF loans shall be used in accordance with 24 CFR Part 93 Subpart E.
   b. Proposed projects involving new construction and requiring the demolition of existing residential units are eligible only if the number of bedrooms in the new project is at least equal to the total number of bedrooms in the demolished structures. The new units may exist on separate parcels provided that all parcels are part of the same project and meet the requirements of scattered site housing described in Section 102(g).
   c. The total amount of NHTF assistance shall not exceed the maximum per-unit development subsidy amount established by the Department as stated in the NOFA.
   d. HHC loans shall be secured by the project's real property and improvements and subject only to liens, encumbrances and other matters of record approved by the Department, consistent with 25 CCR Section 8315. Projects with ground leases shall be subject to 25 CCR Section 8316.
   e. HHC assistance provided as post-construction permanent loans shall have an initial term of 55 years or longer to match the period of affordability restrictions under the tax credit program, commencing on the date of recordation of the HHC loan documents.

(2) Grants for project-based operating assistance in the form of a Capitalized Operating Subsidy Reserve (COSR).

The project's COSR will be for at least 15 years to pay for operating costs of an apartment or apartments receiving capital funding to provide Supportive housing to the Target Population.

(b) Maximum per-unit loan amounts for loans underwritten by the Department shall be published annually for each NOFA and determined as follows:

(1) Maximum per-unit loan amounts shall not exceed the total eligible costs required, when considered with other available financing and assistance, in order to:
a. Enable the funds to be used for the eligible uses;
b. Ensure that rents for Assisted Units comply with Program requirements; and
c. Operate in compliance with all other Program requirements.

(2) The capital portion of the loan amount is further limited to the sum of a base amount per Assisted Unit, plus the amount per Assisted Unit required to reduce rents from 30 percent of the 30 percent of AMI level to the actual maximum restricted rent for the Assisted Unit, with loan limits increasing based on the level of affordability provided.

(3) For loan limit calculations, the Department shall include the number of Assisted Units within a rental housing development and the number of bedrooms per Assisted Unit.

(4) For Assisted Units receiving rental assistance under renewable rental subsidy contracts, the loan amount will be based on the most restrictive level of income restriction that will apply following the closing of the program loan.

(5) Initial base amounts for the portion of the loan that does not include a COSR are set pursuant to the Department's Annual Action Plan.

(6) The COSR portion of the loan shall be determined pursuant to the requirements of Section 108.

(7) Beginning January 2020, the amounts in subparagraph (5), above, will be adjusted annually based upon increases in the Consumer Price Index. The maximum per-unit amounts for loans underwritten by the Department shall be updated annually and published in the NOFA.

(c) Recipients shall ensure that all Assisted Units meet all applicable federal and state property standards. Compliance with 24 CFR 93.301(a)(1) and (2) must be maintained for the duration of the affordability period of 55 years, except projects developed on Indian Reservation or Native American lands, which will be for at least 50 years.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 104. Loan Terms

(a) HHC loans shall have the following terms:

(1) They shall bear simple interest at the rate of 3 percent per annum on the unpaid principal balance, unless the Department reduces this rate pursuant to Health and Safety Code Section 50406.7. Interest shall accrue from the date funds are disbursed to, or on behalf of, the borrower.

(2) Pursuant to 24 CFR section 93.204(b)(1), HCD will charge fees to cover the cost of ongoing monitoring and physical inspection of NHTF rental projects during the state period of affordability and as determined in the NOFA.

(3) Except for the required monitoring fee payment, and if the borrower is not in default, the Department shall permit the deferral of accrued interest for the term of the loan.

(4) The Department may require a third-party tax professional to verify the necessity for reducing the interest rate below 3 percent, the cost of which shall be borne by the Sponsor.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 105. Occupancy and Income Requirements

(a) Household income shall be determined in accordance with the rules in 24 CFR 93.151. At the time of move-in, the household income shall not exceed the established Extremely Low Income (ELI) limits or families with incomes at or below the poverty line (whichever is greater) pursuant to 24 CFR 93.250(a). Income levels shall be expressed in 5 percent increments as a percentage of AMI. The income limits are posted on the Department's website. Assisted units will be restricted per the income limits set forth in the Project Regulatory Agreement.

(b) The Recipient shall maintain documentation of tenant-income eligibility and how they meet the requirements for the Target Population the following ways, as applicable:

(1) Documentation of enrollment in or eligibility for Medi-Cal benefits.

(2) Documentation of a person's status as Chronically homeless could be captured through any of the following:
   a. A client's entry and exits documented in a Homeless Management Information System;
   b. An outreach worker or Case Manager's written observations; or
   c. A client's self-report of episodes of homeless and disability status. Such reports must be done in accordance with procedures established through the local Coordinated Entry System or other procedures established by

the county for determining whether a person qualifies as Homeless and High-cost health user or Chronically homeless.

(3) Documentation of a person's status as a High-cost health user could be captured through any of the following:
   a. Discharge summaries; or
   b. An outreach worker's, case manager's or local County's health department written observations.

(c) Occupancy requirements shall apply for the full term of the regulatory period.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 106. Rent Limits

(a) Assisted Unit rent will be restricted in accordance with the NHTF rent and income limits in 24 CFR 93.302.

(1) ELI tenants. The rent plus utilities of an ELI tenant shall not exceed the greater of 30 percent of the federal poverty line or 30 percent of the income of a family whose annual income equals 30 percent of the median income for the area, as determined by HUD, with adjustments for the number of bedrooms in the unit. HUD will publish the NHTF rent limits on an annual basis. Rents will be further restricted in accordance with Rent and income limits submitted by the Sponsor in its application for the Program loan, approved by the Department, and set forth in the Regulatory Agreement.

(b) The income of each tenant must be determined initially in accordance with 24 CFR 93.151. In addition, in each year during the period of affordability (up to 55 years), the project owner must reexamine each tenant's annual income in accordance with one of the options in 24 CFR 93.151(c) selected by the Recipient and as identified in the tenant selection plan.

(c) Over-income tenants. Assisted Units continue to qualify as affordable housing despite a temporary noncompliance caused by increases in the incomes of existing tenants if actions satisfactory to HUD are being taken to ensure that all vacancies are filled in accordance with 24 CFR Part 93.302(g) until the noncompliance is corrected.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 107. Underwriting Standards

(a) In analyzing feasibility, the Department shall follow the underwriting requirements of its UMRs commencing with 25 CCR Section 8300 and/or federal NHTF regulations, including the following:

(1) 25 CCR Section 8303 (Site Control Requirements and Scattered Site Projects);

(2) 24 CFR 93.201(e) (Operating Cost Assistance and Operating Cost Assistance Reserves);

(3) 25 CCR Section 8309 (Replacement Reserves);

(4) 25 CCR Section 8310 (Underwriting Standards) and 24 CFR 93.300(b). The more strict requirements shall apply;

(5) 25 CCR Section 8311 (Limits on Development Costs);

(6) 25 CCR Section 8312 (Developer Fee);

(7) 25 CCR Section 8314 (Use of Operating Cash Flow), and 24 CFR Part 93. The stricter requirements shall apply; and

(8) 25 CCR Section 8315 (Subordination Policy).

(b) Where there is a difference between the provisions of the UMRs and these Guidelines, the provisions of these Guidelines shall prevail.

(c) Notwithstanding the above, residential stabilized vacancy rates for Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market data or other evidence.

(d) In addition to the operating reserve required by 25 CCR 8308, a Sponsor may establish a COSR for the Assisted Units meeting the requirements of Section 108.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 108. Capitalized Operating Subsidy Reserves

NHTF grant funds may be used to pay for Capitalized Operating Subsidy Reserves (COSR) with the following conditions:

(a) For projects, not more than 100 percent of the total per-unit amount for capital determined pursuant to Section 103 may be provided per unit for a COSR to address project operating deficits attributable to the Assisted Units.

(b) The operating reserves shall be sized to cover anticipated operating deficits attributable to the Assisted Units for a minimum of 15 years. The total amount of each project's operating reserves will be determined based upon the individual project underwriting performed by the Department pursuant to the requirements of these Guidelines.

(c) In determining how to size each project's COSR, the Department shall consider individual project factors such as: the maximum percentage of Assisted Units it will assist; the anticipated project vacancy rates; the anticipated percentage of Assisted

Units that will have other operating or rental subsidy and the term of that operating or rental subsidy contract, and anticipated tenant incomes.

(d) The following standard assumptions will be used for establishing the total amount of the project COSR. The Department may modify these assumptions as necessary to maintain project feasibility or extend the term of the COSR.

(1) All Assisted Units, other than the proportionate share of the manager's unit, shall be counted in calculating the amount of the COSR. An Assisted Unit receiving other rental assistance may receive assistance from the COSR.

(2) The stabilized residential vacancy rate for the Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market or other evidence.

(e) Notwithstanding the above, in order to sustain the availability of the operating reserves for a minimum of 15 years, distributions from the COSR shall be subject to: The Department may not disburse more than 5 percent of the total COSR to a project per year, except that in any given year where the operating deficit attributable to the Assisted Units exceeds this amount, the Department may, in its sole discretion, increase the disbursement to up to 7 percent of the total COSR, in accordance with the operating reserves limits and applicable review processes;

(f) Asset management and partnership management fees and deferred developer fees shall only be paid in accordance with the requirements of Section 107.

(g) In accordance to 24 CFR 93.201(e)(1), Operating Expenses that are eligible to be paid from the COSR include:

(1) Insurance

(2) Utilities

(3) Real property taxes

(4) Maintenance

(5) Scheduled payments to a reserve for replacement of major systems

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 109. Award Limits

(a) The maximum loan limit per Applicant is $20,000,000. The limit on the amount that can be used for the COSR will be one third of the total loan amount, in accordance with 24 CFR 93.200(a)(1).

(b) NHTF funding will be made available to all jurisdictions in California. Pursuant to the Department's Annual Plan, the Department will set-aside at least 20 percent of the funding for projects located in Rural Areas. In the event no projects target the 20 percent set-aside for projects located in Rural Areas, funds will be distributed according to the distribution methods of 24 CFR 91.320(d) and (k).

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 110. Application Process

(a) Contingent upon an annual federal NHTF allocation, the Department shall issue a competitive NOFA for NHTF funding that specifies, among other things, the amount of project funds available, any restrictions on uses of funds, general terms and conditions of funding applications, minimum requirements, timeframe for submittal of applications, application requirements, and rating metrics. Application requirements include, but are not limited to, the following:

(1) Identification of Applicants;

(2) Information on the proposed project;

(3) Adequate information to determine Applicant's eligibility;

(4) Adequate information to determine project's eligibility;

(5) Certification of compliance with federal and state requirements;

(6) Resolution by the governing board authorizing the application and execution of all documents;

(7) Adequate information to determine Applicant's experience;

(8) Site control;

(9) Compliance with the state's policy on Housing First;

(10) Project readiness to proceed;

(11) A Supportive Services plan, including staff-to-client ratio (1:20);

(12) Commitment of services funding; and

(13) Adequate information to determine the project's feasibility.

(b) Applications shall be on forms made available by the Department.

(c) Applications shall be evaluated for compliance with the minimum requirements set forth in Section 102 and will be rated and ranked in accordance with the criteria outlined in Section 111. Applicants that do not meet the minimum requirements will

be rejected and will not be rated. Applicants will be subject to the appeal process as detailed in the NOFA.

(d) If requesting a COSR, the Applicant must comply with the requirements in Section 108 of these Guidelines.

(e) The Department reserves the right to do the following:

(1) Score an application as submitted in the event information is missing from the application; and

(2) Request clarification of unclear or ambiguous statements made in an application, and other supporting documents, when doing so will not impact the competitive scoring of the application. No additional information may be introduced into the application documentation.

(f) Applications selected for funding shall be approved at amounts, terms, and conditions specified by these Guidelines and the NOFA.

(g) Each project must achieve the minimum scores in the Development Team Experience, Supportive Services plan, and Readiness to Proceed scoring categories, as follows:

(1) Development Team Experience: 18 points

(2) Supportive Services plan: 10 points

(3) Readiness to Proceed: 15 points

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 111. Application Selection Criteria

The criteria detailed below and summarized in the following table shall be used to rate applications. In the event of tied point scores, the following tiebreakers shall be used to determine which project is selected for funding, in the order listed:

(1) The Readiness to Proceed point score, pursuant to Section 111(f) of these Guidelines; and

(2) The Supportive Services plan point score, pursuant to Section 111(c) of these Guidelines

	Maximum Applicable Points
Development Team Experience	
Developer Experience	10
Applicant Ownership	5
Property Management	5

Lead Service Provider	15
Total Development Team Experience	**35**
Supportive Housing Units	25
Supportive Services plan	25
Utilization of Funds to Offset Requests	10
Leverage of Rent/Op Subsidies	15
Readiness to Proceed	30
Confirmation of Local Need	5
Location Efficiency and Access to Destinations	5
TOTAL APPLICABLE POINTS	**150**

(a) Development Team Experience (35 points maximum). The Applicant must achieve a minimum of 18 points from this section to receive an award.

(1) Developer Experience (10 points maximum)
   a. Applications will be scored based on the number of affordable rental housing developments completed by the project developer over the past five years, including Supportive housing projects completed in the last three years serving persons similar to the Target Population. Applicant should address whether these projects were completed timely and within budget. Delays and cost overruns should be explained.
   b. Two points will be awarded for each completed development that was timely and within budget, up to a maximum of ten points.

(2) Applicant Ownership and Operations Experience (5 points maximum)
   a. Applications will be scored based on the experience of the Applicant in owning or operating (under a long-term master lease or similar arrangement) supportive and/or affordable rental housing developments.
   b. The Applicant's experience includes the experience of its affiliated entities or principals (including management-level staff), but not the experience of board members. If there are multiple entities that comprise the ownership entity of the proposed project, the score will be based on the experience of the entity with a controlling interest in the ownership entity and a substantial and continued role in the project's operations, as evidenced in the ownership entity's legal documents.
   c. One-half point will be awarded for each affordable housing project, and one point will be awarded for each Supportive housing project, up to a maximum of five points.

(3) Property Manager Experience (5 points maximum)
   a. Applications will be scored based on the number of affordable and Supportive housing developments managed by the designated property management agent at the time of application. One-half point will be awarded for each affordable housing development, and one point will be awarded for each Supportive housing development, up to a maximum of five points.
   b. Points will be awarded for Supportive housing developments that have been in operation for at least two years with units restricted to people

experiencing homelessness.

(4) Lead Service Provider Experience (15 points maximum)

a. Points will be awarded for experience in the last five years providing comprehensive case management and tenancy support to people experiencing homelessness, and for demonstrated expertise working with the Target Population.

b. Experience must be documented through contracts with public agencies, housing owners, or foundations for services in housing projects with at least ten units subject to agreements with public agencies restricting rent or occupancy to Homeless persons or households, or in publicly funded tenant-based housing assistance programs serving at least ten members of the Target Population.

Points will be awarded for the following:

1. Years of experience in permanent Supportive housing (3 points maximum).
   i. One to two years (1 point)
   ii. Three years to four years (2 points)
   iii. Five years or more (3 points)
2. Number of projects or contracts in permanent Supportive housing (3 points maximum).
   i. One to two projects (1 point)
   ii. Three to four projects (2 points)
   iii. Five or more projects (3 points)
3. Years of experience serving the Target Population (3 points maximum).
   i. One to two years (1 point)
   ii. Three years to four years (2 points)
   iii. Five years or more (3 points)
4. Experience providing comprehensive case management, where members of the Target Population were at least 20 percent of the Lead Service Provider's clients during the years for which points are sought in any of the following (two points for either of the following):
   i. Permanent Supportive housing restricted to members of the Target Population; or
   ii. Permanent Supportive housing not restricted to members of the Target Population, with documented experience providing Homeless services with documented retention rates of at least 85 percent after 12 months.

   To receive points under subsection i. or ii. above, the Lead Service Provider must have current staff expertise and organizational experience:
   i. Connecting members of the Target Population and/or Homeless individuals with community-based health care services, including linkage to primary care services and behavioral health care; and
   ii. Staff expertise and experience must be documented through resumes, job descriptions, contracts, staff training descriptions, and letters from Continuums of Care or other supportive services organizations.

5. Experience of a partner agency if the following conditions are satisfied (2 points):
    i. An executed agreement between the two agencies must be submitted with the application for HHC assistance; and
    ii. The agreement must have a term of at least five years and detail the cultural competency services to be provided by the partner agency. These services must include:
        a. Technical assistance with program development;
        b. Training and mentoring of Lead Service Provider leadership and staff for the proposed project;
        c. Assistance with hiring project staff;
        d. Assistance with developing community linkages;
        e. Other technical assistance as needed; and
        f. An agreement to provide services to members of the Target Population residing in the project that are referred by the Lead Service Provider.

6. Documented success in meeting or exceeding specified outcome measures for housing stability under a government contract for at least two years as a Lead Service Provider in Permanent Supportive housing serving persons experiencing homelessness. (2 points)

(b) Supportive Housing (25 points maximum).

(1) Applications will be scored based on the percentage of total project units restricted as Supportive housing in accordance with the table in subsection (2) below.

(2) To receive any points in this category, a minimum of 5 percent of total project units must be restricted as Supportive housing.

The scoring table is as follows:

Percentage of Total Project Units Restricted as Supportive Housing	Points
5%	5
10%	9
15%	13
20%	17
25%	21
30% or more	25

(c) Supportive Services Plan (25 points maximum). The Applicant must achieve a minimum of 10 points from this section to receive an award.

(1) Applications for projects will be scored based on the following:
a. Quality and Quantity of Services (7 points maximum)
    1. The services provided are of appropriate quality and quantity for the Target Population. (2 points)

2. Staff experience, credentials, and job duties include appropriate skills in cultural competency. (2 points)
3. The service delivery model, tailored to Homeless people impacted with one or more chronic health or behavioral health conditions, that includes, but is not limited to, the following: (3 points)
    i. Use of a critical time intervention or assertive community treatment model
    ii. Cognitive behavioral therapy
    iii. Trauma-informed care
    iv. Motivational interviewing and other tools to encourage engagement in services
    v. Other practices recognized as evidenced-based by the Substance Abuse and Mental Health Services Administration (SAMHSA), DHCS, HUD, or other federal or state public agencies

b. The accessibility of services, whether they are on-site or in close proximity to the project, including the hours they are available, and the frequency, travel time and cost of transportation required to access them, including both public transportation and private transportation services (e.g. van owned by the provider), and how the service provider will assist in the expense of public transportation (e.g., provide tokens, negotiate discounts, provide their own shuttle service, etc.). (2 points)
c. Adherence to Section 113, Housing First principles in the provision of services, including provision of flexible services that facilitate Permanent housing access and housing stability. (2 points)
d. The degree to which the physical building space supports social interaction, the provision of services and ensures the safety of all residents, especially those more vulnerable, such as persons with a history of trauma, children, elderly, etc. (1 point)
e. The levels of linkages with local systems for ending homelessness and community-based health care resources for members of the Target Population, including: (5 points)
    1. Participation, verified by the local Continuum of Care, in a local CES that is fully established.
    2. The degree of coordination with primary care providers, behavioral health providers, and health care facilities.

(2) Resident Involvement (3 points maximum)
Points will be awarded based on the quality of:
a. Strategies to engage residents to encourage participation in services (1 point);
b. Strategies to engage residents in services planning and operations (1 point); and
c. Tenant satisfaction surveys to inform and improve services, building operations, and property management. (1 point)

(3) The adequacy of the services budget and the reliability over time of services funding (5 points maximum)
Points will be awarded based on:

a. The adequacy and accuracy of budgeted income sources and uses and the consistency of these amounts with other sections of the services plan. (1 point)
b. The completeness, accuracy, specificity and clarity of the budget document. (1 point)
c. The extent to which the major services funding sources have been accessed by the designated service providers or Applicant in the past. (1 point)
d. The track record of the Applicant and providers in filling gaps in services funding left by the loss of major funding sources. (1 point)
e. The percentage of the total services budget that is committed at the time of application. (1 point)

(d) Utilization of Funds to Offset Requests (10 points maximum)

(1) Applications will be scored based on the ratio of permanent affordable development funding attributable to Assisted Units from sources other than NHTF to the requested NHTF loan amount. Deferred developer fees and funds deposited in a reserve to defray scheduled operating deficits will not be counted in this computation. Land donations will be counted where the value is established by a current appraisal.

(2) For projects utilizing 9 percent competitive low-income housing tax credits, 0.375 points will be awarded for each full 5 percentage point increment above 50 percent. For example, an application proposing other funds equal to 100 percent of the NHTF funds will receive 3.75 points. An application where other funds equal 250 percent of NHTF funds will receive 10 points.

(3) For other projects not utilizing 9 percent competitive low-income housing tax credits, 0.75 points will be awarded for each 5 percentage point increment above 50 percent. For example, an application proposing other funds equal to NHTF funds will receive 7.5 points, and an application where other funds equal 150 percent of NHTF funds will receive 10 points.

(e) Leverage of Rental or Operating Subsidies (15 points maximum)

(1) Applications will be scored based on the percentage of Assisted Units that either:
a. Have committed project-based rental or operating subsidies substantially similar in terms to project-based housing choice vouchers to indicate a high likelihood of receiving similar funding for the proposed project; or
b. Are restricted to rents not exceeding 30 percent of household income, with project feasibility determined based on the assumption that rents will be affordable to tenants of existing projects targeting Homeless populations, as specified in the HHC application.

(2) Project-based housing choice vouchers will be deemed committed if they have been allocated to the project and approved by HUD, or if the Department approves other evidence that they will reliably be available (such as a letter from the housing authority committing to project-based housing choice

vouchers to the project).

(3) One point will be awarded for each 5 percentage point increment, up to a maximum of 15 points.

(f) Readiness to Proceed (30 points maximum). The Applicant must achieve a minimum of 15 points from this section to receive an award.

The Supportive Services must be fully implemented and available for use by the tenant at the time of occupancy. Points will be awarded as shown below to projects for each of the following circumstances as documented in the application. Any application demonstrating that a particular category is not applicable to project readiness for the subject project shall be awarded points in that category.

(1) Obtained enforceable commitments for all construction financing, not including tax-exempt bonds, low-income housing tax credits, and funding to be provided by another Department program. Other Department funds must be awarded prior to the application deadline. (5 points)

(2) Completion of the California Environmental Quality Act, if necessary and not entitled to a streamlined review under AB 2162, and
   a. Phase I Environmental Site Assessment (ESA-ASTM) for projects with NHTF only, or
   b. If any other federal funding sources are utilized, the project must complete a Phase I Environmental Site Assessment with the National Environmental Policy Act. (5 points)

(3) Obtained all necessary and discretionary public land use approvals, except building permits and other ministerial approvals, or documented to be an eligible project under AB 2162. (5 points)

(4) 5 points will be awarded if either:
   a. The Applicant has fee title ownership to the site or a long-term leasehold securing the site meeting the criteria for HHC site control; or
   b. The Applicant can demonstrate that the working drawings are at least 50 percent complete, as certified by the project architect;

(5) Obtained local design review approval to the extent such approval is required. (5 points)

(6) Obtained commitments for all deferred-payment financing, grants and subsidies, in accordance with TCAC requirements and with the same exceptions as allowed by TCAC. Deferred payment financing, grant funds, and subsidies from other Department programs must be awarded prior to application deadline. (5 points)

(g) Local Need (5 points maximum)

More than 400 individuals are Homeless in the Applicant's geographic jurisdiction using the latest PIT count and as stated in the NOFA.

(h) Location Efficiency and Access to Destinations (5 points maximum)

Location Efficiency and Access to Destinations refers to reasonable access and proximity to amenities, services, and public transportation that allows members of the Target Population to have choices in accessing resources for independent living.

Points may be awarded cumulatively across the categories below up to a total of five points. Applicants must provide a map demonstrating proximity for items (1) and (2) to be eligible for the respective points.

(1) Projects located where there is a rapid transit station, light rail station, commuter rail station, ferry terminal, bus station, or public bus stop within one-half mile (one mile for Rural Areas) from the site, with service at least every 30 minutes (or at least two departures during each peak period for a commuter rail station or ferry terminal) during the hours of 7 a.m. - 9 a.m. and 4 p.m. – 6 p.m., Monday through Friday. (1 point)

(2) Projects that provide a map highlighting the location of the existing and operational services within one-half mile of the project area (two miles for Rural Areas), as follows:
   a. (1 point) Grocery store which meets the CalFresh Program requirements;
   b. (1 point) Medi-Cal clinic that accepts Medi-Cal payments;
   c. (1 point) Public elementary, middle or high school; and
   d. (1 point) Licensed child care provider.

(i) Applicants will be subject to the appeal process as detailed in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 112. Supportive Services

(a) Each application must include a project-specific Supportive Services plan. This plan is to be developed by the Lead Service Provider and the property manager and shall include information listed in (c) and (d) of this section. Recipients must utilize a Lead Service Provider.

(b) The property management staff and service providers must make participation in Supportive Services by HHC tenants voluntary. Access to or continued occupancy in housing cannot be conditioned on participation in services or on sobriety. The Supportive Services plan must describe the services to be made available to HHC tenants in a manner that is voluntary, flexible and individualized, so HHC tenants may continue to engage with supportive services providers, even as the intensity of services needed may change. Adaptability in the level of services should support tenant engagement and housing retention.

(c) Using evidence-based models, the following Supportive Services shall be made

available to HHC tenants based on tenant need. Except as otherwise noted below, the following required services shall be provided onsite at the project or offsite at another location easily accessible to tenants, with the majority of case management services offered on-site:

(1) Assistance accessing and linking tenants to Medi-Cal enrollment and enrollment in other benefits the tenant may be eligible for;

(2) Case management;

(3) Peer support activities;

(4) Support in linking to behavioral health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups;

(5) Support in linking to primary care services, including access to routine and preventive health and dental care, medication management, and wellness services;

(6) Benefits counseling and advocacy, including assistance in accessing Supplementary Security Income/State Supplemental Payment (SSI/SSP);

(7) Basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, working with a landlord, getting along with neighbors, and money management); and

(8) Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders not listed above.

The following Supportive Services are not required to be made available but are encouraged to be part of a project's Supportive Services plan.

(1) Recreational and social activities;

(2) Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process;

(3) Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work; and

(4) Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

(d) The following additional information shall be provided in the Supportive Services plan:

(1) Description of the Target Population to be served and identification of any

additional subpopulation target or occupancy preference for the HHC project that the Applicant wishes to undertake beyond what is permitted under the Target Population requirements. Any additional subpopulation targeting or occupancy preference for the HHC project must be approved by the Department prior to construction loan closing and must be consistent with federal and state fair housing requirements;

(2) Description of tenant outreach, engagement, and retention strategies to be used;

(3) Description of each service to be offered, how frequently each service will be offered or provided depending on the nature of the service, who is anticipated to be providing the services, the location, and general hours of availability of the services;

(4) For services provided off-site, the plan must describe what public or private transportation options will be available to HHC tenants in order to provide them reasonable access to these services. Reasonable access is access that does not require walking more than one-half mile;

(5) Description of how the Supportive Services are culturally and linguistically competent for persons of different races, ethnicities, sexual orientations, gender identities, and gender expressions. This includes explaining how services will be provided to HHC tenants who do not speak English or have other communication barriers, including sensory disabilities, and how communication among the services providers, the property manager and these tenants will be facilitated;

(6) Estimated itemized budget and sources of funding for services;

(7) Description of how the supportive services staff and property management staff will work together to prevent evictions, to adopt and ensure compliance with harm reduction principles, and to facilitate the implementation of reasonable accommodation policies from rent-up to ongoing operations of the project;

(8) General service provider and property manager communication protocols;

(9) Description of how the physical design of the project fosters tenant engagement, onsite supportive services provision, safety and security, and sustainability of furnishings, equipment, and fixtures; and

(10) Other information needed by the Department to evaluate the Supportive Services to be offered consistent with the Program.

(e) Copies of draft written agreements or memoranda of understanding (MOUs) that identify the roles and responsibilities of the Recipient, the project owner, other service providers, and the property manager must be provided. The draft written agreements or MOUs must be materially consistent with the information set forth in the Supportive Services plan.

The Department may request that any necessary updates to the Supportive Services plan or related documents, including fully executed written agreements between the county, service providers, the project owner, and the property manager, be provided prior to the beginning of the initial rent-up period or prior to permanent loan closing.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 113. Housing First

(a) Projects shall employ Housing First practices that are documented in the application, property management plan and Supportive Services plan. Adherence to the Housing First core components pursuant to Welfare and Institutions Code Section 8255(b).

(b) For all HHC funded projects, Housing First property management and services delivery practices shall be followed. Housing First practices include the following:

1. Tenant selection practices shall be done in conjunction with the local Coordinated Entry System and promote the acceptance of Applicants regardless to their sobriety or use of substances, completion of treatment, or agreement to participate in services;

2. Applicants are not rejected based on poor credit or financial history, poor or lack of rental history, or criminal convictions unrelated to tenancy, or behaviors that indicate a lack of “housing readiness”;

3. Applicants are assisted in making application for tenancy and reasonable accommodation requests;

4. Supportive Services are flexible and voluntary and focus on housing stability, engagement, and problem solving over therapeutic goals; and

5. The lack of policies or practices regimenting daily activities or limiting privacy, visitors, or the individual’s ability to engage freely in community activities or to manage their own activities of daily living.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 114. Tenant Selection

Tenants must meet income requirements in Section 105 and Target Population requirements in Section 102.

Recipients shall accept referrals through use of a CES or other similar system in accordance with the provisions of 25 CCR Section 8305, and in compliance with Housing First requirements consistent with the core components set forth in Welfare and Institutions Code Division 8 Chapter 6.5 Section 8255 subsection (b), and basic tenant protections established under federal, state, and local law.

(a) Reasonable selection criteria, as referred to in 25 CCR Section 8305(a)(1), shall include priority status under a local CES developed pursuant to 24 CFR 578.7(a)(8).

(b) If the CES existing in the county cannot refer persons in the Target Population, the alternative system used must prioritize those with the greatest needs among those for referral to available Assisted Units.

(c) Recipients shall accept tenants regardless of sobriety, participation in services or treatment, history of incarceration, credit, or history of eviction in accordance with practices permitted pursuant to WIC Section 8255 or other federal or state project funding sources.

(d) Projects must also provide a preference for accessible units to persons with disabilities requiring the features of the accessible units in accordance with Section 10337(b)(2) of the TCAC regulations.

The requirements of 25 CCR Section 8305 (a)(4)(A) and 25 CCR Section 8305 (a)(4)(D) shall be implemented as approved by the Department in a manner that is consistent with the requirements of the CES.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 115. Rental Agreements and Grievance Procedures

Rental or occupancy agreements and grievance procedures for Assisted Units shall comply with 25 CCR Section 8307 and 24 CFR 93.303. Tenants shall not be required to maintain sobriety, be tested for substances, or participate in services or treatment.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 116. Vulnerable Populations Best Practices

The following best practices should be incorporated in the construction of projects that receive funding from HHC, to the extent possible. These best practices work

to further the safety and physical and mental well-being of residents within a project.

(a) General best practices for all developments:

(1) Safety Features:
   a. Site selection and development of the project should consider the safety concerns of the prospective tenants.
   b. Building entrance and exit points should only allow admittance to residents or guests that residents admit.
   c. Common areas within the project should be oriented so as to have:
      1. Two ways to enter or exit the area;

2. Visibility to the area from outside of it, i.e. windows in walls or doors; and
3. A centralized location, to the extent possible.

d. Safety lighting that reduces or eliminates blind or dark spaces where people can hide.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(b) For those populations that have a history of sexual trauma and/or domestic violence:

(1) Safety features incorporate all the general best practices and include the following:

a. For projects that will also be serving women with a history of domestic violence or sexual trauma:

1. Designate at least 25 percent of the Assisted Units will be for women with a history of domestic violence or sexual trauma and/or women with children, thereby ensuring women are not a small minority of the tenancy.
2. Design projects to provide separate and secure floors, wings, or buildings for women with a history of domestic violence or sexual trauma and/or women with children. These separate and secure areas should restrict access to only the residents in the secured area.

b. Security cameras:

1. At entrances, exits and common areas (including hallways, elevators, and stair wells);
2. Written policy on the use of the cameras to specify who has access to see the videos, who monitors the surveillance, and under what conditions footage would be released to the authorities; and
3. Camera recordings should be maintained for at least 30 days.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

The project should have 24-hour security if it serves persons impacted by domestic violence, transition age youth and other vulnerable populations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 117. Reporting Requirements

Recipient must collect and report data, as described in Section 53593, to the Department at annual and midyear intervals. Reporting of the following is required:

(a) Not later than 90 days after the end of each project's fiscal year, the Recipient shall submit an independent audit of the development prepared by a certified public accountant and in accordance with the Department's current audit requirements and all other applicable requirements, as stated by law or included in the NOFA.

(b) Recipients shall report on the sources of tenant referrals for the project and submit both client data and performance outcome data to the Department. Tenant data may include, but is not limited to, demographic information. Performance outcome data shall include, but is not limited to, information on housing stability, tenant satisfaction as measured in a survey, and changes in income and benefits received.

(c) Recipients shall report the number of participants living in the Supportive housing project after 12 months, 24 months, and 36 months, as relevant.

(d) Recipients shall report the number of participants and the type of interventions offered through the grant funds.

(e) Recipients shall report on the number of participants who exited the project each year and where they exited to, including other Permanent housing, homelessness, or death.

(f) To the extent available and feasible, Recipients shall provide data on the impact of the Program on participants' use of corrections systems and law enforcement resources.

(g) If Recipient is a local government, must comply with 2 CFR Part 512, as outlined in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53593.

Section 118. Operating Budgets

The Recipient shall submit proposed operating budgets to the Department prior to occupancy, and annually thereafter. These budgets shall be subject to Department approval and comply with the requirements in 25 CCR Section 7326.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 119. Federal and State Overlays

(a) Federal Overlays. Activities funded with HHC funds are required to comply with 24 CFR Part 93.350 and 24 CFR Part 93.301. Compliance with these requirements include, but are not limited to, environmental provisions, federal Davis-Bacon Wage requirements and state prevailing wage laws, relocation, Equal Opportunity and Fair Housing, Fair Housing Amendments Act, Affirmative Marketing, Section 504 of the Rehabilitation Act and its implementing regulations, and the Americans with Disabilities Act and its implementing regulations, Section 3 (employment of low-income persons), Violence Against Women Act, and Single Audit report 2 CFR Part 200.512. Failure to comply with federal overlays could result in significant project cost increases, and rejection of the HHC application.

(b) State Overlays. Article XXXIV of the California Constitution requires local voter approval before any state public body can develop, construct, or acquire a low-rent housing project in any manner. However, the Public Housing Election Implementation Law (Health & Safety. Code, §§ 37000 - 37002) provides clarification as to when Article XXXIV is applicable.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 120. Legal Documents

After a Recipient is sent a letter providing notice of award pursuant to a NOFA, and prior to actual disbursement of funds pursuant to that award, the Department and Recipient shall enter into a state “Standard Agreement” that shall constitute a conditional commitment of said funds. The Standard Agreement shall require the Recipient to comply with the requirements and provisions of these Guidelines, and generally applicable state contracting rules and requirements. The Standard Agreement shall encumber state moneys in an amount no more than as established in the NOFA and said amount shall be consistent with the application and corresponding award letter. The Standard Agreement shall contain the terms necessary to ensure the Recipient complies with all HHC-NHTF requirements, including, but not limited to, the following:

(a) Requirements for the execution of a promissory note, operating reserve agreement, or other project-specific contracts as may be applicable;

(b) Requirements set forth in the NOFA;

(c) Requirements, where appropriate, for the execution and recordation of covenants, regulatory agreements, or other instruments restricting the use and occupancy of and appurtenant to the project and the property thereunder (for the purposes of these Guidelines, all such documents are collectively herein referred to as the HHC regulatory agreement;

(d) Requirements for the execution of a Deed of Trust or other security instrument securing the debt owed by the borrower to the Department for the amount of the award. The Deed of Trust must be recorded against the fee estate underlying the property; leasehold security will not be accepted unless such security strictly meets

the requirements set forth in 25 CCR Section 8316;

(e) The Recipient's responsibilities for timing and completion of the project, as well as all reporting requirements;

(f) Remedies available to the Department in the event of a violation, breach or default of the Standard Agreement; and

(f) All other provisions necessary to ensure compliance with the requirements of HHC and applicable state and federal law.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2), 53593 and 53595.

Section 121. Defaults and Loan and/or Grant Cancellations

(a) In the event of a breach or violation by the Recipient of any of the provisions of HHC-NHTF requirements, the regulatory agreement, the promissory note, or the deed of trust, or any other agreement pertaining to the project, the Department may give written notice to the Recipient to cure the breach or violation within a period of not less than 15 days. If the breach or violation is not cured to the satisfaction of the Department within the specified time, the Department, at its option, may declare a default under the relevant document(s) and may seek legal remedies for the default, including but not limited to the following:

(1) The Department may accelerate all amounts, including outstanding principal and interest, due under the loan and demand immediate repayment thereof. Upon a failure to repay such accelerated amounts in full, the Department may proceed with a foreclosure in accordance with the provisions of the Deed of Trust and state law regarding foreclosures.

(2) The Department may seek, in a court of competent jurisdiction, an order for specific performance of the defaulted obligation or the appointment of a receiver to operate the project in accordance with HHC-NHTF requirements.

(3) The Department may seek such other remedies as may be available under the relevant agreement or any law as it relates to both the loan and the COSR grant.

(4) Suspension from future Department funding awards.

(5) The Department may seek other remedies set forth in the relevant agreement or any other applicable legal or equitable remedies law.

(b) If the breach or violation involves charging tenants rent or other charges in excess of those permitted under the regulatory agreement, the Department may demand the return of such excess rents or other charges to the respective households. In any action to enforce the provisions of the regulatory agreement, the Department may seek, as an additional remedy, the repayment of such overcharges.

(c) The Department may cancel loan commitments or COSR grants under any of the following conditions:

(1) The objectives and requirements of HHC cannot be met;

(2) Implementation of the project cannot proceed in a timely fashion in accordance with the approved plans and schedules;

(3) Special conditions have not been fulfilled within required time periods;

(4) There has been a material change, not approved by the Department, in the principals or management of the Recipient or project; or

(5) If the Recipient fails to apply for Tax Credit funding, which they relied on for project feasibility in their application, within 18 months of the HHC award date.

The Department, in writing and upon demonstration by the Recipient of good cause, may extend the date for compliance with any of the conditions in this subsection, as long as these extensions are within the established/agreed upon deadlines established in the NOFA.

(d) Upon receipt of a notice from the Department of intent to cancel the loan or request to repay the grant, the Recipient shall have the right to appeal to the Director.

(e) The Department may use any funds available to it to cure or avoid a Recipient's default on the terms of any loan or other obligation that jeopardizes the fiscal integrity of a project or the Department's security in the project. Such defaults may include defaults or impending defaults in payments on mortgages, failures to pay taxes, or failures to maintain insurance or required reserves. The payment or advance of funds by the Department pursuant to this subsection shall be solely within the discretion of the Department and no Recipient shall be entitled to or have any right to payment of these funds. All funds advanced pursuant to this Subsection shall be part of the HHC loan or COSR grant and, upon demand, due and payable to the Department. Where it becomes necessary to use state funds to assist a project to avoid threatened defaults or foreclosures, the Department shall take those actions necessary, including, but not limited to, foreclosure or forced sale of the project property, to prevent further, similar occurrences and ensure compliance with the terms of the applicable agreements.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2), 53593 and 53595.

Article II. Building Homes and Jobs Trust Fund Allocation

Section 200. Purpose and Scope

(a) In September of 2017, AB 74 was signed into law. This legislation authorizes the California Department of Housing and Community Development (Department) to develop the Housing for a Healthy California (HHC) program to create Supportive housing for individuals who are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program. The goal of HHC is to reduce the financial burden on local and state resources due to the overutilization of emergency rooms or incarceration as the first point of health care provision for people who are Chronically homeless or Homeless and a High-cost health user. The Department shall coordinate with the DHCS, consistent with state and federal privacy law, to match Program participant data to Medi-Cal data to identify outcomes among participants, as well as changes in health care costs and utilization associated with housing and services provided under HHC.

(b) AB 74 allows the Department to utilize revenues appropriated to the Department from other revenue sources for HHC purposes. As directed in the 2018-2019 state Budget Act, the Department will utilize a portion of moneys collected in calendar year 2018 and deposited into the Building Homes and Jobs Trust Fund for the HHC program. The Department will allocate these funds competitively to counties for acquisition, new construction or reconstruction and rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and rental subsidies for existing Supportive housing to assist HHC's Target Population. The Department has elected to incentivize utilizing locally committed funding in an amount at least equivalent to the requested HHC funding amount. Note, funds applied pursuant to Health and Safety Code Section 53594(a)(1) acquisition funding, new construction, and rehabilitation shall comply with Federal Housing Trust Fund regulations.

(c) In addition to applicable state and federal laws and regulations, these guidelines (hereinafter "Guidelines") implement, interpret, and make specific the HHC program authorized by Part 14.2 (commencing with Section 53590) of Division 31 of the Health and Safety Code and for Fiscal Year 2018 Chapter 2.5 (commencing with Section 50470) of Part 2 of Division 31 of the Health and Safety Code.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(1), 53594 and 50472.

Section 201. Definitions

All terms not defined below shall, unless their context suggests otherwise, be interpreted in accordance with the meaning of terms described in Part 14.2 of Division 31 of the Health and Safety Code (commencing with Section 53590).

(a) "Applicant" means a County, as defined below.

(b) "Area Median Income" or "AMI" means the most recent applicable County median family income published by HUD.

(c) "Assisted Unit" means a housing unit that is subject to the program's rent and/or occupancy restrictions as a result of the financial assistance provided under the program.

(d) "Case Manager" means a social worker or other qualified individual who works with a tenant to offer individualized service planning that is flexible and creative to help the tenant gain housing stability. It includes working in collaboration with the tenant to plan, assess, coordinate, and reassess the tenant's needs, as well as referrals and advocacy and connection to community support to meet tenants' supportive services needs. Services include, but are not limited to: tenancy support services, coordination of medical and behavioral health, substance use disorder treatment, employment services, life skills training, peer support, and crisis management interventions. Resident service coordinators are not Case Managers.

(e) "Chronically homeless" has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

(f) "Continuum of Care" is defined in 24 CFR Section 578.3.

(g) "Coordinated Entry System" or "CES" means a centralized or coordinated process developed pursuant to 24 CFR Section 578.7(a)(8), designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

(h) "County" means a county, city and county, or a city collaborating with a county to secure services funding.

(i) "DHCS" means the state Department of Health Care Services.

(j) "Department" means the Department of Housing and Community Development.

(k) "Development Sponsor" or "Sponsor", as defined in Section 50675.2 of the Health and Safety Code and subdivision (c) of Section 50669 of the Health and Safety Code,

means any individual, joint venture, partnership, limited partnership, trust, corporation, cooperative, local public entity, duly constituted governing body of an Indian Reservation or Rancheria, or other legal entity, or any combination thereof, certified by the Department as qualified to own, manage, and rehabilitate a rental housing development. A Development Sponsor may be organized for profit, limited profit or be nonprofit, and includes a limited partnership in which the Development Sponsor, or an affiliate of the Development Sponsor, is a general partner.

(l) “Distributions” has the same meaning as under 25 CCR Section 8301(h).

(m)“Fair Market Rent” or “FMR” means the rent, including the cost of utilities, as established by HUD pursuant to Parts 888 and 982 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2018, for units, by number of bedrooms, that must be paid in the market area to rent privately owned, existing, decent, safe, and sanitary rental housing of non-luxury nature with suitable amenities.

(n) "Fiscal Integrity" means, for any project for any given period of time during the term specified in the program’s regulatory agreement, that the total Operating Income for such project for such period of time, plus funds released pursuant to the Program documents from the project’s operating reserve account(s) during such period of time is sufficient to: (1) pay all current Operating Expenses for such project for such period of time; (2) pay all current mandatory debt service (excluding deferred interest) coming due with respect to such project for such period of time; (3) fully fund all reserve accounts established pursuant to the Program documents for such project for such period of time; and (4) pay other costs permitted by the Program documents for such project for such period of time. The ability to pay any or all the permitted annual distributions for a project shall not be considered in determining the Fiscal Integrity of a project.

(o) “Grantee” means an eligible Applicant that has been awarded funds under the program.

(p) “HHC” means the Housing for a Healthy California Program administered by the Department.

(q) “Health Homes Program” means the Health Homes Program, administered by the Department of Health Care Services, established pursuant to Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(r) “High-cost health users” means people who have had either at least three emergency department visits or one hospital inpatient stay over the last year.

(s) “Homeless” has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

(t) “Housing First” has the same meaning as in Welfare and Institutions Code Section 8255.

(u) “Lead Service Provider” or “LSP” means the organization that has the overall responsibility for the provision of Supportive Services and implementation of the Supportive Services plan. The LSP may directly provide comprehensive case management services or contract with other agencies that provide services.

(v) “Long-term rental assistance” means a rental subsidy provided to a housing provider, including a developer leasing affordable housing, to assist a tenant to pay the difference between 30 percent of the tenant’s income and Fair Market Rent or reasonable market rent as determined by the Department.

(w) “NOFA” means a Notice of Funding Availability.

(x) “Operating Expenses” has the same meaning as in 25 CCR Section 8301.

(y) “Operating Income” has the same meaning as in 25 CCR Section 8301.

(z) “Operating Cost Assistance Reserves” has the same meaning as in 25 CCR Section 8308.

(aa) “Permanent housing” means a housing unit where the landlord does not limit the length of stay in the housing unit, the landlord does not restrict the movements of the tenant, and the tenant has a lease and is subject to the rights and responsibilities of tenancy, pursuant to Chapter 2 (commencing with Section 1940) of Title 5 of Part 4 of Division 3 of the Civil Code.

(bb) “Point in Time Count” or “PIT” refers to an annual count of sheltered and unsheltered homeless persons on a single night in January.

(cc) “Program” means the Housing for a Healthy California Program created by this part.

(dd) “Supportive housing” means housing with no limit on length of stay, that is occupied by the Target Population, and that is linked to onsite or offsite services that assist the Supportive housing resident in retaining the housing, improving his/her health status, and maximizes his/her ability to live, and when possible, work in the community.

(ee) “Supportive Services” means social, health, educational, income support and employment services and, benefits; coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

(ff) “Target Population” means a person who is Chronically homeless or is Homeless and a High-cost health user upon initial eligibility, is a Medi-Cal beneficiary, is eligible for Supplemental Security Income, is eligible to receive services under a program providing services promoting housing stability, and is likely to improve his or her health conditions with Supportive housing.

(gg) “UMR” means the Uniform Multifamily Regulations commencing with 25 CCR Section 8300.

(hh) "Whole Person Care" Pilot or "WPC" has the meaning as described in the Medi-Cal 2020 Waiver Special Terms and Conditions (STCs), Sections 110-126, as approved by the federal Centers for Medicare and Medicaid Services on December 30, 2015.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53590 and 53595.

Section 202. Minimum Requirements

The Applicant shall comply with the requirements of HHC and all applicable federal and state laws.

(a) The Applicant shall meet all the following minimum requirements:

(1) Has identified a source of funding for providing intensive services promoting housing stability. Funding for these services may include, but is not limited to, one of more of the following:
   a. County general funds.
   b. WPC pilot program funds, to the extent those funds are available, or the WPC program has been renewed
   c. The Health Homes Program
   d. MHSA program
   e. Managed Care Organization
   f. Other County-controlled funding to provide these services to eligible participants

(2) Has developed a process for administering grant funds implementing affordable and Supportive housing projects. The agency the Applicant is partnering with, or the applying housing agency, must have either administered rental assistance or funded an affordable or Supportive housing project within the past three years.

(3) Agrees to collect and report data, as described in Section 219, to the Department.

(4) Must be compliant with both the housing element and their annual progress report submittals.

(b) The Applicant shall submit an application that meets the following requirements:

(1) The request for funding shall promote housing for persons who meet all the following requirements:
   a. Is Chronically homeless, or is homeless and a high-cost health user upon initial eligibility
   b. Is a Medi-Cal beneficiary
   c. Is eligible for Supplemental Security Income
   d. Is eligible to receive services under a program providing services promoting housing stability, including, but not limited to, the following:
      1. The WPC pilot program, to the extent the WPC program is available or has been renewed
      2. The Health Homes Program

3. A locally controlled service program funding or providing services in Supportive housing

e. Is likely to improve his or her health conditions with Supportive housing

(2) The use of funds proposed by the Applicant shall be clearly connected to the goals and strategies pursuant to Section 53591(a)(1).

(3) The amount requested shall not exceed the maximum amount specified in Section 208.

(4) The proposed projects shall be financially feasible for the duration of the HHC rental subsidy.

(5) A resolution from the County board of supervisors, or other controlling body, that authorizes the County to apply for funding and coordinate referrals and access to health care services to HHC tenants, such as a WPC pilot program, Health Homes Program, or other community-based program funding services.

(6) A County Application Plan as specified in Section 211.

(c) A County subrecipient(s) of HHC funds cannot be debarred or suspended from any state programs.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53592 and 53595.

Section 203. Eligible Uses

(a) A County shall use grants awarded pursuant to this part for any of the following:

(1) Acquisition, new construction, or reconstruction and rehabilitation of (a) project(s). Under this use, Applicants will be subject to Article I, Sections 103(a)(1), 104, 105, 106, 107, and 109(a) of these Guidelines.

(2) Operating assistance, which may include either or both of the following:

a. Long-term rental assistance to private landlords for periods as referenced in the NOFA, subject to renewal grants.

b. A Capitalized Operating Subsidy Reserve (COSR) for at least 15 years to pay for operating costs of an apartment or apartments receiving capital funding to provide Supportive housing to the Target Population.

(3) A County's administrative costs, as determined by the Department NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 204. Site and Neighborhood and Property Standard Requirements

In carrying out the site and neighborhood standards with respect to new construction, the requirements of 24 CFR 983.57(e)(2) apply. These standards do not apply to rehabilitation projects. However, if project-based vouchers are used in an assisted rehabilitation unit, the site and neighborhood standards for project-based vouchers will apply. In addition, the requirements of 24 CFR Part 8 will apply, and specifically address the site selection with respect to accessibility for persons with disabilities.

The Applicant shall ensure that all Assisted Units meet all applicable federal and state property standards. All Assisted Units must also meet the requirements of 25 CCR Section 8304 for the duration of the affordability period. Projects must meet the accessibility requirements specified in the TCAC regulations, as may be amended and renumbered from time to time, including those of Section 10325(f)(7)(K) and, for senior projects, those of Section 10325(g)(2)(B) and (C). Exemption requests, as provided for in the TCAC regulations, must be approved by the Department.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 205. Occupancy and Income Requirements

(a) Household income shall be determined in accordance with the rules in 24 CFR 93.151. At the time of move-in, household income shall not exceed the established extremely low income (ELI) limits or incomes at or below the poverty line, whichever is greater.

(b) The County or subrecipients shall maintain documentation of tenant income eligibility and eligibility in all the following ways, as applicable:

(1) Documentation of enrollment in or eligibility for Medi-Cal benefits.

(2) Documentation of a person's status as Chronically homeless could be captured through any of the following:
   a. A client's entry and exits documented in a Homeless Management Information System;
   b. An outreach worker or Case Manager's written observations; or
   c. A client's self-report of episodes of Homeless and disability status must be done in accordance with procedures established through the local Coordinated Entry System or other procedures established by the County for determining whether a person qualifies as a Homeless and High-cost health user, or Chronically homeless.

(3) Documentation of a person's status as a High-cost health user could be captured through any of the following:
   a. Discharge summaries; or
   b. An outreach worker's, case manager's or local County's health department written observations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 206. Rent Limits

(a) Assisted Unit rent shall not exceed the Fair Market Rent or reasonable market rent as determined by the Department. Tenants must meet the income determination requirements of Section 205.

(b) Over-income tenants - if at the time of re-certification, a tenant household's income exceeds the extremely low-income limit, or income at or below the poverty line, then the County/subrecipient:

(1) Shall re-designate the tenant's Assisted Unit as a non-Assisted Unit and designate the next available non-assisted comparable unit as an Assisted Unit until the unit mix required by the Program regulatory agreement is achieved.

(2) If all the project units are Assisted Units, that project can continue with the over-income unit(s) until such time as those over-income households no longer reside in the project.

(3) A unit shall be deemed "comparable" if it has the same number of bedrooms and reasonably similar square footage as the original unit.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 207. Capitalized Operating Subsidy Reserves (COSR)

HHC grant funds may be used to pay for a COSR with the following conditions:

(a) The COSR shall be sized to cover anticipated operating deficits attributable to the Assisted Units for a minimum of 15 years. The total amount of each project's operating reserves will be determined based upon the individual project underwriting performed by the County pursuant to the requirements of these Guidelines.

(b) In determining how to size each project's COSR, the County shall consider individual project factors, such as: the maximum percentage of Assisted Units it will assist; anticipated project vacancy rates; the anticipated percentage of Assisted Units that will have other operating subsidy and the term of that operating subsidy contract, and anticipated tenant incomes.

(c) The following standard assumptions will be used for establishing the total amount of a COSR. The Department may modify these assumptions as necessary to maintain project feasibility or extend the term of the operating reserves.

(1) All Assisted Units, other than the proportionate share of the manager's unit,

shall be counted in calculating the amount of COSR. An Assisted Unit receiving other rental assistance may receive assistance from a COSR.

(2) In projects of greater than 20 units, HHC will assist no more than 49 percent of the total project units. This limitation shall not be interpreted to preclude occupancy of any project units by persons with disabilities or restrictions by other funding sources, including but not limited to TCAC, that result in more than 49 percent of the total project units being restricted to the Target Population. It shall also not apply to projects complying with alternative requirements for demonstrating Olmstead compliance adopted by local jurisdictions and approved by the Department.

(3) In projects of 20 units or less, up to 100 percent of the units may be Assisted Units.

(4) The stabilized residential vacancy rate for the Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market or other evidence.

(d) Notwithstanding the above, in order to sustain the availability of a COSR for a minimum of 15 years, distributions from a COSR shall be subject to the following:

The County may not disburse more than 5 percent of the total COSR award made to a project per year, except that in any given year where the operating deficit attributable to the Assisted Units exceeds this amount, the Grantee may, in its sole discretion, increase the disbursement to up to 7 percent of the total COSR award, in accordance with the operating reserves limits and applicable review processes.

(e) Operating expenses that are eligible to be paid from a COSR include:

(1) Insurance

(2) Utilities

(3) Real property taxes

(4) Maintenance

(5) Supportive Services costs

(f) The statute/Guidelines do not preclude use of HHC funds on other supportive housing opportunities using capital and operating assistance, as long as the use of the funds is consistent with the requirements of Part 14.2 of Division 31 of the Health and Safety Code, as well as all other state, federal laws and regulations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 208. Maximum Award Limits

The maximum grant limit is $20,000,000 per Applicant for new construction, acquisition, rehabilitation, rental subsidies, administrative costs and/or operating assistance (COSR and/or rental assistance). The actual award amounts may be adjusted for project size and the number of households served.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 209. Fee Limits

A County may use up to 10 percent of the grant, as reflected in the NOFA, to fund administrative costs for the HHC program.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 210. Use of Operating Cash Flow

Regarding allowable uses of operating cash flow for capital or operating subsidies, including a COSR, the County shall follow the requirements commencing with 25 CCR Section 8314, as applicable.

Where there is a difference between the provisions of the UMRs and these Guidelines, the provisions of these Guidelines shall prevail.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 211. County Application Plan

Any plan that meets the following requirements is acceptable, including, but not limited to, Continuum of Care plans, or any other County plan specific to homelessness. Applicant's proposed uses of funds should be clearly connected to the goals and strategies outlined in the plan.

Applicants should include in their application plan the following:

(a) A description of homelessness County-wide, including a discussion of the estimated number of residents experiencing homelessness or chronic homelessness among single adults, families, and unaccompanied youth;

(b) Special challenges or barriers to serving the Target Population;

(c) County resources applied to address homelessness, including efforts undertaken to prevent the criminalization of activities associated with homelessness;

(d) Available community-based resources, including partnerships with community-based organizations and non-profits;

(e) Identification of other partners tasked with addressing Homeless needs;

(f) Systems in place to collect the data required under Section 219;

(g) Efforts that will be undertaken to ensure that access to a CES, and any alternate assessment and referral system established for the Target Population pursuant to the requirements of these Guidelines, will be available on a nondiscriminatory basis;

(h) Applicants may propose an alternative definition of High-cost health user than defined in Section 201 of these Guidelines.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53592 and 53595.

Section 212. Application Process

(a) The Department shall issue a NOFA that details the application process for Applicants that specifies, among other things, the amount of funds available, application requirements, threshold requirements, award requirements, the allocation of rating points, the deadline for submittal of applications, and other general terms and conditions of funding commitments.

(b) The Department shall evaluate applications for compliance with the minimum requirements set forth in Section 202 and score based on the criteria outlined in Section 213.

(c) Applicants that do not meet the minimum requirements will be rejected and will not be rated.

(d) The Department reserves the right to do the following:

(1) Score an application as submitted in the event information is missing from the application; and

(2) Request clarification of unclear or ambiguous statements made in an application and other supporting documents where doing so will not impact the competitive scoring of the application.

(e) Applications selected for funding shall be approved at amounts, terms, and conditions specified by the Guidelines and the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1).

Section 213. Application Selection Criteria

The criteria detailed below and summarized in the following table shall be used to rate applications.

	Maximum Applicable Points
Need	
Number of individuals experiencing homelessness and impact of housing costs (H&S Code 53591(a)(1)(A)	10
Applicant's commitment to address Homeless needs (H&S Code 53591(a)(1)(D)	15
Total Need Points	**25**
Proposed Uses and Process for Using Funds	
Project(s) Description (H&S Code 53591(a)(1)(F)	10
Process for Using Grant Funds (H&S Code 53591(a)(1)(B)	10
Funding Coordination (H&S Code 53591(a)(1)(C)	10
Total Uses of Funds Points	**30**
Experience	
Applicant's experience in rental subsidies, funding, underwriting, or administering Supportive housing projects	15
Applicant's experience with projects comparable in scope/services to proposed project	15
Barriers encountered and addressed	5
Identify any best practices that could be used by other program participants	5
Total Experience Points	**40**
Funding Sources	
Description of plan to sustain funding	30
Total Funding Sources Points	**30**
Incentive Points	
Applicant has Whole Person Care Pilot Program available or renewed, or has Health Homes Program, or has other County-controlled funding that provides similar services to the Target Population. H&S Code 53591(a)(1)(E)	10
Projects with locally committed funding for projects in an amount at least equivalent to requested HHC funding	10
Total Incentive Points	**20**
TOTAL APPLICABLE POINTS	**145**

(a) Need (25 points maximum)

Consideration will be given to the number of individuals experiencing homelessness and the impact of housing costs in the County. Estimated need will be based on the number of Homeless individuals established at the latest PIT count and rent burden in the Applicant's geographic jurisdiction according to the Comprehensive Housing Affordability Strategy (CHAS) data. Points will be awarded as follows:

(1) Estimated Need (10 points maximum)
   a. More than 400 individuals are Homeless in the Applicant's geographic jurisdiction as stated in the NOFA (10 points); or
   b. More than half of the ELI population in the Applicant's geographic jurisdiction pay more than 50 percent of their income towards rent. (5 points)

(2) Describe the Applicant's demonstrated commitment to address the needs of people experiencing homelessness. Applicant has demonstrated successful outcomes in implementing federal and state programs addressing the needs of people experiencing homelessness, along with local commitment of resources. (15 points maximum)
   a. The Applicant has dedicated local resources to provide Permanent housing to residents experiencing homelessness over the last three years and has a plan to address homelessness. The plan has been successful and has been implemented for at least one year (15 points); or
   b. The Applicant has administered programs with successful outcomes in moving people from homelessness to Permanent housing but has not dedicated resources consistently over the last three years. The Applicant has a plan to address homelessness and has been implementing it over the last year (10 points); or
   c. The Applicant proposes to implement some actions in the next 12 months, including implementation of a plan to address homelessness and dedication of local resources. (5 points)

(b) Proposed Uses and Process for Using Funds (30 points maximum)

(1) Project Description. Applicant's description of the specific uses of the grant funds. For each specific planned use of the grant funds, the Applicant must respond to the required items to receive full points: (10 points)
   a. If the Applicant intends to use funding for development, project(s)' location and target date(s) for completion (10 points); or
   b. If the Applicant intends to use funding for rental assistance or a COSR, project(s)' total number of units and the total number of households who will receive Permanent housing and/or rental subsidies under the project (10 points).

(2) Process for Using Grant Funds. The Applicant's description of the following: (10 points maximum)
   a. The Applicant's or agency or agencies responsible for the distribution of the HHC grant funds and the proposed selection criteria and process to identify project(s) and/or sub-recipient(s) (6 points);

b. The timeline with clearly delineated milestones (1 point); and
c. The proposed funding source for the services (3 points)

(3) Funding Coordination. The Applicant's description of how the proposed HHC funding will supplement existing federal, state, and local funding. (10 points maximum)
a. Regarding service provision, the Applicant's description of the following:
1. The funding source(s) (2 points);
2. The amount of funding per participant, per month, the Applicant intends to commit (1 point);
3. The length of time services will be provided (1 point); and
4. The process for selecting the Homeless service provider (2 points).
b. The description of the Applicant's partnerships with affordable and Supportive housing providers to address homelessness (2 points).
c. The description of the Applicant's partnerships with healthcare providers who provide dental, mental health, primary care and substance abuse services (2 points).

(c) Experience (40 points maximum)

(1) The Applicant's experience, for the last three years, in funding and underwriting Supportive housing projects; and/or the Applicant's experience administering Supportive housing projects; and/or the Applicant's experience working with agencies that administer rental subsidies. (15 points maximum)
a. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered four or more projects in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 500 households in the last three years. (15 points)
b. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered at least two to three projects in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 300 households in the last three years. (10 points)
c. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered one project in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 100 households in the last three years. (5 points)

(2) The Applicant's development funding, rental assistance, or other operating assistance to the Target Population that is comparable in scale and scope to the number of projects or rental assistance the Applicant has proposed for the Program. (15 points maximum)
a. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered four or more projects comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance,

the administering agency has administered rental subsidies for at least 500 clients similar to the Target Population. (15 points)

b. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered at least two to three projects comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 300 clients similar to the Target Population. (10 points)

c. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered one project comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 100 clients similar to the Target Population. (5 points)

(3) Description of barrier(s) the Applicant encountered in the implementation of its Homeless strategy or funding and how barriers were resolved. (5 points)

(4) Description of any best practices developed by the Applicant that could be used for other program participants. (5 points)

(d) Funding Sources (30 points maximum)

(1) The Applicant's description of the plan to sustain funding for the program/project. The Applicant may commit to using funding from the Building Homes & Jobs Act allocations to score points in this category. (30 points)

(e) Incentive Points (20 points maximum)

(1) The Applicant has a Whole Person Care Pilot Program or is working with managed care organizations to make available Health Homes Program benefits to people experiencing homelessness. (10 points)

(2) Evidence demonstrating locally committed funding in an amount at least equivalent to requested HHC funding. (10 points)

In the event of tied point scores, the following tiebreakers shall be used to determine which project is selected for funding, in the order listed:

(1) Applicant relevant experience

(2) Need

(3) Application Plan

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1).

Section 214. Supportive Services

(a) Each application must include a County-specific Supportive Services plan that will identify how the County plans to provide or subcontract to provide Supportive Services to participants in the Program.

(b) The County must ensure services are provided to participants, but that participants are not required to participate in services. Access to or continued occupancy in housing cannot be conditioned on participation in services or on sobriety. The Supportive Services plan must describe the services to be made available to HHC tenants in a manner that is voluntary, flexible, and individualized, so HHC tenants may continue to engage with supportive services providers, even as the intensity of services needed may change. The level of services should support tenant engagement and housing retention.

(c) Using evidence-based models, the following Supportive Services shall be made available to HHC tenants based on tenant need. Except as otherwise noted below, the following required services shall be provided onsite at the project or offsite at another location easily accessible to tenants, with the majority of case management services offered on-site:

(1) Housing navigation to assist people experiencing homelessness to establish relationships with private landlords, if the County is using funding for rental assistance, and to apply for housing;

(2) Case management and tenancy support services;

(3) Peer support activities;

(4) Services to link participants, as needed, to behavioral health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups and to coordinate care;

(5) Services to link participants, as needed, to substance abuse disorder treatment;

(6) Support in linking to primary care services, including access to routine and preventive health and dental care, medication management, and wellness services;

(7) Benefits advocacy, including assistance or linkage to services in accessing Medi-Cal and Supplemental Security Income/State Supplementary Payment(SSI/SSP);

(8) Housing retention skills, including working with landlords and neighbors, unit maintenance and upkeep, and money management; and

(9) Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders not listed above.

The following Supportive Services are not required to be made available but are encouraged to be part of an Applicant's plan to provide Supportive Services to participants.

(1) Recreational and social activities;

(2) Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process;

(3) Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work; and

(4) Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

(d) The following additional information shall be provided in the Applicant's plan to provide Supportive Services:

(1) Description of tenant outreach, engagement, and retention strategies to be used;

(2) Description of each service to be offered, how services will be offered or provided depending upon who is anticipated to be providing the services, the location, and general hours of availability of the services;

(3) For services provided off-site, the plan must describe what public or private transportation options will be available to HHC tenants in order to provide them reasonable access to these services. Reasonable access is access that does not require walking more than one-half mile. Case management services should largely be provided on-site;

(4) Description of how the Supportive Services are culturally and linguistically competent for persons of different races, ethnicities, sexual orientations, gender identities, and gender expressions. This includes explaining how services will be provided to HHC tenants who do not speak English, or have other communication barriers, including sensory disabilities, and how communication among the services providers, the property manager, and these tenants will be facilitated;

(5) Estimated itemized budget, and sources of funding for services;

(6) Description of how the supportive services staff and property management staff or landlord will work together to prevent evictions, adopt and ensure compliance with harm reduction principles, and facilitate the implementation of reasonable accommodation policies from rent-up to ongoing operations of the project;

(7) General service provider and property manager communication protocols;

(8) Provider-to-client staff ratio (1:20);

(9) Description of how the physical design of the project fosters tenant engagement, onsite supportive services provision, safety and security, and sustainability of furnishings, equipment, and fixtures; and

(10) Other information needed by the Department to evaluate the Supportive Services to be offered consistent with the program, as specified in the NOFA.

The Department may request that any necessary updates to the plan to provide Supportive Services or related documents, including fully executed written agreements between the County, service providers, the project owner(s), if relevant, and the property manager, if relevant, be provided prior to the beginning of the initial rent-up period or prior to permanent loan closing, or after participants move into private-market apartments.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 215. Housing First

(a) Projects shall employ Housing First practices that are documented in the Applicant's plan to provide Supportive Services in the application. Projects must adhere to the Housing First core components pursuant to Welfare and Institutions Code Section 8255(b).

(b) Housing First practices include the following:

(1) Tenant selection practices that adhere to Section 216 of these Guidelines and promote the acceptance of Applicants regardless of their sobriety or use of substances, completion of treatment, or agreement to participate in services;

(2) Tenants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, or minor criminal convictions;

(3) Tenants are assisted in making application for tenancy and reasonable accommodation requests;

(4) Supportive Services are flexible and voluntary and focus on housing stability, engagement, and problem-solving over therapeutic goals; and

(5) Landlords or property managers do not impose restrictions on daily activities or limiting privacy, visitors, or the individual's ability to engage freely in community activities.

(c) Management and services practices emphasize tenant retention and offer flexibility and services to prevent and resolve lease violations and evictions. Subsidy-only units

shall follow Housing First property management and services practices described in subsection (b) above or implement modified Housing First practices that, at a minimum, incorporate:

(1) Tenant selection practices that promote the acceptance of Applicants regardless of their sobriety or use of substances, completion of treatment, or agreement to participate in services;

(2) Applicants are seldom rejected on the basis of poor credit or financial history, poor or lack of rental history, or minor criminal convictions;

(3) Applicants are assisted in making application for tenancy and reasonable accommodation requests;

(4) Assistance shall be provided in obtaining Permanent housing as rapidly as possible and without preconditions, such as participation in services, length of stay, or successful completion of transitional housing program. Upon exit to Permanent housing, follow up services shall be provided for no less than six months to ensure that tenants retain Permanent housing; and

(d) Services are voluntary unless required by a public agency funding source.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 216. Tenant Selection

(a) Tenants must meet income requirements in Section 205 and Target Population requirements in Section 202.

(b) Tenants shall be selected through use of a CES, in accordance with the provisions of 25 CCR Section 8305 and in compliance with Housing First requirements consistent with the core components set forth in Welfare and Institutions Code Division 8

Chapter 6.5 Section 8255 subsection (b) and basic tenant protections established under federal, state, and local law.

(1) Reasonable selection criteria, as referred to in 25 CCR Section 8305(a)(1), shall include priority status under a local CES developed pursuant to 24 CFR 578.7(a)(8).

(2) If the CES existing in the County cannot refer persons in the Target Population, the alternative system used must prioritize those with the greatest needs among those for referral to available Assisted Units.

(3) Sponsors shall accept tenants regardless of sobriety, participation in services or treatment, history of incarceration, credit, or history of eviction in accordance with practices permitted pursuant to WIC Section 8255 or other federal or state project funding sources.

(c) The requirements of 25 CCR Sections 8305 (a)(4)(A) and 8305 (a)(4)(D) shall be implemented as approved by the Department in a manner that is consistent with the requirements of the CES.

(d) In communities that are not yet referring people experiencing homelessness to programs through CES, Applicants should describe the process of referring residents based on eligibility for the Program.

(e) Projects must also provide a preference for accessible units to persons with disabilities requiring the features of the accessible units in accordance with Section 10337(b)(2) of the TCAC regulations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 217. Rental Agreements and Grievance Procedures

Rental or occupancy agreements and grievance procedures for Assisted Units shall comply with 25 CCR Section 8307 and 24 CFR 93.303. Tenants shall not be required to maintain sobriety, be tested for substances, or participate in services or treatment.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 218. Vulnerable Populations Best Practices

The following best practices should be incorporated in the construction of projects that receive funding from HHC, to the extent possible. These best practices work to further the safety and physical and mental well-being of residents within a project.

(a) General best practices for all developments:

(1) Safety features:
   a. Site selection and development of the project should consider the safety concerns of the prospective tenants.
   b. Building entrance and exit points should only allow admittance to residents or guests that residents admit.
   c. Common areas within the project should be oriented so as to have:
      1. Two ways to enter or exit the area;
      2. Visibility to the area from outside of it, i.e. windows in walls or doors; and
      3. A centralized location, to the extent possible.
   d. Safety lighting that reduces or eliminates blind or dark spaces.

(2) Property Management:
   a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
   b. Post in common areas and annually review with tenants the project's

grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(b) For those populations that have a history of sexual trauma and/or domestic violence:

(1) Safety features incorporate all of the general best practices and include the following:

a. For projects that will also be serving women with a history of domestic violence or sexual trauma:

1. Designate at least 25 percent of the Assisted Units for women with a history of domestic violence or sexual trauma and/or women with children, thereby ensuring women are not a small minority of the tenancy.
2. Design projects to provide separate and secure floors, wings, or buildings for women with a history of domestic violence or sexual trauma and/or women with children. These separate and secure areas should restrict access to only the residents in the secured area.

b. Security cameras:

1. At entrances, exits and common areas (including hallways, elevators, and stair wells);
2. Written policy on the use of the cameras to specify who has access to see the videos, who monitors the surveillance, and under what conditions footage would be released to the authorities; and
3. Camera recordings should be maintained for at least 30 days.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(c) The project should have 24-hour security if it serves persons impacted by domestic violence, transition age youth and other vulnerable populations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 219. Reporting Requirements

The County shall, at annual and midyear intervals, report all of the following data to the Department:

(a) Not later than 90 days after the end of each project's fiscal year, the Grantee shall submit an independent audit of the development prepared by a certified public accountant and in accordance with the Department's current audit requirements and all other applicable requirements, as stated by law or included in the NOFA.

(b) The County shall submit the data as required by the Department to measure the costs and outcomes for each of its Assisted Units. The County shall work with service providers or other sub-recipients to gather the data.

(c) The County shall report on the sources of tenant referrals for the project and submit both client data and performance outcome data to the Department. Tenant data may include, but is not limited to, demographic information. Performance outcome data shall include, but is not limited to, information on housing stability, tenant satisfaction as measured in a survey, and changes in income and benefits received.

(d) The County shall also report on the following:

(1) The number of participants who have received assistance through the Program in that year, and the type of intervention the participant received with HHC funds;

(2) The number of participants living in Supportive housing or other Permanent housing with HHC funds, and exits from the program, and the reasons for the exits; and

(3) To the extent available and feasible, the County shall provide data on the impact of the Program on participant's use of corrections systems and law enforcement resources.

(e) Recipient must comply with 2 CFR Part 512, as outlined in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53593.

Section 220. Operating Budgets

The County shall submit proposed operating budgets to the Department prior to award and annually thereafter. These budgets shall be subject to Department approval and comply with the requirements in 25 CCR Section 7326.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594.

Section 221. Federal and State Overlays

(a) Federal Overlays. Activities funded with HHC funds are required to comply with 24 CFR Part 93.350 and 24 CFR Part 93.301. Compliance with these requirements include, but are not limited to, environmental provisions, federal Davis-Bacon Wage requirements and state prevailing wage laws, relocation, Equal Opportunity and Fair Housing, Fair Housing Amendments Act, Affirmative Marketing, Section 504 of the Rehabilitation Act and its implementing regulations, and the Americans with Disabilities Act and its implementing regulations, Section 3 (employment of low-income persons), Violence Against Women Act, and Single Audit report 2 CFR Part

200.512. Failure to comply with federal overlays could result in significant project cost increases, and rejection of the HHC application.

(b) State Overlays. Article XXXIV of the California Constitution requires local voter approval before any state public body can develop, construct, or acquire a low-rent housing project in any manner. However, the Public Housing Election Implementation Law (Health & Safety. Code, §§ 37000 – 37002) provides clarification as to when Article XXXIV is applicable.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Section 222. Legal Documents

Grants shall be governed by a Standard Agreement or other agreement with the County on a form prescribed by the Department. The agreement shall ensure that the provisions of these Guidelines are applicable to the project(s) covered by the agreement and enforceable by the Department. The agreement will contain such other provisions as the Department determines are necessary to meet the requirements and goals of the program, including, but not limited to, the following:

(a) Requirements for the execution of a promissory note, operating reserve agreement, or other project-specific contracts as may be applicable;

(b) Requirements set forth in the NOFA;

(c) Requirements, where appropriate, for the execution and recordation of covenants, regulatory agreements, or other instruments restricting the use and occupancy of and appurtenant to the project and the property thereunder (for the purposes of these Guidelines, all such documents are collectively herein referred to as the HHC regulatory agreement);

(d) The County's responsibilities for timing and completion of Projects, if applicable, as well as any and all reporting requirements;

(e) Remedies available to the Department in the event of a violation, breach or default of the Standard Agreement; and

(f) Any and all other provisions necessary to ensure compliance with the requirements of HHC and applicable state and federal law.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Section 223. Defaults and Grant Cancellations

In the event the Department becomes aware of a breach or violation by the Grantee or its participating entities engaged in the delivery of HHC, any of the provisions of HHC–SB 2 requirements or Standard Agreement, or the locally executed HHC loan or

grant pertaining to the project, the Department may give written notice to violators to cure the breach or violation within a period of not less than 15 days. If the breach or violation is not cured to the satisfaction of the Department within the specified time period, the Department, at its option, may declare a default under the relevant document(s) and may seek legal remedies for the default, including but not limited to the following:

(a) Termination of the Grant Agreement and full or partial repayment of the awarded amount.

(b) Suspension from future Department funding awards.

(c) The Department may seek other remedies set forth in the Grant Agreement or any other applicable legal or equitable remedies.

If the breach or violation involves charging tenants rent or other charges in excess of those permitted under the Standard Agreement, the Department may demand the return of such excess rents or other charges to the respective households. In any action to enforce the provisions of the Standard Agreement, the Department may seek, as an additional remedy, the repayment of such overcharges.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Actions Related to CalOptima's Health Homes Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions
1. Authorize and direct the Chief Executive Officer, subject to any revisions required by the California Department of Health Care Services:
    A. To implement the Health Homes Program (HHP) network delivery model for the Medi-Cal program;
    B. With the assistance of Legal Counsel to enter into:
        i. Amendments to the CalOptima Medi-Cal contract with health networks to provide HHP services including responsibilities as Community-Based – Care Management Entities (CB-CMEs);
        ii. An amendment to the Behavioral Health Memorandum of Understanding (MOU) with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in Health Homes Program; and
2. Authorize CalOptima staff to conduct a Request for Proposal (RFP) process and to select and contract with a vendor(s) to provide HHP accompaniment and housing related services effective January 1, 2020.

Background
The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. The intent of HHP is to improve member outcomes and reduce health care costs. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program. HHP, which is an entitlement benefit, is being implemented in selected counties in a phased in implementation approach, with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

To support development of HHP, Section 2703 of the ACA provides enhanced funding to states. Rather than the standard Medicaid funding (Federal 50%/State 50%), the Center for Medicare & Medicaid Services (CMS) will fund 90% for the first two years following implementation, effective for each phase. California Assembly Bill 361 requires budget neutrality and that no state general funds are used towards the program. As such, the California Endowment is funding the remaining 10% of funds for HHP. After the first two years, it returns to the standard Medicaid funding (Federal 50%/State 50%).

Back to Agenda

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, MCPs will be responsible for overall administration, including development of HHP network. DHCS also published an HHP Program Guide that outlines the responsibilities of the MCPs and CB-CMEs. Per the DHCS requirements, HHP services are to be provided and coordinated through the network of Community-Based Care Management Entities (CB-CMEs). CB-CMEs are responsible for coordinating care with members, providers and other agencies as appropriate. HHP Program Guide requires the following six core service categories for members enrolled in HHP:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Services

DHCS has also established HHP staffing requirements, which are to be utilized across health networks, including: Clinical Consultant; HHP Director; Dedicated Care Coordinator; Housing Navigator for members experiencing homelessness; and, Community Health Worker (recommended, but not required).

Additionally, pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans, MCPs participating in HHP must coordinate care for members enrolled in HHP who also receive care through the Mental Health Plan (MHP or County). The MOU with the Orange County Health Care Agency is the vehicle for ensuring this coordination.

Discussion

HHP Eligible Members and HHP Enrollment
Members with certain chronic physical conditions, SUD and SMI and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must actively choose to enroll into HHP. Based on DHCS eligibility criteria, CalOptima staff plans to actively outreach to Medi-Cal only members potentially eligible for HHP and actively engage these members through written, telephonic, and face-to-face encounters to encourage member participation in HHP. CalOptima anticipates that approximately 23,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. CalOptima's dually eligible membership will participate in HHP through referrals only.

HHP Network Delivery Model
In developing CalOptima's HHP strategy, staff has considered the impact of these new HHP requirements to CalOptima's current delivery system. The impact analysis has included reviewing staffing resources, process and system enhancements, data exchange, and available community resources for new HHP services, such as accompaniment to appointments, housing transition services and tenancy sustaining services. Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. For HHP, CalOptima is able to leverage existing infrastructure to incorporate the new HHP services.

Back to Agenda

HHP focuses on a small percentage of CalOptima's overall membership. Based on the member distribution of HHP enrollment projections within the health networks, CalOptima staff's initial recommended approach was to provide health networks with an option of participating in HHP; however, this approach would potentially have required members to change their health networks and/or primary care providers when enrolling in HHP. In January 2019, DHCS advised that CalOptima must adhere to HHP expectation of not requiring members to change their health networks and/or primary care providers in order to participate in the HHP. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

Health Network Contract
In order to implement HHP, CalOptima health network contracts will need to be modified to include expectations of CB-CME responsibilities to provide HHP services effective no sooner than January 1, 2020. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate

HHP Select Services
New HHP services include accompaniment to appointments, housing transition services and tenancy sustaining services. For these new HHP select services, CalOptima staff proposes to conduct Request For Proposal (RFP) processes to procure vendors for these services, with staff conducting the RFPs, and selecting and contracting with vendor(s) to provide services beginning January 1, 2020. Health networks, as CB-CMEs, will have the ability to contract with these selected vendor(s).

Amendment to County Behavioral Health MOU
The Behavioral Health MOU between CalOptima and the County of Orange will need to be modified in order to reflect that CalOptima and the County will agree to written policies and procedures for coordinating appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

Implementation Efforts
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and modify operational procedures and polices outlining HHP requirements and operational processes impacting member engagement and enrollment, care management, CB-CME network and its responsibilities, staffing requirements and MCP oversight role. CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

Fiscal Impact
The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and

draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Should total enrollment fall below thresholds necessary to fund minimum staffing requirements, program costs may exceed projected revenue, resulting in a possible operating deficit of between $3 million and $7 million for the program's three-year period. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

Back to Agenda

Continued to a Future Board Meeting

Attachment to the August 1, 2019 Board of Directors Meeting – Agenda Item 19

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal 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
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	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
Kaiser Foundation Health Plan, Inc.	393 Walnut St	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	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

Back to Agenda

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

Back to Agenda

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

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

5/30/2018 — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM

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

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

Back to Agenda

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

Back to Agenda

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

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

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

Back to Agenda

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

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

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

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

Back to Agenda

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

Back to Agenda

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

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

5/30/2018 — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM

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

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

Back to Agenda

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

Back to Agenda

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

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

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

Back to Agenda

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

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

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

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

Back to Agenda

Medi-Cal Health Homes Program
Program Guide
7/01/19

Back to Agenda

I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

S06.346S, S06.347A, S06.347D, S06.347S, S06.348A, S06.348D, S06.348S, S06.349A, S06.349D, S06.349S, S06.350A, S06.350D, S06.350S, S06.351A, S06.351D, S06.351S, S06.352A, S06.352D, S06.352S, S06.353A, S06.353D, S06.353S, S06.354A, S06.354D, S06.354S, S06.355A, S06.355D, S06.355S, S06.356A, S06.356D, S06.356S, S06.357A, S06.357D, S06.357S, S06.358A, S06.358D, S06.358S, S06.359A, S06.359D, S06.359S, S06.360A, S06.360D, S06.360S, S06.361A, S06.361D, S06.361S, S06.362A, S06.362D, S06.362S, S06.363A, S06.363D, S06.363S, S06.364A, S06.364D, S06.364S, S06.365A, S06.365D, S06.365S, S06.366A, S06.366D, S06.366S, S06.367A, S06.367D, S06.367S, S06.368A, S06.368D, S06.368S, S06.369A, S06.369D, S06.369S, S06.370A, S06.370D, S06.370S, S06.371A, S06.371D, S06.371S, S06.372A, S06.372D, S06.372S, S06.373A, S06.373D, S06.373S, S06.374A, S06.374D, S06.374S, S06.375A, S06.375D, S06.375S, S06.376A, S06.376D, S06.376S, S06.377A, S06.377D, S06.377S, S06.378A, S06.378D, S06.378S, S06.379A, S06.379D, S06.379S, S06.380A, S06.380D, S06.380S, S06.381A, S06.381D, S06.381S, S06.382A, S06.382D, S06.382S, S06.383A, S06.383D, S06.383S, S06.384A, S06.384D, S06.384S, S06.385A, S06.385D, S06.385S, S06.386A, S06.386D, S06.386S, S06.387A, S06.387D, S06.387S, S06.388A, S06.388D, S06.388S, S06.389A, S06.389D, S06.389S, S06.4X0A, S06.4X0D, S06.4X0S, S06.4X1A, S06.4X1D, S06.4X1S, S06.4X2A, S06.4X2D, S06.4X2S, S06.4X3A, S06.4X3D, S06.4X3S, S06.4X4A, S06.4X4D, S06.4X4S, S06.4X5A, S06.4X5D, S06.4X5S, S06.4X6A, S06.4X6D, S06.4X6S, S06.4X7A, S06.4X7D, S06.4X7S, S06.4X8A, S06.4X8D, S06.4X8S, S06.4X9A, S06.4X9D, S06.4X9S, S06.5X0A, S06.5X0D, S06.5X0S, S06.5X1A, S06.5X1D, S06.5X1S, S06.5X2A, S06.5X2D, S06.5X2S, S06.5X3A, S06.5X3D, S06.5X3S, S06.5X4A, S06.5X4D, S06.5X4S, S06.5X5A, S06.5X5D, S06.5X5S, S06.5X6A, S06.5X6D, S06.5X6S, S06.5X7A, S06.5X7D, S06.5X7S, S06.5X8A, S06.5X8D, S06.5X8S, S06.5X9A, S06.5X9D, S06.5X9S, S06.6X0A, S06.6X0D, S06.6X0S, S06.6X1A, S06.6X1D, S06.6X1S, S06.6X2A, S06.6X2D, S06.6X2S, S06.6X3A, S06.6X3D, S06.6X3S, S06.6X4A, S06.6X4D, S06.6X4S, S06.6X5A, S06.6X5D, S06.6X5S, S06.6X6A, S06.6X6D, S06.6X6S, S06.6X7A, S06.6X7D, S06.6X7S, S06.6X8A, S06.6X8D, S06.6X8S, S06.6X9A, S06.6X9D, S06.6X9S, S06.810A, S06.810D, S06.810S, S06.811A, S06.811D, S06.811S, S06.812A, S06.812D, S06.812S, S06.813A, S06.813D, S06.813S, S06.814A, S06.814D, S06.814S, S06.815A, S06.815D, S06.815S, S06.816A, S06.816D, S06.816S, S06.817A, S06.817D, S06.817S, S06.818A, S06.818D, S06.818S, S06.819A, S06.819D, S06.819S, S06.820A, S06.820D, S06.820S, S06.821A, S06.821D, S06.821S, S06.822A, S06.822D, S06.822S, S06.823A, S06.823D, S06.823S, S06.824A, S06.824D, S06.824S, S06.825A, S06.825D, S06.825S, S06.826A, S06.826D, S06.826S, S06.827A, S06.827D, S06.827S, S06.828A, S06.828D, S06.828S, S06.829A, S06.829D, S06.829S, S06.890A, S06.890D, S06.890S, S06.891A, S06.891D, S06.891S, S06.892A, S06.892D, S06.892S, S06.893A, S06.893D, S06.893S, S06.894A, S06.894D, S06.894S, S06.895A, S06.895D, S06.895S, S06.896A, S06.896D, S06.896S, S06.897A, S06.897D, S06.897S, S06.898A, S06.898D, S06.898S, S06.899A, S06.899D, S06.899S, S06.9X0A, S06.9X0D, S06.9X0S, S06.9X1A, S06.9X1D, S06.9X1S, S06.9X2A, S06.9X2D, S06.9X2S, S06.9X3A, S06.9X3D, S06.9X3S, S06.9X4A, S06.9X4D, S06.9X4S, S06.9X5A, S06.9X5D, S06.9X5S, S06.9X6A, S06.9X6D, S06.9X6S, S06.9X7A, S06.9X7D, S06.9X7S, S06.9X8A, S06.9X8D, S06.9X8S, S06.9X9A, S06.9X9D, S06.9X9S, S14.0XXS, S14.101S, S14.102S, S14.103S, S14.104S, S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S,

S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S14.2XXS, S14.3XXS, S14.4XXS, S14.5XXS, S14.8XXS, S14.9XXS, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S24.2XXS, S24.3XXS, S24.4XXS, S24.8XXS, S24.9XXS, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S, S34.21XS, S34.22XS, S34.3XXS, S34.4XXS, S34.5XXS, S34.6XXS, S34.8XXS, S34.9XXS, S44.00XS, S44.01XS, S44.02XS, S44.10XS, S44.12XS, S44.20XS, S44.21XS, S44.22XS, S44.30XS, S44.31XS, S44.32XS, S44.40XS, S44.41XS, S44.42XS, S44.50XS, S44.51XS, S44.52XS, S44.8X1S, S44.8X2S, S44.8X9S, S44.90XS, S44.91XS, S44.92XS, S54.00XS, S54.01XS, S54.02XS, S54.10XS, S54.11XS, S54.12XS, S54.20XS, S54.21XS, S54.22XS, S54.30XS, S54.31XS, S54.32XS, S54.8X1S, S54.8X2S, S54.8X9S, S54.90XS, S54.91XS, S54.92XS, S64.00XS, S64.01XS, S64.02XS, S64.21XS, S64.22XS, S64.30XS, S64.31XS, S64.32XS, S64.40XS, S64.490S, S64.491S, S64.492S, S64.493S, S64.494S, S64.495S, S64.496S, S64.497S, S64.498S, S64.8X1S, S64.8X2S, S64.8X9S, S64.90XS, S64.91XS, S64.92XS, S74.00XS, S74.01XS, S74.02XS, S74.10XS, S74.11XS, S74.12XS, S74.20XS, S74.21XS, S74.22XS, S74.8X1S, S74.8X2, S74.8X9S, S74.90XS, S74.91XS, S74.92XS, S84.00XS, S84.01XS, S84.02XS, S84.10XS, S84.11XS, S84.12XS, S84.20XS, S84.21XS, S84.22XS, S84.801S, S84.802S, S84.809S, S84.90XS, S84.91XS, S84.92XS, S94.00XS, S94.01XS, S94.02XS, S94.10XS, S94.11XS, S94.12XS, S94.20XS, S94.21XS, S94.22XS, S94.30XS, S94.31XS, S94.32XS, S94.8X1S, S94.8X2S, S94.8X9S, S94.90XS, S94.91XS, S94.92XS
Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Back to Agenda

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Meeting of the CalOptima Board of Directors

Report Item

20. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the CEO, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement increase

Back to Agenda

is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be complaint with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Continued to a Future Board Meeting

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 20

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

Back to Agenda

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

Back to Agenda

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

Back to Agenda

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

Back to Agenda

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Back to Agenda

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more detail regarding the Ground Emergency Medical Tran port QAF Program and the reporting requirement and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
    a. Up to $10,000 and staff participation at the Vietnamese Cultural Center's 2019 Mid-Autumn Festival on Saturday, September 14, 2019 at Mile Square Park Freedom Hall in Fountain Valley;
    b. Up to $2,600 and staff participation in the Orange County Iranian American Chamber of Commerce (OCIACC) Health Expo on Saturday, September 14, 2019 at Quail Hill Community Center in Irvine;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners.

Back to Agenda

a. **Vietnamese Cultural Center's 2019 Mid-Autumn Festival in Fountain Valley**. Staff recommends the authorization of expenditures for participation in the Vietnamese Cultural Center's 2019 Mid-Autumn Moon Festival. Also known as "Children's Day," this is a traditional festival for the Vietnamese community. The Mid-Autumn Festival celebrates three fundamental concepts of Gathering, Thanksgiving, and Praying. Children light lanterns and participate in a parade as part of the celebration. CalOptima has participated in this event for four years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2019, which includes the following: Opportunity for CalOptima's Chief Executive Officer to be a part of the event program, one (1) 10x10 exhibitor space, logo on promotional flyers, 1,500 lanterns to be distributed at the event, and one (1) CalOptima banner on the stage at the festival. The anticipated number of attendees is more than 3,000 throughout the day. This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about all CalOptima's programs and services with this under-served and hard to reach population.

b. **Orange County Iranian American Chamber of Commerce (OCIACC) Health Expo.** Staff recommends the authorization of expenditures for participation in the Orange County Iranian American Chamber of Commerce (OCIACC) Health Expo, which will be held in collaboration with OMID Multicultural Institute of Development, Alzheimer's Orange County, Iranian American Medical Association (AMA) and SEEB Medical Magazine. This is an educational event focused on providing health information, resources and health screenings. The event will feature experts in the areas of orthopedics, spine health, geriatrics, mental health and heart health and will offer free screenings for memory, Body Mass Index (BMI), blood pressure, hearing, vision and blood glucose. Staff recommends CalOptima's support for this event with a $2,600 financial commitment, which includes the following: one exhibit table, recognition at the event, CalOptima's logo on printed materials, marketing materials, OCIACC social media outlets, free advertising on OCIACC's e-newsletter 4 times a year, and $350 credit towards OCIACC membership. This is an educational event that will allow staff to provide outreach and education to the Iranian community and serve members speaking CalOptima's threshold languages of Farsi and Arabic. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services with this under-served and hard to reach population.

CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;

Back to Agenda

5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact
Funding for the recommended action of up to $12,600 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. 2019 Vietnamese Cultural Center Mid-Autumn Festival Sponsorship Request Letter; and
2. Orange County Iranian American Chamber of Commerce Sponsorship Request.

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

July 9, 2019

Mr. Michael Schrader
CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the 2019 Mid-Autumn Festival – Saturday, September 13, 2019

Dear Mr. Schrader:

On behalf of the Vietnamese Cultural Center, we would like to thank you for your support and participation in last year's Mid-Autumn Festival held at Mile Square Park in Fountain Valley. As you might remember the last event had approximately 3,000 attendees throughout the day and was a great success.

The Mid-Autumn Festival is a traditional festival for the Vietnamese community also known as "Children's Day." The Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving and Praying. During this time various activities are held to celebrate, such as harvesting rice before the 15th of the eight lunar months, provide offerings to the God of Earth, setting up platforms with light lanterns during the evening. The Mid-Autumn Festival is a day where families gather and enjoy time with their children. The tradition of brightly lit lanterns lends to the legend that Cuoi floated to the moon on a banyan tree and was stranded there. Children light lanterns and participate in a procession to show Cuoi the way back to Earth.

This year, the 2019 Mid-Autumn Festival event will take place on Saturday, September 13, 2019 at Mile Square Park in Fountain Valley from 6:30 PM – 8:30 PM. We anticipate a greater attendance at the event this year, of which will consist of families with children and older adults.

We would like to ask for CalOptima's participation and sponsorship in the amount of estimate **$10,000.00 for this year 2019** Mid-Autumn Festival.

I also look forward to seeing you to be a part of the event program on stage. Should you have any questions regarding the event, please contact me at (714) 548-4845 or by e-mail at promath10@yahoo.com. The Vietnamese Cultural Center appreciates CalOptima's support.

Sincerely,

Pho Huynh

Pho Huynh
Program Director
Vietnamese Cultural Center

TRUNG TÂM VĂN HÓA VIỆT NAM • TRƯỜNG VIỆT NGỮ •

Back to Agenda

OCIACC
Orange County Iranian American Chamber Of Commerce
اتاق بازرگانی ایرانیان امریکایی اورنج‌کانتی

- **Saturday** 9/14 /2019
- **11:00** AM to **3:00** PM

OCIACC HEALTH EXPO

In collaboration with **OMID** Multicultural Institute of Development, Alzheimer's OC, Iranian American Medical Association (IAMA) and **SEEB** Medical Magazine

Come learn from our experts on Orthopaedics and Spine Health, Geriatrics, Mental Health, Heart Health, and more.

- Sign up for free memory test. Screenings for Body Mass Index (BMI), Blood Pressure, Hearing, Vision & Blood Glucose.

- **This event is free to public**

- اگر می‌خواهید درباره سلامت ستون فقرات، بیماری‌های سالمندان، سلامت عقل و روان و سلامت قلب بیشتر بدانید، در نمایشگاه سلامتی (Health Expo) حضور یابید.

- **بازدید از نمایشگاه و شرکت در سخنرانی‌های متعدد آن برای عموم آزاد است.**

- در این نمایشگاه سلامتی خدماتی نظیر تست حافظه، اندازه‌گیری شاخص توده بدن (BMI)، فشار خون، قند خون، تست شنوایی و بینایی به‌طور رایگان انجام می‌شود.

این نمایشگاه با همکاری اتاق بازرگانی ایرانیان امریکایی اورنج‌کانتی، موسسه امید، موسسه آلزایمر اورنج‌کانتی، جامعهٔ پزشکان ایرانی-امریکایی (IAMA) و مجله سیب برگزار می‌شود.

www.ociacc.com
(949) 370 - 0102

Quail Hill Community Center
39 Shady Canyon Drive, Irvine CA, 92603

Back to Agenda

2019 Health Expo Sponsorship Packages

	Silver Sponsor $900	Gold Sponsor $1800	Platinum Sponsor $2600	Diamond Sponsor $3400
Free Exhibit Table	✓	✓	✓	✓
Blog Post on OCIACC Website	✓	✓	✓	✓
Recognition as a Sponsor at the Event	✓	✓	✓	✓
Social Media Promotion Facebook, Instagram, LinkedIn, Twitter		✓	✓	✓
Company Logo on Printed Materials		✓	✓	✓
Included in Pre-Event Email Blasts		✓	✓	✓
Included in Post-Event Email Blasts		✓	✓	✓
Company Logo and Web Link on OCIACC's Website Event Page			✓	✓
Free Advertising on OCIACC's e-Newsletter			4 times a year	8 times a year
Credit towards OCIACC Annual Membership or Renewal			$ 350 Value	$ 750 Value
Freestanding Banner at the Event				✓
Speaking Opportunity at the Event				✓

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

Back to Agenda

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

Back to Agenda

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Back to Agenda

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

Back to Agenda

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

Back to Agenda

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Back to Agenda

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

Contact

Belinda Abeyta, Interim Executive Director Operations (714) 246-8400

Recommended Actions

The MAC recommends:

1. Reappointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2019 to June 30, 2021:
    a. Sandy Finestone as the Adult Beneficiaries Representative;
    b. Ilia Rolon as the Family Support Representative;
    c. Patty Mouton as the Medi-Cal Beneficiaries Representative;
    d. Suzanne Butler as the Persons with Disabilities Representative;
    e. Diana Cruz-Toro as the Recipients of CalWORKs Representative; and
    f. Mallory Vega as the Seniors Representative.

Background

The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms with the exception of the two standing seats, which are representatives from the Social Services Agency (SSA) and the Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members. With the fiscal year ending on June 30, 2019, six MAC seats will expire: Adult Beneficiaries, Family Support, Medi-Cal Beneficiaries, Persons with Disabilities, Recipients of CalWORKs, and Seniors.

Discussion

CalOptima conducted outreach from March 1, 2019 through April 30, 2019 to recruit potential candidates. The recruitment included the following notification methods: placing articles in newsletters, community-based organizations (CBOs); and targeting community outreach to agencies and CBOs that serve the open positions; and posting recruitment materials on the CalOptima website. After a 60-day recruitment, CalOptima staff received applications from incumbent candidates only and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on May 22, 2019, subcommittee members evaluated each of the incumbent applications. The subcommittee included Members Connie Gonzalez, Jacquelyn Ruddy and Christine Tolbert, who recommended a candidate for each of the open seats and forwarded the proposed slate of candidates to the MAC for consideration.

At the June 13, 2019 Special MAC meeting, MAC voted to accept the recommended slate of candidates as proposed by the Nominations Ad Hoc.

Back to Agenda

Candidates for open positions are as follows:

Adult Beneficiaries Representative Candidates

Sandy Finestone*

Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators. Ms. Finestone works with individuals who have become disable due to stage IV cancer and facilitates support groups, meets individually with patients and their families and has created a peer support system. Ms. Finestone has been involved with the delivery of health care in the community for over thirty years, both as an advocate and as a health care provider. Ms. Finestone is a current committee member of CalOptima's FY 2019- 2020 OneCare Connect Member Advisory Committee.

Medi-Cal Beneficiaries Representative Candidates

Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in the area of health care for older adults for 17 years. Ms. Mouton oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. In addition, Ms. Mouton speaks to community groups about issues of medical coverage and defining the continuum of care. Ms. Mouton is a current committee member of CalOptima's FY 2019-2020 OneCare Connect Member Advisory Committee.

Persons with Disabilities Representative Candidates

Suzanne Butler*

Suzanne Butler has worked with individuals with developmental disabilities for over 25 five years. In her current position with the Regional Center of Orange County (RCOC), Ms. Butler assists RCOC staff, individuals with disabilities and their families understand Social Security, Medi-Cal, and Medicare benefits and how to access the appropriate services and supports through those agencies.

Recipients of CalWORKs Persons Representative Candidates

Diana Cruz-Toro*

Diana Cruz-Toro is an Administrative Manager for Family Self-Sufficiency and Adult Services at the Orange County Social Services Agency where Ms. Cruz-Toro has worked directly with clients for over 30 years. Having worked in various positions, Ms. Cruz-Toro has experience in the development, implementation and oversight of medical and employment programs funded by state and federal funding. Ms. Cruz-Toro assists families in need, including the CalWORKs program.

Seniors Representative Candidates

Mallory Vega*

Mallory Vega has been the Executive Director of Acacia Adult Day Services for over 30 years, providing adult day care, adult day health care, dementia care, and now Community Based Adult Services to seniors. In addition, Ms. Vega serves on numerous community agency boards that serve this population. Ms. Vega is a current committee member of CalOptima's PACE Development Advisory Committee (PDAC).

Family Support Representative Candidates

Ilia Rolon*

*Indicates MAC recommendation

Back to Agenda

Ilia Rolon is the Director, Children and Families Commission of Orange County. Ms. Rolon has managed and coordinated health promotion programs for families and clients from low-income communities for twenty-five years. In Ms. Rolon's current role, she oversees the development, implementation and management of the Healthy Children funding portfolio.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The MAC met to discuss the recommended slate of candidates and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence
Member Advisory Committee Nominations Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

s/s Michael Schrader — *7/24/19*
Authorized Signature — **Date**

*Indicates MAC recommendation

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
24. Consider Approval of New CalOptima Policy GA.4010: Service Animals

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

Recommended Action(s)
Authorize and approve new CalOptima Policy GA.4010: Service Animals

Background
In response to questions from employees regarding CalOptima members, PACE participants, visitors, or tenants entering CalOptima property with a service animal, Management determined that there is a need for a policy and procedure addressing service animals.

Discussion
CalOptima Policy GA.4010: Service Animals was developed to address the following areas:

- Where service animals are allowed on CalOptima property;
- Assessment factors to determine whether a service animal can be accommodated in the facility;
- What questions can be asked of the handler; and
- CalOptima's response to service animals behaving in a way that poses a direct threat to the health or safety of CalOptima members, PACE participants, employees, visitors or tenants.

The policy was developed to comply with Americans with Disabilities Act and Title 28, Code of Federal Regulations, Sections 35.104 and 36.302(c).

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The policy describes CalOptima's policy for individuals with disabilities entering CalOptima property with a service animal.

Concurrence
Gary Crockett, Chief Counsel

Attachments
CalOptima Policy GA.4010 Service Animals

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

Policy #:	GA.4010PP
Title:	**Service Animals**
Department:	Facilities
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	TBD
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes CalOptima's policy for individuals with disabilities, including Members, Participants, visitors, or tenants entering CalOptima Property with a Service Animal.

II. POLICY

A. CalOptima shall allow a Service Animal to accompany individuals with disabilities in all areas where the public are generally allowed on CalOptima Property.

1. For the CalOptima Program for All-Inclusive Care for the Elderly (PACE) Center, Service Animals may accompany individuals with disabilities in all areas of the facility where the public is normally allowed to go.

    a. Service Animals are excluded from the kitchen, staff lounge, medication room, lab room, locked storage areas and the administration hallway area.

2. If individuals with disabilities require entry into an area on CalOptima Property where security card access is required, CalOptima shall allow the Service Animal to accompany the handler.

3. Members are not allowed in areas where security card access is necessary to enter.

B. CalOptima shall require a Service Animal have a harness, leash, or tether, unless the handler is unable to use a tether because of a disability or the use of a tether would interfere with the Service Animal's ability to safely perform its work or tasks. In this case the Service Animal must be under control by the handler through hand signals, voice commands, or other effective means.

C. CalOptima shall allow Service Animals in training on CalOptima Property while following the same procedures found in this Policy for animals trained to perform tasks or do work related to the handler's disability.

D. CalOptima shall allow Service Animals that have been individually trained to do work or perform tasks for individuals with disabilities. CalOptima shall allow Service Animals to accompany individuals with disabilities in all areas where the public are generally allowed on CalOptima Property where reasonable.

Back to Agenda

1. CalOptima shall use the following assessment factors to determine whether a Service Animal can be accommodated in the facility:

    a. Whether the Service Animal is housebroken;

    b. Whether the Service Animal is under the owner's control;

    c. Whether CalOptima Property can accommodate the size and weight of the Service Animal; and

    d. Whether the presence of the Service Animal will not compromise legitimate safety requirements necessary for safe operation of CalOptima Property.

E. CalOptima Property shall not deny access for individuals with disabilities using a Service Animal due to allergies or fear of dogs.

F. CalOptima shall not discriminate against an individual using a Service Animal.

III. PROCEDURE

A. When it is not evident what service the animal provides, CalOptima shall only be allowed to ask two (2) questions of the handler as follows:

1. Is the Service Animal required because of a disability?

2. What work or task has the animal been trained to perform?

B. If a Service Animal behaves in a way that poses a direct threat to the health or safety of CalOptima Members, employees, visitors, or tenants, and/or is not under control of its handler or is not house broken, CalOptima may exclude the Service Animal from CalOptima Property. CalOptima shall consider each situation on a case-by-case basis. If the Service Animal is excluded, CalOptima must still offer the individual services without the Service Animal present.

C. If a Service Animal is excluded for reasons listed in Section III B., CalOptima shall provide individuals with disabilities the necessary assistance required in the absence of the Service Animal.

C. Dogs whose sole function is to provide comfort or emotional support do not qualify as Service Animals under the Americans with Disabilities Act (ADA) as amended.

D. CalOptima shall prohibit an individual from bringing a pet(s) (e.g., a domestic animal kept for pleasure or companionship) within CalOptima Property, with the exception of Service Animals providing reasonable accommodations for persons with disabilities under the ADA.

E. CalOptima shall not require Service Animals to wear a vest or ID tag identifying them as a Service Animal.

F. CalOptima shall not insist on proof of state certification, license, or any type of certification before permitting the Service Animal into CalOptima Property.

G. CalOptima shall not request documentation for the Service Animal or require the Service Animal to perform its task or ask about the individual's disability.

H. CalOptima shall not be responsible for the care or supervision of any Service Animal including feeding or providing a special location for the Service Animal.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. Americans with Disabilities Act
B. Title 28, Code of Federal Regulations (C.F.R.), §§35.104, 35.136, and 36.302(c))

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GA.4010PP	Service Animal	Administrative

Back to Agenda

IX. GLOSSARY

Term	Definition
Americans with Disabilities Act (ADA)	A civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else. (adata.org)
CalOptima Property	Any real property under the control of CalOptima including but not limited to, CalOptima's administration building located at 505 City Parkway West, Orange, CA 92868 and CalOptima's PACE Center located at 13300 Garden Grove Boulevard, Garden Grove, CA 92843, inclusive of inside the facility and up to and including the perimeter of the property line.
Participant	An individual enrolled in our CalOptima PACE program
Member	A beneficiary who is enrolled in a CalOptima program.
Service Animal	Any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not Service Animals for the purposes of this definition. While the definition of service animal extends only to dogs, ADA regulations also allow for the use of miniature horse that have been individually trained to do work or perform tasks for individuals with disabilities as service animals. Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.

Board of Directors Meeting
August 1, 2019

Member Advisory Committee (MAC) Update

June 13, 2019 Special MAC Meeting

MAC members reviewed the FY 2018-2019 MAC Accomplishments and approved the MAC meeting schedule for FY 2019-20. MAC Member Christine Tolbert presented the MAC Nominations Ad Hoc's recommended slate of candidates for FY 2019-20. The ad hoc recommended that the Board reappoint current members to the MAC for additional terms which included: Patty Mouton, Medi-Cal Beneficiaries Representative; Sandra Finestone, Adult Beneficiaries Representative; Ilia Rolon, Family Support Representative; Suzanne Butler, Persons with Disabilities Representative; Diana Cruz-Toro, Recipients of CalWORKs Representative; and Mallory Vega, Seniors Representative.

Ladan Khamseh, Chief Operating Officer, provided updates on the Whole-Child Model (WCM) program implementation, the Homeless Health Initiative and Proposition 56 rates. Ms. Khamseh notified the MAC that Chapman Consulting would be reaching out to all the advisory committee chairs and vice chairs to schedule a conference call to discuss CalOptima's FY 2020-23 Strategic Plan that is currently being developed. Ms. Khamseh also noted that MAC members would have the opportunity to provide comments on the strategic plan prior to CalOptima's Board of Directors meeting scheduled December 5, 2019.

David Ramirez, M.D., Chief Medical Officer, notified the MAC that the management of CalOptima's Behavioral Health benefit for OneCare and OneCare Connect will be transitioning from Magellan to CalOptima effective January 1, 2020. Dr. Ramirez also discussed Telehealth, noting that CalOptima was looking forward to receiving an All Plan Letter (APL) from the DHCS and to beginning the implementation process. Dr. Ramirez also noted that CalOptima is submitting the Quality Measure outcomes to the National Committee for Quality Assurance (NCQA) in the near future and that the first phase of Health Homes Program (HHP) would be starting January 2020.

MAC also received updates from Candice Gomez, Executive Director, Program Implementation, and Tracy Hitzeman, Executive Director, Clinical Operations, on the WCM implementation scheduled to begin on July 1, 2019. Ms. Hitzeman also provided an update on CalOptima's Case Management Department's work on the Homeless Health Initiative. MAC Members also received a demonstration from Mauricio Flores, Manager Customer Service on the new Member Portal that can be found on the new CalOptima website.

MAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the MAC's current activities.

Back to Agenda

Board of Directors Meeting
August 1, 2019

Provider Advisory Committee (PAC) Update

June 13, 2019 PAC Meeting

PAC members welcomed Tina Bloomer as the Nurse Representative who was appointed by the Board at its June 6, 2019 meeting. PAC members reviewed and approved their FY 2018-19 Accomplishments.

PAC members received a presentation from Healthy Smile's Dental Program. CalOptima Board Member and Healthy Smiles for Kids CEO Ria Berger, Harvey Lee, DDS, Chief Dental Officer spoke about the need for early dental intervention for children. PAC recommended this presentation be shared with the health networks at an upcoming Health Network Forum.

Ladan Khamseh, Chief Operations Officer, provided updates on the Whole-Child Model implementation, Homeless Health Initiative and Proposition 56 rates. Ms. Khamseh notified the PAC that Chapman Consulting would be reaching out to all the advisory committee chairs and vice chairs regarding the 2020-2023 Strategic Plan with a joint meeting to be held for all committees on October 10, 2019.

David Ramirez, M.D., Chief Medical Officer, notified the PAC that the OneCare and OneCare Connect behavioral health lines of business would be transitioning to CalOptima on January 1, 2020. Dr. Ramirez also discussed telehealth, noting that CalOptima was looking forward to receiving an All Plan Letter (APL) from the DHCS and to begin the implementation process. He also noted that CalOptima is submitting the Quality Measure outcomes to National Committee for Quality Assurance (NCQA) in the near future.

PAC also received updates from Michelle Laughlin, Executive Director, Network Operations; Candice Gomez, Executive Director, Program Implementation; and Tracy Hitzeman, Executive Director, Clinical Operations, regarding the Whole-Child Model implementation scheduled to begin on July 1, 2019. Ms. Hitzeman also presented along with Sloane Petrillo, Director, Case Management on Case Management's role in the Homeless Health Initiative.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

Back to Agenda

CALOPTIMA
BOARD OF DIRECTORS
NETWORK PAYMENT MODELS
AUGUST 1, 2019

Back to Agenda

Prepared by Pacific Health Consulting Group and Milliman

August 1, 2019

Meeting Agenda

- Introductions
- Project Overview
- Board Interview Themes
- Network Models
- CalOptima Networks
- Comparable Networks
- Next Session

Introductions
Pacific Health Consulting Group and Milliman

Bobbie Wunsch
Founder and Partner

Tim Reilly
Founder and Partner

Andrew Naugle
Principal & Healthcare Management Consultant

Back to Agenda

Project Overview

- Approach
  - Board interviews
  - Document review
  - Staff interviews
  - Team experience and knowledge
- Board Educational Presentations
  - August – Network Models
  - September – Models to Motivate Network Outcomes
  - October – Presentation of Project Findings and Recommendations
- **Today's Goal**
  - **Understanding network models as a basis for network strategy assessment**

Board Interviews
Key Themes

- The existing networks provide value.
- There needs to be objective criteria for Network entry.
- There needs to be measurable performance criteria applied regularly to all networks in a transparent manner.
- CalOptima has an important role in improving the quality, outcomes, and cost of services to its members in all networks.
- CalOptima needs to stay abreast of all network and provider reimbursement developments, both local and national.

Categorizing Model Networks

- Nationally, and in California, most types of Networks can be categorized in the following groups:

- Direct Contracted-Contracts with individual providers. Delivery system organized by health plan. Individual Physicians or Physician Groups are typically paid Fee For Service (FFS) and the health plan organizes a system around them.

- Partially Delegated-Contracts with entities that organize part of the delivery system and are delegated a wide scope of professional benefits and administrative functions. Capitation is usually the main reimbursement method for the entity. Typical entities are IPAs and Medical groups.

- Fully Delegated-Contracts with entities that organize a complete delivery system and are delegated a full scope of benefits and administrative functions. These entities are paid capitation. ACOs, PHCs, Dual Capitated Hospitals and Physician Groups, and other HMOs are typical participants. In California these entities must be licensed by DMHC.

Key features of three basic types of Networks-Direct Contracted Networks

- Health plan puts together a complete network of providers under contract.
- The health plan directly controls payments, quality programs, incentives, and utilization management (UM).
- Maximum control for plan and allows the network to be targeted to certain populations.
- Allows physicians to participate who may not be affiliated with organized physician entities.
- CalOptima's CCN Complex and CCN General are examples of these types of networks.

Key features of three basic types of Networks-Delegated Contracted Networks

- There are two types of delegated networks: Full and Partial.
- Delegated entity puts together a complete networks of providers under contract.
- The delegated entity directly controls payments, quality programs, incentives, and UM.
- Maximum control for provider organized networks and allows decisions about care to be may by provider closest to the patient.
- The goal is a more provider integrated system.
- CalOptima's delegates Kaiser, HMOs, PHCs, and SRGs are examples of these types of networks.

CalOptima Networks

Model	Entities	Members	Percentage
Kaiser	1	44,557	6.0%
HMO*	3	118,215	16.0%
PHC**	3	210,235	28.7%
SRG	5	187,524	25.5%
CCN	-	77,333	10.0%
COD	-	98,873	13.8%
Total	**12**	**736,737**	**100.0%**

Model	Professional	Hospital	Pharmacy	Other Medical
Kaiser	Capitation	Capitation	Capitation	Capitation
HMO*	Capitation	Capitation	Fee-For-Service	Fee-For-Service
PHC**	Capitation	Capitation	Fee-For-Service	Fee-For-Service
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service
CCN	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service
COD	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service

* HMO – Comprised of one entity; assumes both professional and hospital risk. Not to be confused with industry terminology.

** PHC – Comprised of two entities; one for professional risk and one for hospital risk

Source: CalOptima Delivery System Review, September 6, 2018, Greg Hamblin

Back to Agenda

CA MCMC Model Overview

- LA Care-LA Care is primarily a delegated network. Sub contracting HMOs (Kaiser, Anthem, and Blue Shield) and capitated IPAs with Shared Risk make up 95% of the network. LA Care is expanding its Direct network at this time.

- Inland Empire Health Plan (IEHP)-IEHP uses all three types of networks but its enrollment is mainly split between delegated IPAs and a Direct network. Kaiser has a small market share as well. IEHP has been expanding its Direct network, particularly after two of its IPAs had compliance problems.

- Other County Organized Health Systems (COHS)-Most of the other COHSs' networks are heavily dominated by Direct networks and only utilize other types of networks when important providers insist on a particular model.

IEHP and LA Care Networks

Monthly Enrollment

	Kaiser	HMO	Restricted License	Dual Cap/PHC	Cap IPA/SRG	Direct	Total
IEHP	112,392	0	8,548	0	554,531	508,074	1,183,545
LA Care	205,451	779,339	50,000	350,000	669,203	126,398	2,180,391

Enrollment Percent

	Kaiser	HMO	Restricted License	Dual Cap/PHC	Cap IPA/SRG	Direct	Total
IEHP	9.50%	0.00%	0.72%	0.00%	46.85%	42.93%	100.00%
LA Care	9.42%	35.74%	2.29%	16.05%	30.69%	5.80%	100.00%

CalOptima Networks Comparison

- Categorizing the networks to be comparable

Monthly Enrollment

	HMO	Full Risk	Cap/Shared Risk	Direct	Total
IEHP	112,392	8,548	554,531	508,074	1,183,545
CalOptima	44,587	328,450	187,524	176,206	736,767
LA Care	984,790	400,000	669,203	126,398	2,180,391

Enrollment Percent

	HMO	Full Risk	Cap/Shared Risk	Direct
IEHP	9.50%	0.72%	46.85%	42.93%
CalOptima	6.05%	44.58%	25.45%	23.92%
LA Care	45.17%	18.35%	30.69%	5.80%

CalOptima Networks Comparison

- The southern California region uses more capitation and delegation than northern California, and LA Care and CalOptima were started out with heavily delegated networks.
- All three plans have increased their Direct networks over time.
- CalOptima utilizes in a significant fashion three different network types. LA Care and IEHP are more concentrated.

Next Session

- September 5, 2019
- Models to Motivate Network Outcomes

Behavioral Health 2018 First Year Update

Board of Directors Meeting
August 1, 2019

Donald Sharps, M.D.
Medical Director, Behavioral Health

Back to Agenda

2018 First Year Update
Behavioral Health Integration (BHI)

- CalOptima began directly managing Medi-Cal Behavioral Health (BH) / Behavioral Health Treatment (BHT)
  - Member support, provider network, claims and utilization management
  - CalOptima had delegated Medi-Cal BH and BHT to Managed Behavioral Healthcare Organizations (MBHO) from 2014 to 2017
- Magellan's MBHO continues to manage OneCare and OneCare Connect (OC/OCC) BH
  - OC/OCC BH has been a CalOptima benefit since 2005
- County level of care for Medi-Cal Specialty Mental Health unchanged with Affordable Care Act in January 2014

CalOptima BHI Strategic Focus

- Integrated care
  - Mental health screening at primary care settings
  - Psychological factors affecting physical health
  - Co-location of behavioral and physical health services
  - Interdisciplinary care team
- Network development
  - Special populations
  - Specialty areas
- Quality of care
  - Access and availability
  - Member satisfaction

Back to Agenda

CalOptima Medi-Cal BH in 2018

- 47,012 incoming calls to access a provider
- 18 percent transferred to clinical team for additional support
- No prior authorization with monitoring of quality of care
- Top 10 diagnoses included:
  - Generalized anxiety disorder and unspecified, major depressive disorders — single and recurrent without psychosis, dysthymia, bipolar unspecified
  - For autism and mild to profound intellectual disability
    - If mild to moderate BH impairment, CalOptima offers medication management and counseling for BH needs.
    - If severe BH impairment, CalOptima assists Regional Center of Orange County (RCOC) in linking members to county mental health services for included BH diagnoses.

CalOptima Medi-Cal BH in 2018 (cont.)

- 18,050 average encounters per month
  - 25,861 unique members for the year
    - 4.1 percent yearly penetrance
- Average penetrance rate by type for under 18 years of age
  - Psychotherapy — 0.5 percent vs 1.0 percent for over 18
  - Psychiatrist visit — 0.2 percent vs 1.2 percent for over 18
- Providers
  - 155 psychiatrists*
  - 32 nurse practitioners*
  - 10 physician assistants*
  - 608 therapists*

*2018 claims data

CalOptima Behavioral Health Treatment (BHT) 2018

- BHT includes Applied Behavior Analysis (ABA)
- 3,789 unique members received ABA
  - One in 84 <21 year old members received ABA (1.2 percent penetrance)
- 10,117 authorizations requests with Treatment Reports
- Eight hours per week average for all ages
- More than 60 providers (CalOptima has met with half)
- Five meetings of ABA Transition Council

BHT and BH Claims Trend Analysis

	BHT / ABA		Behavioral Health		Combined	
	Unique Utilizers	Claims Paid	Unique Utilizers	Claims Paid	Unique Utilizers	Claims Paid
2017 Magellan Totals	2,562	$47,327,539	22,366	$12,576,030	24,472	$59,903,569
2018 CalOptima Totals	3,789	$49,121,393	26,252	$14,704,637	29,390	$63,826,031

Back to Agenda

CalOptima OCC/OC BH in 2018

- 8,680 incoming calls to access a provider
- 1,067 average encounters per month
  - 7–10 percent new starts each month
  - 1,769 unique members (11 percent annual penetrance)
- 33 psychiatrists/nurse practitioners with claims
- 62 therapists with claims
- No prior authorization with monitoring of quality of care
- Top 10 diagnoses included:
  - Major depressive disorders, schizophrenia, schizoaffective, bipolar disorders, generalized anxiety disorder

CalOptima OCC/OC BH Transition

- Board approval May 2, 2019
  - Integrate OneCare Connect (Medicare-Medicaid Plan) and OneCare (HMO Special Needs Population) covered Behavioral Health (BH) services within CalOptima internal operations effective January 1, 2020
- CalOptima Information Services and BHI
  - Transition Project began May 3, 2019
  - Focus on network contracting
  - Formal notification sent to Magellan June 3, 2019
  - Transition Meeting with Magellan began June 24, 2019

Drug Medi-Cal Organized Delivery System 2018

- **July–December, 2018**
- **631** screenings for clients seeking Drug Medi-Cal services
  - 41 percent referred for residential
- **354** clients in outpatient contracted programs (32 in 2017)
  - Nine contract locations and four county operated sites
  - 48 clients have received Vivitrol
- **1,750** clients in methadone programs
  - Providers now include subutex, antabuse and naloxone
- Medical admits versus voluntary inpatient detoxication(VID)
  - CalOptima had 882 Medi-Cal admissions with primary alcohol diagnoses in 2016
  - DHCS offers VID as a prior authorized hospitalization (APL 18-001)

Back to Agenda

*Beneficiary Access Line (BAL): (800)-723-8641

CalOptima BH Line 855-877-3885

- Medi-Cal
  - Toll-free number for members to access outpatient MH and BHT services
  - Staffed by customer service representatives, licensed behavioral health clinicians and member liaison specialists
  - Level of care screening
  - Routine with assistance
- OC/OCC members are connected to Magellan MBHO

CalOptima's Mission

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

Back to Agenda

Back to Agenda

Financial Summary

May 2019

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2018-19: Consolidated Enrollment

May 2019 MTD

Overall enrollment was 760,421 members

- Actual lower than budget 22,522 members or 2.9%
  - ➢ Medi-Cal unfavorable variance of 21,913 members
    - o Whole Child Model (WCM) unfavorable variance of 12,502 members
      - WCM members will remain in their original aid codes until the program begins 7/1/19
    - o Medi-Cal Expansion (MCE) unfavorable variance of 9,143 members
    - o Temporary Assistance for Needy Families (TANF) unfavorable variance of 2,391 members
    - o Long-Term Care (LTC) unfavorable variance of 166 members
    - o Seniors and Persons with Disabilities (SPD) favorable variance of 2,289 members
  - ➢ OneCare Connect unfavorable variance of 803 members
- 476 decrease from April
  - o Medi-Cal decrease of 413 members
  - o OneCare Connect decrease of 121 members
  - o OneCare increase of 57 members
  - o PACE increase of 1 member

FY 2018-19: Consolidated Enrollment (cont.)

May 2019 YTD

Overall enrollment was 8,450,776 member months

- Actual lower than budget 172,988 members or 2.0%
  - Medi-Cal unfavorable variance of 169,261 members or 2.0%
    - MCE unfavorable variance of 62,884 members
    - WCM unfavorable variance of 62,510 members
      - WCM members will remain in their original aid codes until the program begins 7/1/19
    - TANF unfavorable variance of 50,218 members
    - LTC unfavorable variance of 1,107 members
    - SPD favorable variance of 7,458 members
  - OneCare Connect unfavorable variance of 4,954 members or 3.0%
  - OneCare favorable variance of 1,273 members or 8.7%
  - PACE unfavorable variance of 46 members or 1.4%

FY 2018-19: Consolidated Revenues

May 2019 MTD

- Actual higher than budget $69.2 million or 23.1%
  - ➢ Medi-Cal favorable to budget $71.8 million or 26.6%
    - o Unfavorable volume variance of $7.7 million
    - o Favorable price variance of $79.5 million
      - $56.2 million of Coordinated Care Initiative (CCI) revenue due to favorable paid rate adjustment by DHCS
      - $16.9 million of LTC revenue for services provided to non-LTC aid code members
      - $4.7 million in revenue due to Proposition 56
      - Offset by $22.9 million of WCM revenue due to delay of program start
  - ➢ OneCare Connect unfavorable to budget $3.1 million or 11.8%
    - o Unfavorable volume variance of $1.4 million
    - o Unfavorable price variance of $1.7 million
      - $5.7 million of CY 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) recoupment and unfavorable rates
      - Offset by CY 2019 Hierarchical Condition Category (HCC) and risk adjustments

FY 2018-19: Consolidated Revenues (cont.)

May 2019 MTD

- OneCare favorable to budget $308.5 thousand or 18.8%
  - Favorable volume variance of $260.9 thousand
  - Favorable price variance of $47.6 thousand
- PACE favorable to budget $238.7 thousand or 9.6%
  - Unfavorable volume variance of $123.9 thousand
  - Favorable price variance of $362.5 thousand

FY 2018-19: Consolidated Revenues (cont.)

May 2019 YTD

- Actual higher than budget $57.7 million or 1.8%
  - ➢ Medi-Cal favorable to budget $63.2 million or 2.2%
    - o Unfavorable volume variance of $56.9 million
    - o Favorable price variance of $120.0 million due to:
      - $58.5 million of prior year (PY) rates
      - $55.4 million of CCI revenue
      - $52.3 million of Proposition 56 revenue
      - $42.8 million Intergovernmental Transfer (IGT) revenue
      - $22.0 million due to favorable rates
      - Offset by unfavorable variance due to $114.3 million of WCM revenue

Back to Agenda

FY 2018-19: Consolidated Revenues (cont.)

May 2019 YTD

- OneCare Connect unfavorable to budget $7.2 million or 2.6%
  - Unfavorable volume variance of $8.5 million
  - Favorable price variance of $1.3 million
- OneCare favorable to budget $1.2 million or 6.8%
  - Favorable volume variance of $1.6 million
  - Unfavorable price variance of $0.4 million
- PACE favorable to budget $0.6 million or 2.3%
  - Unfavorable volume variance of $0.3 million
  - Favorable price variance of $0.9 million

Back to Agenda

FY 2018-19: Consolidated Medical Expenses

May 2019 MTD

- Actual higher than budget $7.6 million or 2.6%
  - ➢ Medi-Cal unfavorable variance of $4.4 million
    - o Favorable volume variance of $7.4 million
    - o Unfavorable price variance of $11.8 million
      - Professional Claims expenses unfavorable variance of $8.8 million
      - MLTSS expenses unfavorable variance of $7.1 million
      - Prescription Drug expenses favorable variance of $4.1 million mainly due to delay of WCM program
      - Facilities expenses unfavorable variance of $3.3 million
      - Provider Capitation expenses favorable variance of $2.8 million

Back to Agenda

FY 2018-19: Consolidated Medical Expenses (cont.)

May 2019 MTD

- OneCare Connect unfavorable variance of $2.7 million or 10.5%
  - Favorable volume variance of $1.4 million
  - Unfavorable price variance of $4.0 million
- OneCare unfavorable variance of $238.6 thousand or 15.0%
  - Unfavorable volume variance of $252.9 thousand
  - Favorable price variance of $14.3 thousand
- PACE unfavorable variance of $287.2 thousand or 12.4%
  - Favorable volume variance of $114.9 thousand
  - Unfavorable price variance of $402.1 thousand

Back to Agenda

FY 2018-19: Consolidated Medical Expenses (cont.)

May 2019 YTD

- Actual lower than budget $46.2 million or 1.5%
  - ➢ Medi-Cal favorable variance of $50.2 million
    - o Favorable volume variance of $54.1 million
    - o Unfavorable price variance of $3.9 million
      - Provider Capitation expenses unfavorable variance of $41.9 million
      - Prescription Drug expenses favorable variance of $38.5 million
      - Facilities expenses unfavorable variance of $37.4 million
      - Professional Claims expenses favorable variance of $33.9 million
  - ➢ OneCare Connect unfavorable variance of $4.4 million
    - o Favorable volume variance of $8.2 million
    - o Unfavorable price variance of $12.6 million

Medical Loss Ratio (MLR)

- May 2019 MTD: Actual: 80.2% Budget: 96.1%
- May 2019 YTD: Actual: 92.0% Budget: 95.1%

Back to Agenda

FY 2018-19: Consolidated Administrative Expenses

May 2019 MTD

- Actual lower than budget $2.7 million or 20.7%
  - Salaries, wages and benefits: favorable variance of $1.5 million
  - Other categories: favorable variance of $1.2 million

May 2019 YTD

- Actual lower than budget $22.9 million or 16.3%
  - Salaries, wages and benefits: favorable variance of $11.7 million
  - Other categories: favorable variance of $11.2 million

Administrative Loss Ratio (ALR)

- May 2019 MTD: Actual: 2.8% Budget: 4.4%
- May 2019 YTD: Actual: 3.6% Budget: 4.4%

Back to Agenda

FY 2018-19: Change in Net Assets

May 2019 MTD

- $68.1 million change in net assets
- $69.3 million favorable to budget
  - Higher than budgeted revenue of $69.2 million
  - Higher than budgeted medical expenses of $7.6 million
  - Lower than budgeted administrative expenses of $2.76 million
  - Higher than budgeted investment and other income of $5.0 million

May 2019 YTD

- $180.1 million change in net assets
- $161.0 million favorable to budget
  - Higher than budgeted revenue of $57.7 million
  - Lower than budgeted medical expenses of $46.2 million
  - Lower than budgeted administrative expenses of $22.9 million
  - Higher than budgeted investment and other income of $34.2 million

Back to Agenda

Enrollment Summary: May 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
65,089	66,010	(921)	(1.4%)	Aged	707,618	713,785	(6,167)	(0.9%)
592	620	(28)	(4.5%)	BCCTP	6,604	6,820	(216)	(3.2%)
47,390	44,152	3,238	7.3%	Disabled	517,257	503,417	13,840	2.7%
303,462	302,788	674	0.2%	TANF Child	3,382,386	3,411,602	(29,216)	(0.9%)
89,167	92,232	(3,065)	(3.3%)	TANF Adult	1,013,383	1,034,385	(21,002)	(2.0%)
3,392	3,558	(166)	(4.7%)	LTC	37,426	38,533	(1,107)	(2.9%)
235,411	244,554	(9,143)	(3.7%)	MCE	2,608,302	2,671,186	(62,884)	(2.4%)
-	12,502	(12,502)	(100.0%)	WCM*	-	62,510	(62,510)	(100.0%)
744,503	**766,416**	**(21,913)**	**(2.9%)**	**Medi-Cal**	**8,272,976**	**8,442,237**	**(169,261)**	**(2.0%)**
14,057	**14,860**	**(803)**	**(5.4%)**	**OneCare Connect**	**158,652**	**163,606**	**(4,954)**	**(3.0%)**
1,535	**1,324**	**211**	**15.9%**	**OneCare**	**15,837**	**14,564**	**1,273**	**8.7%**
326	**343**	**(17)**	**(5.0%)**	**PACE**	**3,311**	**3,357**	**(46)**	**(1.4%)**
760,421	**782,943**	**(22,522)**	**(2.9%)**	**CalOptima Total**	**8,450,776**	**8,623,764**	**(172,988)**	**(2.0%)**

*Note: WCM members will remain in their original aid codes until the program begins 7/1/19

Back to Agenda

Financial Highlights: May 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
760,421	782,942	(22,521)	-2.9%	Member Months	8,450,776	8,623,763	(172,987)	-2.0%
369,412,129	300,193,466	69,218,664	23.1%	Revenues	3,217,962,845	3,160,267,301	57,695,544	1.8%
296,232,047	288,625,605	(7,606,443)	-2.6%	Medical Expenses	2,959,255,375	3,005,486,219	46,230,844	1.5%
10,467,907	13,195,738	2,727,832	20.7%	Administrative Expenses	117,399,887	140,293,675	22,893,788	16.3%
62,712,175	**(1,627,877)**	**64,340,052**	**3952.4%**	**Operating Margin**	**141,307,583**	**14,487,407**	**126,820,175**	**875.4%**
5,398,547	416,667	4,981,880	1195.7%	Non Operating Income (Loss)	38,755,481	4,583,333	34,172,147	745.6%
68,110,722	**(1,211,210)**	**69,321,932**	**5723.4%**	**Change in Net Assets**	**180,063,063**	**19,070,741**	**160,992,322**	**844.2%**
80.2%	96.1%	16.0%		Medical Loss Ratio	92.0%	95.1%	3.1%	
2.8%	4.4%	1.6%		Administrative Loss Ratio	3.6%	4.4%	0.8%	
17.0%	-0.5%	17.5%		Operating Margin Ratio	4.4%	0.5%	3.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima A Public Agency Better. Together.

Consolidated Performance Actual vs. Budget: May 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
68.9	(0.8)	69.6	Medi-Cal	156.3	23.4	132.8
(6.1)	(0.8)	(5.3)	OCC	(17.2)	(8.3)	(8.9)
0.0	(0.1)	0.1	OneCare	0.1	(0.7)	0.7
(0.1)	(0.0)	(0.1)	PACE	2.2	0.0	2.1
62.7	**(1.6)**	**64.3**	**Operating**	**141.3**	**14.5**	**126.8**
5.4	0.4	5.0	Inv./Rental Inc, MCO tax	38.8	4.6	34.2
5.4	**0.4**	**5.0**	**Non-Operating**	**38.8**	**4.6**	**34.2**
68.1	**(1.2)**	**69.3**	**TOTAL**	**180.1**	**19.1**	**161.0**

Back to Agenda

Consolidated Revenue & Expense: May 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	509,092	235,411	744,503	14,057	1,535	326	760,421
REVENUES							
Capitation Revenue	$ 222,769,613	$ 118,584,767	$ 341,354,380	$ 23,374,745	$ 1,945,375	$ 2,737,629	$ 369,412,129
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	222,769,613	118,584,767	341,354,380	23,374,745	1,945,375	2,737,629	369,412,129
MEDICAL EXPENSES							
Provider Capitation	36,488,595	52,227,650	88,716,245	14,637,002	562,082		103,915,329
Facilities	23,598,944	25,393,550	48,992,494	4,139,449	464,953	897,190	54,494,086
Ancillary	-	-	-	739,666	88,524	-	828,191
Professional Claims	25,547,144	11,815,162	37,362,306	-	-	565,438	37,927,744
Prescription Drugs	18,738,139	21,074,271	39,812,410	5,446,512	562,572	205,913	46,027,408
MLTSS	39,999,776	3,391,344	43,391,120	1,485,157	64,855	40,820	44,981,952
Medical Management	2,396,491	958,554	3,355,045	1,231,587	82,517	726,628	5,395,776
Quality Incentives	753,685	410,243	1,163,927	272,600		3,260	1,439,787
Reinsurance & Other	573,874	398,293	972,168	83,204		166,404	1,221,776
Total Medical Expenses	148,096,647	115,669,068	263,765,715	28,035,177	1,825,503	2,605,653	296,232,047
Medical Loss Ratio	66.5%	97.5%	77.3%	119.9%	93.8%	95.2%	80.2%
GROSS MARGIN	**74,672,966**	**2,915,700**	**77,588,665**	**(4,660,432)**	**119,872**	**131,976**	**73,180,082**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,982,126	815,044	29,515	146,017	6,972,701
Professional fees			162,366	4,166	14,667	123	181,322
Purchased services			907,395	(69,083)	769	45,623	884,704
Printing & Postage			313,452	43,235	4,777	1,227	362,691
Depreciation & Amortization			456,004			2,076	458,080
Other expenses			1,189,231	44,426	(51)	39,282	1,272,888
Indirect cost allocation & Occupancy			(298,089)	586,645	43,167	3,797	335,521
Total Administrative Expenses			8,712,485	1,424,432	92,844	238,146	10,467,907
Admin Loss Ratio			2.6%	6.1%	4.8%	8.7%	2.8%
INCOME (LOSS) FROM OPERATIONS			68,876,181	(6,084,864)	27,028	(106,170)	62,712,175
INVESTMENT INCOME							5,398,531
OTHER INCOME			15				15
CHANGE IN NET ASSETS			**$ 68,876,196**	**$ (6,084,864)**	**$ 27,028**	**$ (106,170)**	**$ 68,110,722**
BUDGETED CHANGE IN NET ASSETS			(753,845)	(784,583)	(83,725)	(5,724)	(1,211,210)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 69,630,041	$ (5,300,281)	$ 110,753	$ (100,446)	$ 69,321,932

Back to Agenda

CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: May 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,664,674	2,608,302	8,272,976	158,652	15,837	3,311	8,450,776
REVENUES							
Capitation Revenue	$ 1,614,252,813	$ 1,284,906,720	$ 2,899,159,533	$ 274,916,219	$ 18,940,332	$ 24,946,761	$ 3,217,962,845
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,614,252,813	1,284,906,720	2,899,159,533	274,916,219	18,940,332	24,946,761	3,217,962,845
MEDICAL EXPENSES							
Provider Capitation	416,684,145	577,399,756	994,083,901	133,994,420	5,320,921		1,133,399,242
Facilities	251,633,765	268,369,524	520,003,288	41,074,252	5,299,475	5,111,886	571,488,902
Ancillary	-	-	-	7,361,551	495,152	-	7,856,702
Professional Claims	196,262,448	79,644,901	275,907,349	-	-	5,184,192	281,091,541
Prescription Drugs	191,328,015	216,210,859	407,538,874	58,789,435	5,259,370	2,001,375	473,589,054
MLTSS	359,460,023	31,691,588	391,151,611	15,166,566	550,714	169,164	407,038,056
Medical Management	23,624,007	10,919,042	34,543,049	12,439,636	699,518	6,985,837	54,668,040
Quality Incentives	8,402,314	4,507,337	12,909,651	3,184,980		33,110	16,127,741
Reinsurance & Other	5,866,478	4,273,240	10,139,718	2,075,788	37,298	1,743,295	13,996,098
Total Medical Expenses	1,453,261,194	1,193,016,247	2,646,277,441	274,086,628	17,662,448	21,228,859	2,959,255,375
Medical Loss Ratio	90.0%	92.8%	91.3%	99.7%	93.3%	85.1%	92.0%
GROSS MARGIN	**160,991,619**	**91,890,473**	**252,882,092**	**829,592**	**1,277,885**	**3,717,901**	**258,707,470**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			67,894,450	8,289,696	355,469	1,154,188	77,693,804
Professional fees			2,068,386	238,306	161,334	6,861	2,474,887
Purchased services			8,398,465	1,772,995	158,602	152,992	10,483,054
Printing & Postage			3,480,141	666,669	88,889	73,823	4,309,522
Depreciation & Amortization			4,823,596			22,883	4,846,479
Other expenses			13,313,951	505,225	1,083	70,302	13,890,561
Indirect cost allocation & Occupancy			(3,346,676)	6,553,403	435,413	59,441	3,701,581
Total Administrative Expenses			96,632,313	18,026,294	1,200,790	1,540,490	117,399,887
Admin Loss Ratio			3.3%	6.6%	6.3%	6.2%	3.6%
INCOME (LOSS) FROM OPERATIONS			156,249,779	(17,196,703)	77,095	2,177,411	141,307,583
INVESTMENT INCOME							38,754,601
OTHER INCOME			879				879
CHANGE IN NET ASSETS			**$ 156,250,659**	**$(17,196,703)**	**$ 77,095**	**$ 2,177,411**	**$ 180,063,063**
BUDGETED CHANGE IN NET ASSETS			23,426,235	(8,327,168)	(656,692)	45,033	19,070,741
VARIANCE TO BUDGET - FAV (UNFAV)			$ 132,824,424	$ (8,869,535)	$ 733,787	$ 2,132,378	$ 160,992,322

Back to Agenda

CalOptima A Public Agency Better. Together.

Balance Sheet: As of May 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$466,563,150	Accounts Payable	$28,054,462
Investments	462,428,939	Medical Claims liability	709,302,385
Capitation receivable	311,526,261	Accrued Payroll Liabilities	11,154,777
Receivables - Other	25,639,703	Deferred Revenue	87,775,768
Prepaid expenses	5,803,188	Deferred Lease Obligations	50,870
		Capitation and Withholds	112,122,304
Total Current Assets	**1,271,961,240**	**Total Current Liabilities**	**948,460,567**
Capital Assets			
Furniture & Equipment	37,167,625		
Building/Leasehold Improvements	5,475,375		
505 City Parkway West	50,411,374		
	93,054,375		
Less: accumulated depreciation	(45,849,778)		
Capital assets, net	47,204,597	Other (than pensions) post employment benefits liability	25,920,862
Other Assets		Net Pension Liabilities	23,602,064
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	60,000,000		
Board-designated assets:		**TOTAL LIABILITIES**	**997,983,493**
Cash and Cash Equivalents	6,936,986		
Long-term Investments	550,511,596	**Deferred Inflows**	
Total Board-designated Assets	557,448,582	Change in Assumptions	4,747,505
		Excess Earnings	156,330
Total Other Assets	617,748,582		
TOTAL ASSETS	**1,936,914,419**	**Net Position**	
		TNE	84,969,966
Deferred Outflows		Funds in Excess of TNE	859,591,574
		TOTAL NET POSITION	944,561,540
Pension Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,947,448,868**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,947,448,868**

Back to Agenda

CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of May 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	152,706,361				
	Tier 1 - Logan Circle	151,849,431				
	Tier 1 - Wells Capital	152,009,049				
Board-designated Reserve		456,564,841	330,027,466	507,883,509	126,537,375	(51,318,668)
TNE Requirement	Tier 2 - Logan Circle	100,883,741	84,969,966	84,969,966	15,913,775	15,913,775
	Consolidated:	**557,448,582**	**414,997,433**	**592,853,475**	**142,451,149**	**(35,404,893)**
	Current reserve level	*1.88*	*1.40*	*2.00*		

Back to Agenda

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

May 2019

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Eleven Months Ended May 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
760,421	782,943	(22,522)	-2.9%	Member Months	8,450,776	8,623,764	(172,988)	-2.0%
369,412,129	300,193,466	69,218,664	23.1%	Revenues	3,217,962,845	3,160,267,301	57,695,544	1.8%
296,232,047	288,625,605	(7,606,443)	-2.6%	Medical Expenses	2,959,255,375	3,005,486,219	46,230,844	1.5%
10,467,907	13,195,738	2,727,832	20.7%	Administrative Expenses	117,399,887	140,293,675	22,893,788	16.3%
62,712,175	**(1,627,877)**	**64,340,052**	**3952.4%**	**Operating Margin**	**141,307,583**	**14,487,407**	**126,820,175**	**875.4%**
5,398,547	416,667	4,981,880	1195.7%	Non Operating Income (Loss)	38,755,481	4,583,333	34,172,147	745.6%
68,110,722	**(1,211,210)**	**69,321,932**	**5723.4%**	**Change in Net Assets**	**180,063,063**	**19,070,741**	**160,992,322**	**844.2%**
80.2%	96.1%	16.0%		Medical Loss Ratio	92.0%	95.1%	3.1%	
2.8%	4.4%	1.6%		Administrative Loss Ratio	3.6%	4.4%	0.8%	
17.0%	-0.5%	17.5%		Operating Margin Ratio	4.4%	0.5%	3.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Eleven Months Ended May 31, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	744,503	766,416	(21,913)	(2 9%)
OneCare Connect	14,057	14,860	(803)	(5 4%)
OneCare	1,535	1,324	211	15 9%
PACE	326	343	(17)	(5 0%)
Total	760,421	782,943	(22,522)	(2 9%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 68,876	$ (754)	$ 69,630	9234 7%
OneCare Connect	(6,085)	(785)	(5,300)	(675 2%)
OneCare	27	(84)	111	132 1%
PACE	(106)	(6)	(100)	(1666 7%)
505 Bldg	-	-	-	0 0%
Investment Income & Other	5,399	417	4,982	1194 7%
Total	$ 68,111	$ (1,212)	$ 69,323	5719 7%

MLR

	Actual	Budget	% Point Var
Medi-Cal	77 3%	96 2%	18 9
OneCare Connect	119 9%	95 7%	(24 2)
OneCare	93 8%	96 9%	3 1

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,712	$ 10,951	$ 2,238	20 4%
OneCare Connect	1,424	1,925	501	26 0%
OneCare	93	134	41	30 6%
PACE	238	186	(52)	(27 9%)
Total	$ 10,468	$ 13,196	$ 2,728	20 7%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	995	1,119	124
OneCare Connect	221	234	13
OneCare	5	6	1
PACE	72	90	17
Total	1,292	1,449	156

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	748	685	64
OneCare Connect	64	63	0
OneCare	316	221	96
PACE	5	4	1
Total	1,133	973	160

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	8,272,976	8,442,237	(169,261)	(2 0%)
OneCare Connect	158,652	163,606	(4,954)	(3 0%)
OneCare	15,837	14,564	1,273	8 7%
PACE	3,311	3,357	(46)	(1 4%)
Total	8,450,776	8,623,764	(172,988)	(2 0%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 156,251	$ 23,426	$ 132,825	567 0%
OneCare Connect	(17,197)	(8,327)	(8,870)	(106 5%)
OneCare	77	(657)	734	111 7%
PACE	2,177	45	2,132	4737 8%
505 Bldg	-	-	-	0 0%
Investment Income & Other	38,755	4,583	34,172	745 6%
Total	$ 180,063	$ 19,070	$ 160,993	844 2%

MLR

	Actual	Budget	% Point Var
Medi-Cal	91 3%	95 1%	3 8
OneCare Connect	99 7%	95 6%	(4 1)
OneCare	93 3%	95 5%	2 3

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 96,632	$ 116,089	$ 19,457	16 8%
OneCare Connect	18,026	20,825	2,799	13 4%
OneCare	1,201	1,454	253	17 4%
PACE	1,540	1,926	385	20 0%
Total	$ 117,400	$ 140,294	$ 22,894	16 3%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	10,619	11,830	1,211
OneCare Connect	2,432	2,575	143
OneCare	54	66	12
PACE	724	906	181
Total	13,829	15,377	1,547

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	779	714	65
OneCare Connect	65	64	2
OneCare	293	221	72
PACE	5	4	1
Total	1,142	1,002	140

Back to Agenda

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended May 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	760,421		782,943		(22,522)	
REVENUE						
Medi-Cal	$ 341,354,380	$ 458.50	$ 269,553,875	$ 351.71	$ 71,800,506	$ 106.79
OneCare Connect	23,374,745	1,662.85	26,503,725	1,783.68	(3,128,980)	(120.83)
OneCare	1,945,375	1,267.35	1,636,902	1,236.33	308,473	31.02
PACE	2,737,629	8,397.63	2,498,964	7,285.61	238,665	1,112.02
Total Operating Revenue	369,412,129	485.80	300,193,466	383.42	69,218,664	102.38
MEDICAL EXPENSES						
Medi-Cal	263,765,715	354.28	259,357,002	338.40	(4,408,713)	(15.88)
OneCare Connect	28,035,177	1,994.39	25,363,290	1,706.93	(2,671,887)	(287.46)
OneCare	1,825,503	1,189.25	1,586,872	1,198.54	(238,631)	9.29
PACE	2,605,653	7,992.80	2,318,441	6,759.30	(287,212)	(1,233.50)
Total Medical Expenses	296,232,047	389.56	288,625,605	368.64	(7,606,443)	(20.92)
GROSS MARGIN	73,180,082	96.24	11,567,861	14.78	61,612,221	81.46
ADMINISTRATIVE EXPENSES						
Salaries and benefits	6,972,701	9.17	8,466,103	10.81	1,493,402	1.64
Professional fees	181,322	0.24	533,008	0.68	351,686	0.44
Purchased services	884,704	1.16	1,286,436	1.64	401,732	0.48
Printing & Postage	362,691	0.48	493,980	0.63	131,289	0.15
Depreciation & Amortization	458,080	0.60	464,167	0.59	6,087	(0.01)
Other expenses	1,272,888	1.67	1,579,812	2.02	306,925	0.35
Indirect cost allocation & Occupancy expense	335,521	0.44	372,233	0.48	36,712	0.04
Total Administrative Expenses	10,467,907	13.77	13,195,738	16.85	2,727,832	3.08
INCOME (LOSS) FROM OPERATIONS	62,712,175	82.47	(1,627,877)	(2.08)	64,340,052	84.55
INVESTMENT INCOME						
Interest income	3,176,463	4.18	416,667	0.53	2,759,796	3.65
Realized gain/(loss) on investments	302,176	0.40	-	-	302,176	0.40
Unrealized gain/(loss) on investments	1,919,893	2.52	-	-	1,919,893	2.52
Total Investment Income	5,398,531	7.10	416,667	0.53	4,981,865	6.57
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**68,110,722**	**89.57**	**(1,211,210)**	**(1.55)**	**69,321,932**	**91.12**
MEDICAL LOSS RATIO	**80.2%**		**96.1%**		**16.0%**	
ADMINISTRATIVE LOSS RATIO	**2.8%**		**4.4%**		**1.6%**	

Back to Agenda

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	8,450,776		8,623,763		(172,987)	
REVENUE						
Medi-Cal	$ 2,899,159,533	$ 350.44	$ 2,835,998,899	$ 335.93	$ 63,160,634	$ 14.51
OneCare Connect	274,916,219	1,732.83	282,149,672	1,724.58	(7,233,453)	8.25
OneCare	18,940,332	1,195.95	17,742,267	1,218.23	1,198,066	(22.28)
PACE	24,946,761	7,534.51	24,376,464	7,261.38	570,297	273.13
Total Operating Revenue	3,217,962,845	380.79	3,160,267,301	366.46	57,695,544	14.33
MEDICAL EXPENSES						
Medi-Cal	2,646,277,441	319.87	2,696,483,779	319.40	50,206,338	(0.47)
OneCare Connect	274,086,628	1,727.60	269,651,517	1,648.19	(4,435,111)	(79.41)
OneCare	17,662,448	1,115.26	16,945,172	1,163.50	(717,275)	48.24
PACE	21,228,859	6,411.62	22,405,751	6,674.34	1,176,892	262.72
Total Medical Expenses	2,959,255,375	350.18	3,005,486,219	348.51	46,230,844	(1.67)
GROSS MARGIN	258,707,470	30.61	154,781,082	17.95	103,926,388	12.66
ADMINISTRATIVE EXPENSES						
Salaries and benefits	77,693,804	9.19	89,394,582	10.37	11,700,779	1.18
Professional fees	2,474,887	0.29	4,800,191	0.56	2,325,304	0.27
Purchased services	10,483,054	1.24	13,753,682	1.59	3,270,629	0.35
Printing & Postage	4,309,522	0.51	5,738,766	0.67	1,429,244	0.16
Depreciation & Amortization	4,846,479	0.57	5,105,828	0.59	259,349	0.02
Other expenses	13,890,561	1.64	17,406,057	2.02	3,515,496	0.38
Indirect cost allocation & Occupancy expense	3,701,581	0.44	4,094,567	0.47	392,986	0.03
Total Administrative Expenses	117,399,887	13.89	140,293,675	16.27	22,893,788	2.38
INCOME (LOSS) FROM OPERATIONS	141,307,583	16.72	14,487,407	1.68	126,820,175	15.04
INVESTMENT INCOME						
Interest income	31,352,709	3.71	4,583,333	0.53	26,769,376	3.18
Realized gain/(loss) on investments	(1,455,520)	(0.17)	-	-	(1,455,520)	(0.17)
Unrealized gain/(loss) on investments	8,857,412	1.05	-	-	8,857,412	1.05
Total Investment Income	38,754,601	4.59	4,583,333	0.53	34,171,268	4.06
OTHER INCOME	879	-	-	-	879	-
CHANGE IN NET ASSETS	**180,063,063**	**21.31**	**19,070,741**	**2.21**	**160,992,322**	**19.10**
MEDICAL LOSS RATIO	**92.0%**		**95.1%**		**3.1%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.4%**		**0.8%**	

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended May 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	509,092	235,411	744,503	14,057	1,535	326	760,421
REVENUES							
Capitation Revenue	$ 222,769,613	$ 118,584,767	$ 341,354,380	$ 23,374,745	$ 1,945,375	$ 2,737,629	$ 369,412,129
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	222,769,613	118,584,767	341,354,380	23,374,745	1,945,375	2,737,629	369,412,129
MEDICAL EXPENSES							
Provider Capitation	36,488,595	52,227,650	88,716,245	14,637,002	562,082		103,915,329
Facilities	23,598,944	25,393,550	48,992,494	4,139,449	464,953	897,190	54,494,086
Ancillary	-	-	-	739,666	88,524	-	828,191
Professional Claims	25,547,144	11,815,162	37,362,306	-	-	565,438	37,927,744
Prescription Drugs	18,738,139	21,074,271	39,812,410	5,446,512	562,572	205,913	46,027,408
MLTSS	39,999,776	3,391,344	43,391,120	1,485,157	64,855	40,820	44,981,952
Medical Management	2,396,491	958,554	3,355,045	1,231,587	82,517	726,628	5,395,776
Quality Incentives	753,685	410,243	1,163,927	272,600		3,260	1,439,787
Reinsurance & Other	573,874	398,293	972,168	83,204		166,404	1,221,776
Total Medical Expenses	148,096,647	115,669,068	263,765,715	28,035,177	1,825,503	2,605,653	296,232,047
Medical Loss Ratio	66 5%	97 5%	77 3%	119 9%	93 8%	95 2%	80 2%
GROSS MARGIN	**74,672,966**	**2,915,700**	**77,588,665**	**(4,660,432)**	**119,872**	**131,976**	**73,180,082**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,982,126	815,044	29,515	146,017	6,972,701
Professional fees			162,366	4,166	14,667	123	181,322
Purchased services			907,395	(69,083)	769	45,623	884,704
Printing & Postage			313,452	43,235	4,777	1,227	362,691
Depreciation & Amortization			456,004			2,076	458,080
Other expenses			1,189,231	44,426	(51)	39,282	1,272,888
Indirect cost allocation & Occupancy			(298,089)	586,645	43,167	3,797	335,521
Total Administrative Expenses			8,712,485	1,424,432	92,844	238,146	10,467,907
Admin Loss Ratio			2 6%	6 1%	4 8%	8 7%	2 8%
INCOME (LOSS) FROM OPERATIONS			68,876,181	(6,084,864)	27,028	(106,170)	62,712,175
INVESTMENT INCOME							5,398,531
OTHER INCOME			15				15
CHANGE IN NET ASSETS			**$ 68,876,196**	**$ (6,084,864)**	**$ 27,028**	**$ (106,170)**	**$ 68,110,722**
BUDGETED CHANGE IN NET ASSETS			(753,845)	(784,583)	(83,725)	(5,724)	(1,211,210)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 69,630,041	$ (5,300,281)	$ 110,753	$ (100,446)	$ 69,321,932

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ended May 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,664,674	2,608,302	8,272,976	158,652	15,837	3,311	8,450,776
REVENUES							
Capitation Revenue	$ 1,614,252,813	$ 1,284,906,720	$ 2,899,159,533	$ 274,916,219	$ 18,940,332	$ 24,946,761	$ 3,217,962,845
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,614,252,813	1,284,906,720	2,899,159,533	274,916,219	18,940,332	24,946,761	3,217,962,845
MEDICAL EXPENSES							
Provider Capitation	416,684,145	577,399,756	994,083,901	133,994,420	5,320,921		1,133,399,242
Facilities	251,633,765	268,369,524	520,003,288	41,074,252	5,299,475	5,111,886	571,488,902
Ancillary	-	-	-	7,361,551	495,152	-	7,856,702
Professional Claims	196,262,448	79,644,901	275,907,349	-	-	5,184,192	281,091,541
Prescription Drugs	191,328,015	216,210,859	407,538,874	58,789,435	5,259,370	2,001,375	473,589,054
MLTSS	359,460,023	31,691,588	391,151,611	15,166,566	550,714	169,164	407,038,056
Medical Management	23,624,007	10,919,042	34,543,049	12,439,636	699,518	6,985,837	54,668,040
Quality Incentives	8,402,314	4,507,337	12,909,651	3,184,980		33,110	16,127,741
Reinsurance & Other	5,866,478	4,273,240	10,139,718	2,075,788	37,298	1,743,295	13,996,098
Total Medical Expenses	1,453,261,194	1,193,016,247	2,646,277,441	274,086,628	17,662,448	21,228,859	2,959,255,375
Medical Loss Ratio	90 0%	92 8%	91 3%	99 7%	93 3%	85 1%	92 0%
GROSS MARGIN	**160,991,619**	**91,890,473**	**252,882,092**	**829,592**	**1,277,885**	**3,717,901**	**258,707,470**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			67,894,450	8,289,696	355,469	1,154,188	77,693,804
Professional fees			2,068,386	238,306	161,334	6,861	2,474,887
Purchased services			8,398,465	1,772,995	158,602	152,992	10,483,054
Printing & Postage			3,480,141	666,669	88,889	73,823	4,309,522
Depreciation & Amortization			4,823,596			22,883	4,846,479
Other expenses			13,313,951	505,225	1,083	70,302	13,890,561
Indirect cost allocation & Occupancy			(3,346,676)	6,553,403	435,413	59,441	3,701,581
Total Administrative Expenses			96,632,313	18,026,294	1,200,790	1,540,490	117,399,887
Admin Loss Ratio			3 3%	6 6%	6 3%	6 2%	3 6%
INCOME (LOSS) FROM OPERATIONS			156,249,779	(17,196,703)	77,095	2,177,411	141,307,583
INVESTMENT INCOME							38,754,601
OTHER INCOME			879				879
CHANGE IN NET ASSETS			**$ 156,250,659**	**$ (17,196,703)**	**$ 77,095**	**$ 2,177,411**	**$ 180,063,063**
BUDGETED CHANGE IN NET ASSETS			23,426,235	(8,327,168)	(656,692)	45,033	19,070,741
VARIANCE TO BUDGET - FAV (UNFAV)			$ 132,824,424	$ (8,869,535)	$ 733,787	$ 2,132,378	$ 160,992,322

Back to Agenda

May 31, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $68.1 million, $69.3 million favorable to budget
- Operating surplus is $62.7 million, with a surplus in non-operating income of $5.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $180.1 million, $161.0 million favorable to budget
- Operating surplus is $141.3 million, with a surplus in non-operating income of $38.8 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
68.9	(0.8)	69.6	Medi-Cal	156.3	23.4	132.8
(6.1)	(0.8)	(5.3)	OCC	(17.2)	(8.3)	(8.9)
0.0	(0.1)	0.1	OneCare	0.1	(0.7)	0.7
(0.1)	(0.0)	(0.1)	PACE	2.2	0.0	2.1
62.7	**(1.6)**	**64.3**	**Operating**	**141.3**	**14.5**	**126.8**
5.4	0.4	5.0	Inv./Rental Inc, MCO tax	38.8	4.6	34.2
5.4	**0.4**	**5.0**	**Non-Operating**	**38.8**	**4.6**	**34.2**
68.1	**(1.2)**	**69.3**	**TOTAL**	**180.1**	**19.1**	**161.0**

Back to Agenda

CalOptima - Consolidated
Enrollment Summary
For the Eleven Months Ended May 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
65,089	66,010	(921)	(1.4%)	Aged	707,618	713,785	(6,167)	(0.9%)
592	620	(28)	(4.5%)	BCCTP	6,604	6,820	(216)	(3.2%)
47,390	44,152	3,238	7.3%	Disabled	517,257	503,417	13,840	2.7%
303,462	302,788	674	0.2%	TANF Child	3,382,386	3,411,602	(29,216)	(0.9%)
89,167	92,232	(3,065)	(3.3%)	TANF Adult	1,013,383	1,034,385	(21,002)	(2.0%)
3,392	3,558	(166)	(4.7%)	LTC	37,426	38,533	(1,107)	(2.9%)
235,411	244,554	(9,143)	(3.7%)	MCE	2,608,302	2,671,186	(62,884)	(2.4%)
-	12,502	(12,502)	(100.0%)	WCM*	-	62,510	(62,510)	(100.0%)
744,503	**766,416**	**(21,913)**	**(2.9%)**	**Medi-Cal**	**8,272,976**	**8,442,237**	**(169,261)**	**(2.0%)**
14,057	**14,860**	**(803)**	**(5.4%)**	**OneCare Connect**	**158,652**	**163,605**	**(4,954)**	**(3.0%)**
1,535	**1,324**	**211**	**15.9%**	**OneCare**	**15,837**	**14,564**	**1,273**	**8.7%**
326	**343**	**(17)**	**(5.0%)**	**PACE**	**3,311**	**3,357**	**(46)**	**(1.4%)**
760,421	**782,943**	**(22,522)**	**(2.9%)**	**CalOptima Total**	**8,450,776**	**8,623,763**	**(172,987)**	**(2.0%)**

* Whole Child Model (WCM) was budgeted based on initial implementation date. Enrollment for WCM was transferred from the other seven aid categories.

				Enrollment (By Network)				
164,336	166,708	(2,372)	(1.4%)	HMO	1,826,856	1,843,748	(16,892)	(0.9%)
212,411	221,730	(9,319)	(4.2%)	PHC	2,373,973	2,442,548	(68,575)	(2.8%)
190,169	186,083	4,086	2.2%	Shared Risk Group	2,114,037	2,091,280	22,757	1.1%
177,587	191,895	(14,308)	(7.5%)	Fee for Service	1,958,110	2,064,661	(106,551)	(5.2%)
744,503	**766,416**	**(21,913)**	**(2.9%)**	**Medi-Cal**	**8,272,976**	**8,442,237**	**(169,261)**	**(2.0%)**
14,057	**14,860**	**(803)**	**(5.4%)**	**OneCare Connect**	**158,652**	**163,605**	**(4,954)**	**(3.0%)**
1,535	**1,324**	**211**	**15.9%**	**OneCare**	**15,837**	**14,564**	**1273**	**8.7%**
326	**343**	**(17)**	**(5.0%)**	**PACE**	**3,311**	**3,357**	**(46)**	**(1.4%)**
760,421	**782,943**	**(22,522)**	**(2.9%)**	**CalOptima Total**	**8,450,776**	**8,623,763**	**(172,987)**	**(2.0%)**

Back to Agenda

CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	MMs
HMO													
Aged	3,844	3,866	3,841	3,841	3,854	3,842	3,837	3,821	3,783	3,760	3,780		42,069
BCCTP	1	1	1	1	1	1	1	1	1	1	1		11
Disabled	6,744	6,789	6,789	6,811	6,838	6,813	6,807	6,824	6,835	6,832	6,874		74,956
TANF Child	58,435	58,267	58,162	58,110	57,723	56,929	56,504	56,327	56,636	55,937	56,028		629,058
TANF Adult	29,473	29,373	29,404	29,529	29,392	29,131	28,926	28,716	28,656	28,084	28,183		318,867
LTC	2	2	3	4	1	1	2	2	3	3	2		25
MCE	68,597	68,602	68,919	69,646	69,547	69,385	69,020	69,207	70,003	69,476	69,468		761,870
WCM	-	-	-	-	-	-	-	-	-	-	-		-
	167,096	**166,900**	**167,119**	**167,942**	**167,356**	**166,102**	**165,097**	**164,898**	**165,917**	**164,093**	**164,336**		**1,826,856**
PHC													
Aged	1,600	1,621	1,620	1,673	1,673	1,645	1,593	1,565	1,535	1,528	1,517		17,570
BCCTP	-	-	-	-	-	-	-	-	-	-	-		-
Disabled	7,243	7,239	7,230	7,212	7,226	7,231	7,190	7,187	7,225	7,190	7,227		79,400
TANF Child	157,157	156,755	157,444	158,169	157,483	156,497	155,299	154,625	155,297	153,634	154,475		1,716,835
TANF Adult	12,731	12,684	12,787	12,785	12,596	12,476	12,049	11,890	11,851	11,536	11,385		134,770
LTC	-	1	-	-	-	1	1	-	-	-	1		4
MCE	39,060	38,992	39,234	39,568	39,402	39,204	37,896	38,002	38,255	37,975	37,806		425,394
WCM	-	-	-	-	-	-	-	-	-	-	-		-
	217,791	**217,292**	**218,315**	**219,407**	**218,380**	**217,054**	**214,028**	**213,269**	**214,163**	**211,863**	**212,411**		**2,373,973**
Shared Risk Group													
Aged	3,593	3,605	3,621	3,642	3,610	3,589	3,635	3,614	3,632	3,613	3,617		39,771
BCCTP	-	-	-	-	-	-	-	-	-	1	-		1
Disabled	7,626	7,554	7,486	7,473	7,493	7,463	7,409	7,419	7,426	7,484	7,501		82,334
TANF Child	67,471	67,226	67,159	67,251	66,739	66,119	65,717	65,144	65,328	64,401	65,088		727,643
TANF Adult	30,936	30,567	30,622	30,670	30,417	30,217	29,947	29,702	29,756	29,163	28,997		330,994
LTC	2	-	1	1	-	2	-	-	1	2	1		10
MCE	83,554	83,443	84,008	85,253	85,270	84,916	85,218	85,265	86,207	85,185	84,965		933,284
WCM	-	-	-	-	-	-	-	-	-	-	-		-
	193,182	**192,395**	**192,897**	**194,290**	**193,529**	**192,306**	**191,926**	**191,144**	**192,350**	**189,849**	**190,169**		**2,114,037**
Fee for Service (Dual)													
Aged	49,903	50,943	50,657	50,741	51,018	51,265	51,130	51,194	51,296	51,058	51,291		560,496
BCCTP	16	15	18	14	13	11	11	10	11	13	13		145
Disabled	20,706	20,863	20,741	20,761	20,812	20,921	20,739	20,879	20,732	20,584	20,776		228,514
TANF Child	2	3	2	2	1	2	2	2	2	2	2		22
TANF Adult	1,081	1,083	1,064	1,055	1,038	1,029	1,028	992	1,014	993	998		11,375
LTC	3,025	3,019	3,007	3,077	3,079	3,096	3,062	3,027	3,054	3,059	3,033		33,538
MCE	2,327	2,367	2,416	2,388	2,237	2,141	2,086	2,141	2,216	2,111	2,128		24,558
WCM	-	-	-	-	-	-	-	-	-	-	-		-
	77,060	**78,293**	**77,905**	**78,038**	**78,198**	**78,465**	**78,058**	**78,245**	**78,325**	**77,820**	**78,241**		**858,648**
Fee for Service (Non-Dual)													
Aged	4,702	3,727	4,153	4,118	4,018	4,128	4,311	4,347	4,568	4,756	4,884		47,712
BCCTP	613	596	601	581	589	574	584	579	579	573	578		6,447
Disabled	4,802	4,672	4,617	4,678	5,209	4,676	4,068	4,686	4,822	4,811	5,012		52,053
TANF Child	30,166	31,801	28,765	26,649	25,545	26,010	27,672	26,188	28,242	29,921	27,869		308,828
TANF Adult	20,308	20,588	20,198	19,628	19,315	19,401	19,614	19,442	19,761	19,518	19,604		217,377
LTC	353	360	367	347	356	340	351	350	333	337	355		3,849
MCE	44,399	44,410	43,161	40,810	40,393	41,103	42,153	42,065	42,283	41,375	41,044		463,196
WCM	-	-	-	-	-	-	-	-	-	-	-		-
	105,343	**106,154**	**101,862**	**96,811**	**95,425**	**96,232**	**98,753**	**97,657**	**100,588**	**101,291**	**99,346**		**1,099,462**
MEDI-CAL TOTAL													
Aged	63,642	63,762	63,892	64,015	64,173	64,469	64,506	64,541	64,814	64,715	65,089		707,618
BCCTP	630	612	620	596	603	586	596	590	591	588	592		6,604
Disabled	47,121	47,117	46,863	46,935	47,578	47,104	46,213	46,995	47,040	46,901	47,390		517,257
TANF Child	313,231	314,052	311,532	310,181	307,491	305,557	305,194	302,286	305,505	303,895	303,462		3,382,386
TANF Adult	94,529	94,295	94,075	93,667	92,758	92,254	91,564	90,742	91,038	89,294	89,167		1,013,383
LTC	3,382	3,382	3,378	3,429	3,436	3,440	3,416	3,379	3,391	3,401	3,392		37,426
MCE	237,937	237,814	237,738	237,665	236,849	236,749	236,373	236,680	238,964	236,122	235,411		2,608,302
WCM	-	-	-	-	-	-	-	-	-	-	-		-
	760,472	**761,034**	**758,098**	**756,488**	**752,888**	**750,159**	**747,862**	**745,213**	**751,343**	**744,916**	**744,503**		**8,272,976**
OneCare Connect	16,399	13,137	14,681	14,665	14,610	14,301	14,287	14,209	14,128	14,178	14,057		158,652
OneCare	1,390	1,384	1,375	1,404	1,423	1,435	1,453	1,472	1,488	1,478	1,535		15,837
PACE	273	286	286	289	295	299	304	308	320	325	326		3,311
TOTAL	**778,534**	**775,841**	**774,440**	**772,846**	**769,216**	**766,194**	**763,906**	**761,202**	**767,279**	**760,897**	**760,421**		**8,450,776**

Back to Agenda

ENROLLMENT:

Overall May enrollment was 760,421

- Unfavorable to budget 22,522 or 2.9%
- Decreased 476 or 0.1% from prior month (April 2019)
- Decreased 21,953 or 2.8% from prior year (May 2018)

Medi-Cal enrollment was 744,503

- Unfavorable to budget 21,913 or 2.9%
  - Whole Child Model (WCM) unfavorable 12,502
    - WCM members will remain in their original aid codes until the program begins 7/1/19
  - Medi-Cal Expansion (MCE) unfavorable 9,143
  - Temporary Assistance for Needy Families (TANF) unfavorable 2,391
  - Long-Term Care (LTC) unfavorable 166
  - Seniors and Persons with Disabilities (SPD) favorable 2,289
- Decreased 413 from prior month

OneCare Connect enrollment was 14,057

- Unfavorable to budget 803 or 5.4%
- Decreased 121 from prior month

OneCare enrollment was 1,535

- Favorable to budget 211 or 15.9%
- Increased 57 from prior month

PACE enrollment was 326

- Unfavorable to budget 17 or 5.0%
- Increased 1 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
744,503	**766,416**	**(21,913)**	**(2.9%)**	**Member Months**	**8,272,976**	**8,442,237**	**(169,261)**	**(2.0%)**
				Revenues				
341,354,380	269,553,875	71,800,506	26 6%	Capitation revenue	2,899,159,533	2,835,998,899	63,160,634	2 2%
-	-	-	0 0%	Other income	-	-	-	0 0%
341,354,380	**269,553,875**	**71,800,506**	**26.6%**	**Total Operating Revenue**	**2,899,159,533**	**2,835,998,899**	**63,160,634**	**2.2%**
				Medical Expenses				
89,880,172	95,372,291	5,492,119	5 8%	Provider capitation	1,006,993,552	984,878,235	(22,115,317)	(2 2%)
48,992,494	47,013,642	(1,978,852)	(4 2%)	Facilities	520,003,288	492,455,099	(27,548,189)	(5 6%)
37,362,306	29,525,846	(7,836,460)	(26 5%)	Professional Claims	275,907,349	316,186,110	40,278,762	12 7%
39,812,410	45,218,328	5,405,918	12 0%	Prescription drugs	407,538,874	455,206,947	47,668,073	10 5%
43,391,120	37,402,915	(5,988,205)	(16 0%)	MLTSS	391,151,611	400,047,124	8,895,513	2 2%
3,355,045	4,293,345	938,300	21 9%	Medical management	34,543,049	41,873,289	7,330,240	17 5%
972,168	530,634	(441,534)	(83 2%)	Reinsurance & other	10,139,718	5,836,974	(4,302,744)	(73 7%)
263,765,715	**259,357,002**	**(4,408,713)**	**(1.7%)**	**Total Medical Expenses**	**2,646,277,441**	**2,696,483,779**	**50,206,338**	**1.9%**
77,588,665	**10,196,873**	**67,391,793**	**660.9%**	**Gross Margin**	**252,882,092**	**139,515,120**	**113,366,972**	**81.3%**
				Administrative Expenses				
5,982,126	7,369,163	1,387,037	18 8%	Salaries, wages & employee benefits	67,894,450	77,818,670	9,924,220	12 8%
162,366	470,325	307,958	65 5%	Professional fees	2,068,386	4,110,674	2,042,288	49 7%
907,395	996,569	89,174	8 9%	Purchased services	8,398,465	10,565,148	2,166,683	20 5%
313,452	384,144	70,692	18 4%	Printing and postage	3,480,141	4,530,571	1,050,430	23 2%
456,004	462,076	6,072	1 3%	Depreciation and amortization	4,823,596	5,082,831	259,235	5 1%
1,189,231	1,492,034	302,803	20 3%	Other operating expenses	13,313,951	16,440,494	3,126,543	19 0%
(298,089)	(223,592)	74,497	33 3%	Indirect cost allocation, Occupancy Expense	(3,346,676)	(2,459,504)	887,172	36 1%
8,712,485	**10,950,718**	**2,238,233**	**20.4%**	**Total Administrative Expenses**	**96,632,313**	**116,088,885**	**19,456,572**	**16.8%**
				Operating Tax				
11,279,354	10,928,214	351,140	3 2%	Tax Revenue	125,325,975	119,321,619	6,004,357	5 0%
11,279,354	10,928,214	(351,140)	(3 2%)	Premium tax expense	125,325,975	108,537,481	(16,788,495)	(15 5%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	(0)	(0)	**100.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
46,312	249,874	(203,562)	(81 5%)	Grant Revenue	465,572	2,748,614	(2,283,042)	(83 1%)
34,000	223,107	189,107	84 8%	Grant expense - Service Partner	315,138	2,454,177	2,139,040	87 2%
12,312	26,767	14,455	54 0%	Grant expense - Administrative	150,434	294,437	144,003	48 9%
-	-	-	**0.0%**	**Total Grant Income**	-	-	-	**0.0%**
15	**-**	**15**	**0.0%**	**Other income**	**879**	**-**	**879**	**0.0%**
68,876,196	**(753,845)**	**69,630,041**	**9236.7%**	**Change in Net Assets**	**156,250,659**	**23,426,235**	**132,824,424**	**567.0%**
77.3%	***96.2%***	***18.9%***	***19.7%***	***Medical Loss Ratio***	***91.3%***	***95.1%***	***3.8%***	***4.0%***
2.6%	***4.1%***	***1.5%***	***37.2%***	***Admin Loss Ratio***	***3.3%***	***4.1%***	***0.8%***	***18.6%***

Back to Agenda

MEDI-CAL INCOME STATEMENT - MAY MONTH:

REVENUES of $341.4 million are favorable to budget $71.8 million driven by:

- Unfavorable volume related variance of $7.7 million
- Favorable price related variance of $79.5 million due to:
  - ➢ $56.2 million of Coordinated Care Initiative (CCI) revenue due to favorable paid rate adjustment by DHCS
  - ➢ $16.9 LTC revenue for services provided to non-LTC aid code members
  - ➢ $4.7 million due to Proposition 56
  - ➢ Offset by $22.9 million of WCM revenue due to delay of program start

MEDICAL EXPENSES of $263.8 million are unfavorable to budget $4.4 million driven by:

- **Professional Claims** expense is unfavorable to budget $7.8 million, due to:
  - ➢ $6.1 million of accrued expenses for Ground Emergency Medical Transportation (GEMT)
- **MLTSS** expense is unfavorable to budget $6.0 million due to LTC rate adjustment
- **Provider Capitation** expense is favorable to budget $5.5 million due:
  - ➢ $12.0 million of WCM expense due to delay of program start
  - ➢ Offset by $6.7 million of Proposition 56 expense
- **Prescription Drug** expense is favorable to budget $5.4 million due to delay of WCM program start

ADMINISTRATIVE EXPENSES of $8.7 million are favorable to budget $2.2 million driven by:

- Salaries & Benefit expenses are favorable to budget $1.4 million due to open positions
- Other Non-Salary expenses are favorable to budget $0.9 million

CHANGE IN NET ASSETS is $68.9 million for the month, favorable to budget $69.6 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,057	**14,860**	**(803)**	**(5.4%)**	**Member Months**	**158,652**	**163,606**	**(4,954)**	**(3.0%)**
				Revenues				
2,425,999	3,133,467	(707,468)	(22.6%)	Medi-Cal Capitation revenue	28,872,058	35,769,171	(6,897,113)	(19.3%)
15,859,138	18,526,655	(2,667,517)	(14.4%)	Medicare Capitation revenue part C	188,797,744	194,008,635	(5,210,891)	(2.7%)
5,089,609	4,843,603	246,006	5.1%	Medicare Capitation revenue part D	57,246,417	52,371,866	4,874,551	9.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
23,374,745	**26,503,725**	**(3,128,980)**	**(11.8%)**	**Total Operating Revenue**	**274,916,219**	**282,149,672**	**(7,233,453)**	**(2.6%)**
				Medical Expenses				
14,909,602	12,320,738	(2,588,864)	(21.0%)	Provider capitation	137,179,400	130,024,654	(7,154,746)	(5.5%)
4,139,449	3,799,136	(340,313)	(9.0%)	Facilities	41,074,252	40,164,941	(909,311)	(2.3%)
739,666	724,600	(15,066)	(2.1%)	Ancillary	7,361,551	7,412,970	51,419	0.7%
1,485,157	1,563,275	78,118	5.0%	Long Term Care	15,166,566	17,829,329	2,662,763	14.9%
5,446,512	5,460,665	14,153	0.3%	Prescription drugs	58,789,435	58,267,713	(521,722)	(0.9%)
1,231,587	1,352,987	121,400	9.0%	Medical management	12,439,636	14,374,417	1,934,781	13.5%
83,204	141,889	58,685	41.4%	Other medical expenses	2,075,788	1,577,493	(498,295)	(31.6%)
28,035,177	**25,363,290**	**(2,671,887)**	**(10.5%)**	**Total Medical Expenses**	**274,086,628**	**269,651,517**	**(4,435,111)**	**(1.6%)**
(4,660,432)	**1,140,435**	**(5,800,867)**	**(508.7%)**	**Gross Margin**	**829,592**	**12,498,155**	**(11,668,563)**	**(93.4%)**
				Administrative Expenses				
815,044	910,054	95,010	10.4%	Salaries, wages & employee benefits	8,289,696	9,660,720	1,371,024	14.2%
4,166	42,917	38,751	90.3%	Professional fees	238,306	472,083	233,777	49.5%
(69,083)	251,415	320,498	127.5%	Purchased services	1,772,995	2,765,566	992,571	35.9%
43,235	86,202	42,967	49.8%	Printing and postage	666,669	948,218	281,550	29.7%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
44,426	77,036	32,611	42.3%	Other operating expenses	505,225	847,401	342,176	40.4%
586,645	557,394	(29,251)	(5.2%)	Indirect cost allocation	6,553,403	6,131,334	(422,069)	(6.9%)
1,424,432	**1,925,018**	**500,586**	**26.0%**	**Total Administrative Expenses**	**18,026,294**	**20,825,323**	**2,799,029**	**13.4%**
(6,084,864)	**(784,583)**	**(5,300,281)**	**(675.6%)**	**Change in Net Assets**	**(17,196,703)**	**(8,327,168)**	**(8,869,535)**	**(106.5%)**
119.9%	***95.7%***	***(24.2%)***	***(25.3%)***	***Medical Loss Ratio***	***99.7%***	***95.6%***	***(4.1%)***	***(4.3%)***
6.1%	***7.3%***	***1.2%***	***16.1%***	***Admin Loss Ratio***	***6.6%***	***7.4%***	***0.8%***	***11.2%***

Back to Agenda

ONECARE CONNECT INCOME STATEMENT - MAY MONTH:

REVENUES of $23.4 million are unfavorable to budget $3.1 million driven by:

- Unfavorable volume related variance of $1.4 million
- Unfavorable price related variance of $1.7 million due to
  - ➢ $5.7 million of CY 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) recoupment and unfavorable rates
  - ➢ Offset by CY 2019 Hierarchical Condition Category (HCC) and risk adjustments

MEDICAL EXPENSES of $28.0 million are unfavorable to budget $2.7 million driven by:

- Favorable volume related variance of $1.4 million
- Unfavorable price related variance of $4.0 million due to CY 2019 HCC capitation expense

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.5 million

C**HANGE IN NET ASSETS** is ($6.1) million, unfavorable to budget $5.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,535	**1,324**	**211**	**15.9%**	**Member Months**	**15,837**	**14,564**	**1,273**	**8.7%**
				Revenues				
1,343,219	1,125,533	217,685	19.3%	Medicare Part C revenue	12,961,428	12,259,221	702,206	5.7%
602,156	511,369	90,787	17.8%	Medicare Part D revenue	5,978,905	5,483,045	495,860	9.0%
1,945,375	**1,636,902**	**308,473**	**18.8%**	**Total Operating Revenue**	**18,940,332**	**17,742,267**	**1,198,066**	**6.8%**
				Medical Expenses				
562,082	446,663	(115,418)	(25.8%)	Provider capitation	5,320,921	4,953,627	(367,294)	(7.4%)
464,953	552,353	87,400	15.8%	Inpatient	5,299,475	5,755,448	455,973	7.9%
88,524	61,928	(26,597)	(42.9%)	Ancillary	495,152	629,313	134,162	21.3%
64,855	26,857	(37,997)	(141.5%)	Skilled nursing facilities	550,714	290,233	(260,482)	(89.7%)
562,572	454,747	(107,826)	(23.7%)	Prescription drugs	5,259,370	4,852,561	(406,809)	(8.4%)
82,517	34,551	(47,965)	(138.8%)	Medical management	699,518	375,765	(323,753)	(86.2%)
-	9,773	9,773	100.0%	Other medical expenses	37,298	88,224	50,927	57.7%
1,825,503	**1,586,872**	**(238,631)**	**(15.0%)**	**Total Medical Expenses**	**17,662,448**	**16,945,172**	**(717,275)**	**(4.2%)**
119,872	**50,030**	**69,842**	**139.6%**	**Gross Margin**	**1,277,885**	**797,094**	**480,791**	**60.3%**
				Administrative Expenses				
29,515	41,676	12,161	29.2%	Salaries, wages & employee benefits	355,469	440,915	85,445	19.4%
14,667	19,600	4,934	25.2%	Professional fees	161,334	215,600	54,266	25.2%
769	17,425	16,656	95.6%	Purchased services	158,602	191,675	33,073	17.3%
4,777	13,206	8,429	63.8%	Printing and postage	88,889	145,265	56,376	38.8%
(51)	6,883	6,934	100.7%	Other operating expenses	1,083	75,717	74,634	98.6%
43,167	34,965	(8,202)	(23.5%)	Indirect cost allocation, occupancy expense	435,413	384,615	(50,798)	(13.2%)
92,844	**133,755**	**40,911**	**30.6%**	**Total Administrative Expenses**	**1,200,790**	**1,453,787**	**252,996**	**17.4%**
27,028	**(83,725)**	**110,753**	**132.3%**	**Change in Net Assets**	**77,095**	**(656,692)**	**733,787**	**111.7%**
93.8%	***96.9%***	***3.1%***	***3.2%***	***Medical Loss Ratio***	***93.3%***	***95.5%***	***2.3%***	***2.4%***
4.8%	***8.2%***	***3.4%***	***41.6%***	***Admin Loss Ratio***	***6.3%***	***8.2%***	***1.9%***	***22.6%***

Back to Agenda

CalOptima
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
326	**343**	**(17)**	**(5.0%)**	**Member Months**	**3,311**	**3,357**	**(46)**	**-1.4%**
				Revenues				
2,003,130	1,921,305	81,825	4 3%	Medi-Cal capitation revenue	18,681,764	18,793,045	(111,281)	(0 6%)
604,948	466,788	138,160	29 6%	Medicare Part C revenue	4,938,326	4,500,757	437,569	9 7%
129,550	110,871	18,679	16 8%	Medicare Part D revenue	1,326,671	1,082,662	244,009	22 5%
2,737,629	**2,498,964**	**238,665**	**9.6%**	**Total Operating Revenue**	**24,946,761**	**24,376,464**	**570,297**	**2.3%**
				Medical Expenses				
726,628	827,992	101,364	12 2%	Medical Management	6,985,837	8,179,409	1,193,572	14 6%
897,190	538,900	(358,290)	(66 5%)	Claims payments to hospitals	5,111,886	5,124,028	12,142	0 2%
565,438	557,104	(8,334)	(1 5%)	Professional claims	5,184,192	5,405,534	221,342	4 1%
166,404	152,906	(13,498)	(8 8%)	Patient transportation	1,743,295	1,496,517	(246,778)	(16 5%)
205,913	203,120	(2,793)	(1 4%)	Prescription drugs	2,001,375	1,957,711	(43,664)	(2 2%)
40,820	35,219	(5,601)	(15 9%)	MLTSS	169,164	210,102	40,938	19 5%
3,260	3,200	(60)	(1 9%)	Other Expenses	33,110	32,450	(660)	(2 0%)
2,605,653	**2,318,441**	**(287,212)**	**(12.4%)**	**Total Medical Expenses**	**21,228,859**	**22,405,751**	**1,176,892**	**5.3%**
131,976	**180,523**	**(48,547)**	**-26.9%**	**Gross Margin**	**3,717,901**	**1,970,713**	**1,747,188**	**88.7%**
				Administrative Expenses				
146,017	145,210	(807)	(0 6%)	Salaries, wages & employee benefits	1,154,188	1,474,277	320,089	21 7%
123	167	43	26 0%	Professional fees	6,861	1,833	(5,028)	(274 2%)
45,623	21,027	(24,596)	(117 0%)	Purchased services	152,992	231,293	78,302	33 9%
1,227	10,428	9,201	88 2%	Printing and postage	73,823	114,712	40,889	35 6%
2,076	2,091	15	0 7%	Depreciation & amortization	22,883	22,997	114	0 5%
39,282	3,859	(35,424)	(918 0%)	Other operating expenses	70,302	42,445	(27,857)	(65 6%)
3,797	3,466	(331)	(9 6%)	Indirect cost allocation, Occupancy Expense	59,441	38,122	(21,319)	(55 9%)
238,146	**186,247**	**(51,899)**	**(27.9%)**	**Total Administrative Expenses**	**1,540,490**	**1,925,680**	**385,190**	**20.0%**
				Operating Tax				
4,838	-	4,838	0 0%	Tax Revenue	47,615	-	47,615	0 0%
4,838	-	(4,838)	0 0%	Premium tax expense	47,615	-	(47,615)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
(106,170)	**(5,724)**	**(100,446)**	**(1754.9%)**	**Change in Net Assets**	**2,177,411**	**45,033**	**2,132,378**	**4735.2%**
95.2%	***92.8%***	***(2.4%)***	***(2.6%)***	***Medical Loss Ratio***	***85.1%***	***91.9%***	***6.8%***	***7.4%***
8.7%	***7.5%***	***(1.2%)***	***(16.7%)***	***Admin Loss Ratio***	***6.2%***	***7.9%***	***1.7%***	***21.8%***

Back to Agenda

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
34,773	22,981	(11,792)	(51.3%)	Purchase services	366,690	252,798	(113,892)	(45.1%)
163,558	162,935	(623)	(0.4%)	Depreciation & amortization	1,794,733	1,792,280	(2,453)	(0.1%)
17,476	15,917	(1,559)	(9.8%)	Insurance expense	177,295	175,084	(2,211)	(1.3%)
106,898	173,136	66,238	38.3%	Repair and maintenance	1,090,259	1,904,496	814,237	42.8%
30,520	1,635	(28,885)	(1766.7%)	Other Operating Expense	448,266	17,985	(430,281)	(2392.4%)
(353,227)	(376,604)	(23,377)	(6.2%)	Indirect allocation, Occupancy	(3,877,244)	(4,142,643)	(265,399)	(6.4%)
(0)	**-**	**0**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
0	**-**	**0**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

Back to Agenda

OTHER INCOME STATEMENTS - MAY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $27.0 thousand, $110.8 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is ($106.2) thousand, $100.4 thousand unfavorable to budget

CalOptima
Balance Sheet
May 31, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$466,563,150	Accounts Payable	$28,054,462
Investments	462,428,939	Medical Claims liability	709,302,385
Capitation receivable	311,526,261	Accrued Payroll Liabilities	11,154,777
Receivables - Other	25,639,703	Deferred Revenue	87,775,768
Prepaid expenses	5,803,188	Deferred Lease Obligations	50,870
		Capitation and Withholds	112,122,304
Total Current Assets	**1,271,961,240**	**Total Current Liabilities**	**948,460,567**
Capital Assets			
Furniture & Equipment	37,167,625		
Building/Leasehold Improvements	5,475,375		
505 City Parkway West	50,411,374		
	93,054,375		
Less: accumulated depreciation	(45,849,778)		
Capital assets, net	47,204,597	Other (than pensions) post employment benefits liability	25,920,862
Other Assets		Net Pension Liabilities	23,602,064
Restricted Deposit & Other	300,000	Bldg. 505 Development Rights	-
Homeless Health Reserve	60,000,000		
Board-designated assets:		**TOTAL LIABILITIES**	**997,983,493**
Cash and Cash Equivalents	6,936,986		
Long-term Investments	550,511,596		
Total Board-designated Assets	557,448,582	Deferred Inflows	
		Change in Assumptions	4,747,505
Total Other Assets	617,748,582	Excess Earnings	156,330
TOTAL ASSETS	**1,936,914,419**		
Deferred Outflows		Net Position	
		TNE	84,969,966
Pension Contributions	686,962	Funds in Excess of TNE	859,591,574
Difference in Experience	3,419,328	**TOTAL NET POSITION**	944,561,540
Excess Earning	-		
Changes in Assumptions	6,428,159		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,947,448,868**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,947,448,868**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of May 31, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	152,706,361				
	Tier 1 - Logan Circle	151,849,431				
	Tier 1 - Wells Capital	152,009,049				
Board-designated Reserve		456,564,841	330,027,466	507,883,509	126,537,375	(51,318,668)
TNE Requirement	Tier 2 - Logan Circle	100,883,741	84,969,966	84,969,966	15,913,775	15,913,775
	Consolidated:	**557,448,582**	**414,997,433**	**592,853,475**	**142,451,149**	**(35,404,893)**
	Current reserve level	*1.88*	*1.40*	*2.00*		

Back to Agenda

CalOptima
Statement of Cash Flows
May 31, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	68,110,722	180,063,064
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	621,638	6,641,212
Changes in assets and liabilities:		
Prepaid expenses and other	772,939	494,158
Catastrophic reserves		
Capitation receivable	54,694,069	(16,014,948)
Medical claims liability	4,135,570	(123,317,227)
Deferred revenue	35,341,886	(25,927,181)
Payable to providers	(28,913,112)	15,673,413
Accounts payable	9,255,089	20,552,147
Other accrued liabilities	117,069	(312,840)
Net cash provided by/(used in) operating activities	144,135,869	57,851,797
GASB 68 CalPERS Adjustments	-	2,173,056
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	2,866,910	2,866,910
Net cash provided by/(used in) capital and related financing activities	2,866,910	2,866,910
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	40,375,561	117,870,009
Change in Property and Equipment	(129,751)	(3,087,559)
Change in Board designated reserves	(3,367,327)	(19,200,909)
Change in Homeless Health reserve	-	(60,000,000)
Net cash provided by/(used in) investing activities	36,878,483	35,581,541
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	183,881,262	98,473,304
CASH AND CASH EQUIVALENTS, beginning of period	282,681,887	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**466,563,150**	**466,563,150**

Back to Agenda

BALANCE SHEET - MAY MONTH:

ASSETS of $1.9 billion increased $90.9 million from April or 4.9%

- **Operating Cash** increased $183.9 million primarily due to Quality Assurance Fee (QAF) payment in April
- **Capitation Receivables** decreased $54.6 million or 14.9% due to receipts and timing of Department of Healthcare Services (DHCS) capitation payments

LIABILITIES increased $19.6 million from April or 2.0%

- **Deferred Revenue** increased $35.3 million due to timing of capitation payment from CMS
- **Accounts Payable** increased $10.9 million due to quarterly Managed Care Organization (MCO) tax payment
- **Capitation and Withholds** decreased $28.9 million due to timing of capitation payments

NET ASSETS total $944.6 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2019

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	**0**	**0**	**0.0%**	**Total Operating Revenue**	**0**	**0**	**0**	**0.0%**
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	68,026	68,026	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	32,833	32,833	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
0	229,840	229,840	100.0%	Other	12,000	2,528,237	2,516,237	99.5%
0	**239,009**	**239,009**	**100%**	**Total Operating Expenditures**	**12,000**	**2,629,096**	**2,617,096**	**99.5%**
4,577	**0**	**4,577**	**0.0%**	**Investment Income**	**35,771**	**0**	**35,771**	**0.0%**
4,577	**(239,009)**	**243,585**	**101.9%**	**Program Income**	**23,771**	**(2,629,096)**	**2,652,867**	**100.9%**

Back to Agenda

CalOptima Foundation
Balance Sheet
May 31, 2019

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	$0	Accounts payable-Current	$0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**0**	Grants-Foundation	0
		Total Current Liabilities	**0**
		Total Liabilities	**0**
		Net Assets	**0**
TOTAL ASSETS	**$0**	**TOTAL LIABILITIES & NET ASSETS**	**$0**

Back to Agenda

CALOPTIMA FOUNDATION FINANCIAL STATEMENTS – MAY MONTH AND YTD:

OVERVIEW - CalOptima Foundation was formed as a not-for-profit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. The activities of the Foundation are presented in the financial statements.
CalOptima Foundation last date of operations is May 31, 2019

INCOME STATEMENT

REVENUES - no activity for the month of May or YTD FY 2019

OPERATING EXPENSES

- May - $0 for the month, favorable to budget $239.0 thousand
- YTD - $12.0 thousand for the year, favorable to the budget $2.6 million

INVESTMENT INCOME

- May - $4.6 thousand for the month
- YTD - $35.8 thousand for the year

CHANGE IN NET INCOME

- May - $4.6 thousand for the month, favorable to budget $243.6 thousand
- YTD - $23.8 thousand, favorable to budget $2.7 million

BALANCE SHEET

ASSETS

- Cash - $2.9 that remained from the FY 2014 $3.0 million grant was transferred back to CalOptima due to the dissolution of Foundation, leaving $0.0 in Assets

LIABILITIES

- $0.0 in Liabilities

Homeless Health Initiatives and Allocated Funds
As of May 31, 2019

		Amount
Program Commitment		**$100,000,000**
Funds Allocation, approved initiatives:		
Be Well OC	11,400,000	
Recuperative Care	11,000,000	
Clinical Field Team Start-up & FQHC's	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
Funds Allocation Total		40,000,000
Program Commitment Balance, available for new initiatives		**$60,000,000**

Back to Agenda

Budget Allocation Changes
Reporting Changes for May 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
November	Medi-Cal	Facilities - Capital Project (8th Floor HR Remodel)	Facilities - Capital Project (Replace Master Control Center)	$22,500	Reallocate $22,500 from Capital Project (8th Floor hr. Remodel) to Capital Project (Replace Master Control Center)	2019
December	Medi-Cal	Facilities - Office Supplies	Facilities - Computer Supply/Minor Equipment	$60,000	Reallocate $60,000 from Office Supplies to Computer Supplies/Minor Equipment to furniture needs of the staff	2019
December	Medi-Cal	Strategic Development - Professional Fees (Covered CA Consulting)	Strategic Development - Professional Fees (Strategic Planning Consulting)	$50,000	Repurpose $50,000 from Professional Fees (Covered CA Consulting) to Professional Fees (Strategic Planning Consulting)	2019
January	Medi-Cal	IS Application Development - Training & Seminars	IS Application Development - Maintenance HW/SW	$11,000	Reallocate $11,000 from training & seminars to maintenance HW/SW to pay for additional Tableau licenses	2019
February	No Reported Changes					
March	No Reported Changes					
April	No Reported Changes					
May	No Reported Changes					

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Financial Summary

Unaudited

June 2019

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2018-19: Consolidated Enrollment

June 2019 MTD

Overall enrollment was 759,923 members

- Actual lower than budget 22,689 members or 2.9%
  - Medi-Cal unfavorable variance of 22,135 members
    - Whole Child Model (WCM) unfavorable variance of 12,502 members
      - WCM members will remain in their original aid codes until the program begins 7/1/19
    - Medi-Cal Expansion (MCE) unfavorable variance of 9,534 members
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 2,509 members
    - Long-Term Care (LTC) unfavorable variance of 167 members
    - Seniors and Persons with Disabilities (SPD) favorable variance of 2,577 members
  - OneCare Connect unfavorable variance of 743 members
- 498 decrease from May
    - Medi-Cal decrease of 567 members
    - OneCare Connect increase of 66 members
    - OneCare increase of 2 members
    - PACE increase of 1 member

Back to Agenda

FY 2018-19: Consolidated Enrollment (cont.)

June 2019 YTD

Overall enrollment was 9,210,699 member months

- Actual lower than budget 195,677 members or 2.1%
  - Medi-Cal unfavorable variance of 191,396 members or 2.1%
    - WCM unfavorable variance of 75,012 members
      - WCM members will remain in their original aid codes until the program begins 7/1/19
    - MCE unfavorable variance of 72,417 members
    - TANF unfavorable variance of 52,727 members
    - LTC unfavorable variance of 1,274 members
    - SPD favorable variance of 10,034 members
  - OneCare Connect unfavorable variance of 5,697 members or 3.2%
  - OneCare favorable variance of 1,486 members or 9.4%
  - PACE unfavorable variance of 70 members or 1.9%

FY 2018-19: Consolidated Revenues

June 2019 MTD

- Actual lower than budget $43.6 million or 14.5%
  - ➢ Medi-Cal unfavorable to budget $34.7 million or 12.8%
    - o Unfavorable volume variance of $7.8 million
    - o Unfavorable price variance of $26.9 million
      - $22.9 million of WCM revenue due to delay of program start
      - $11.5 million of prior year (PY) revenue
      - Offset by $4.7 million due to Proposition 56 revenue
      - $3.5 million of Coordinated Care Initiative (CCI) revenue
  - ➢ OneCare Connect unfavorable to budget $8.9 million or 33.8%
    - o Unfavorable volume variance of $1.3 million
    - o Unfavorable price variance of $7.6 million
      - $6.9 million of PY revenue
      - $5.7 million of calendar year (CY) 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) records adjustment
      - Offset by $6.6 million of PY 2017 Quality Withhold payback

FY 2018-19: Consolidated Revenues (cont.)

June 2019 MTD

- OneCare favorable to budget $57.6 thousand or 3.6%
  - Favorable volume variance of $259.9 thousand
  - Unfavorable price variance of $202.3 thousand
- PACE unfavorable to budget $91.8 thousand or 3.6%
  - Unfavorable volume variance of $174.8 thousand
  - Favorable price variance of $82.9 thousand

Back to Agenda

FY 2018-19: Consolidated Revenues (cont.)

June 2019 YTD

- Actual higher than budget $14.1 million or 0.4%
  - ➢ Medi-Cal favorable to budget $28.5 million or 0.9%
    - o Unfavorable volume variance of $64.6 million
    - o Favorable price variance of $93.1 million due to:
      - $59.0 million of CCI revenue
      - $56.9 million of Proposition 56 revenue
      - $47.0 million of PY revenue
      - $42.8 million Intergovernmental Transfer (IGT) 8 revenue
      - $24.0 million due to favorable rates
      - Offset by unfavorable variance of $137.4 million due to WCM revenue

FY 2018-19: Consolidated Revenues (cont.)

June 2019 YTD

- OneCare Connect unfavorable to budget $16.2 million or 5.2%
  - Unfavorable volume variance of $9.9 million
  - Unfavorable price variance of $6.3 million
- OneCare favorable to budget $1.3 million or 6.5%
  - Favorable volume variance of $1.8 million
  - Unfavorable price variance of $0.6 million
- PACE favorable to budget $0.5 million or 1.8%
  - Unfavorable volume variance of $0.5 million
  - Favorable price variance of $1.0 million

Back to Agenda

FY 2018-19: Consolidated Medical Expenses

June 2019 MTD

- Actual lower than budget $26.6 million or 9.4%
  - ➢ Medi-Cal favorable variance of $20.3 million or 8.0%
    - o Favorable volume variance of $7.4 million
    - o Favorable price variance of $12.9 million
      - Professional Claims expenses favorable variance of $10.7 million
      - Provider Capitation expenses favorable variance of $5.3 million
      - Prescription Drug expenses favorable variance of $4.3 million mainly due to delay of WCM program
      - Reinsurance and Other unfavorable variance of $3.8 million
      - Facilities expenses unfavorable variance of $3.0 million

FY 2018-19: Consolidated Medical Expenses (cont.)

June 2019 MTD

- OneCare Connect favorable variance of $5.1 million or 20.4%
  - Favorable volume variance of $1.2 million
  - Favorable price variance of $3.8 million
- OneCare favorable variance of $0.9 million or 60.7%
  - Unfavorable volume variance of $0.2 million
  - Favorable price variance of $1.2 million
- PACE favorable variance of $256.7 thousand or 11.0%
  - Favorable volume variance of $159.0 thousand
  - Favorable price variance of $97.7 thousand

Back to Agenda

FY 2018-19: Consolidated Medical Expenses (cont.)

June 2019 YTD

- Actual lower than budget $72.8 million or 2.2%
  - ➢ Medi-Cal favorable variance of $70.5 million
    - o Favorable volume variance of $61.4 million
    - o Favorable price variance of $9.2 million
      - Professional Claims expenses favorable variance of $44.6 million
      - Prescription Drug expenses favorable variance of $42.9 million
      - Facilities expenses unfavorable variance of $40.4 million
      - Provider Capitation expenses unfavorable variance of $36.6 million
  - ➢ OneCare Connect favorable variance of $0.7 million
    - o Favorable volume variance of $9.4 million
    - o Unfavorable price variance of $8.7 million

Medical Loss Ratio (MLR)

- June 2019 MTD: Actual: 100.3% Budget: 94.6%
- June 2019 YTD: Actual: 92.6% Budget: 95.1%

Back to Agenda

FY 2018-19: Consolidated Administrative Expenses

June 2019 MTD

- Actual lower than budget $0.2 million or 1.5%
  - Salaries, wages and benefits: favorable variance of $1.7 million
  - Other categories: unfavorable variance of $1.5 million

June 2019 YTD

- Actual lower than budget $23.1 million or 15.1%
  - Salaries, wages and benefits: favorable variance of $13.4 million
  - Other categories: favorable variance of $9.7 million

Administrative Loss Ratio (ALR)

- June 2019 MTD: Actual: 4.9% Budget: 4.2%
- June 2019 YTD: Actual: 3.7% Budget: 4.4%

Back to Agenda

FY 2018-19: Change in Net Assets

June 2019 MTD

- ($8.4) million change in net assets
- $12.4 million unfavorable to budget
  - Lower than budgeted revenue of $43.6 million
  - Lower than budgeted medical expenses of $26.6 million
  - Lower than budgeted administrative expenses of $0.2 million
  - Higher than budgeted investment and other income of $4.5 million

June 2019 YTD

- $171.6 million change in net assets
- $148.6 million favorable to budget
  - Higher than budgeted revenue of $14.1 million
  - Lower than budgeted medical expenses of $72.8 million
  - Lower than budgeted administrative expenses of $23.1 million
  - Higher than budgeted investment and other income of $38.6 million

Back to Agenda

Enrollment Summary: June 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
65,454	66,234	(780)	(1.2%)	Aged	773,072	780,018	(6,946)	(0.9%)
579	620	(41)	(6.6%)	BCCTP	7,183	7,440	(257)	(3.5%)
47,558	44,161	3,397	7.7%	Disabled	564,815	547,578	17,237	3.1%
302,498	302,269	229	0.1%	TANF Child	3,684,884	3,713,871	(28,987)	(0.8%)
89,149	91,887	(2,738)	(3.0%)	TANF Adult	1,102,532	1,126,272	(23,740)	(2.1%)
3,402	3,569	(167)	(4.7%)	LTC	40,828	42,102	(1,274)	(3.0%)
235,296	244,830	(9,534)	(3.9%)	MCE	2,843,598	2,916,015	(72,417)	(2.5%)
-	12,502	(12,502)	(100.0%)	WCM*	-	75,012	(75,012)	(100.0%)
743,936	**766,071**	**(22,135)**	**(2.9%)**	**Medi-Cal**	**9,016,912**	**9,208,308**	**(191,396)**	**(2.1%)**
14,123	**14,866**	**(743)**	**(5.0%)**	**OneCare Connect**	**172,775**	**178,472**	**(5,697)**	**(3.2%)**
1,537	**1,324**	**213**	**16.1%**	**OneCare**	**17,374**	**15,888**	**1,486**	**9.4%**
327	**351**	**(24)**	**(6.8%)**	**PACE**	**3,638**	**3,708**	**(70)**	**(1.9%)**
759,923	**782,612**	**(22,689)**	**(2.9%)**	**CalOptima Total**	**9,210,699**	**9,406,376**	**(195,677)**	**(2.1%)**

*Note: WCM members will remain in their original aid codes until the program begins 7/1/19

Back to Agenda

Financial Highlights: June 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
759,923	782,612	(22,689)	(2.9%)	Member Months	9,210,699	9,406,376	(195,677)	(2.1%)
256,671,533	300,295,343	(43,623,810)	(14.5%)	Revenues	3,474,634,378	3,460,562,644	14,071,734	0.4%
257,444,151	284,033,294	26,589,144	9.4%	Medical Expenses	3,216,699,526	3,289,519,514	72,819,987	2.2%
12,549,309	12,742,712	193,404	1.5%	Administrative Expenses	129,949,196	153,036,387	23,087,191	15.1%
(13,321,926)	**3,519,336**	**(16,841,263)**	**(478.5%)**	**Operating Margin**	**127,985,656**	**18,006,743**	**109,978,913**	**610.8%**
4,884,623	416,667	4,467,957	1072.3%	Non Operating Income (Loss)	43,640,104	5,000,000	38,640,104	772.8%
(8,437,303)	**3,936,003**	**(12,373,306)**	**(314.4%)**	**Change in Net Assets**	**171,625,760**	**23,006,744**	**148,619,017**	**646.0%**
100.3%	94.6%	(5.7%)		Medical Loss Ratio	92.6%	95.1%	2.5%	
4.9%	4.2%	(0.6%)		Administrative Loss Ratio	3.7%	4.4%	0.7%	
(5.2%)	1.2%	(6.4%)		Operating Margin Ratio	3.7%	0.5%	3.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

Consolidated Performance Actual vs. Budget: June 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(10.2)	3.9	(14.1)	Medi-Cal	146.1	27.3	118.7
(4.2)	(0.4)	(3.8)	OCC	(21.4)	(8.7)	(12.7)
0.9	(0.1)	1.0	OneCare	1.0	(0.7)	1.7
0.2	0.1	0.1	PACE	2.3	0.1	2.3
(13.3)	**3.5**	**(16.8)**	**Operating**	**128.0**	**18.0**	**110.0**
4.9	0.4	4.5	Inv./Rental Inc, MCO tax	43.6	5.0	38.6
4.9	**0.4**	**4.5**	**Non-Operating**	**43.6**	**5.0**	**38.6**
(8.4)	**3.9**	**(12.4)**	**TOTAL**	**171.6**	**23.0**	**148.6**

Back to Agenda

Consolidated Revenue & Expense: June 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,640	235,296	743,936	14,123	1,537	327	759,923
REVENUES							
Capitation Revenue	$ 129,025,657	$ 105,996,427	$ 235,022,084	$ 17,512,190	$ 1,673,272	$ 2,463,986	$ 256,671,533
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	129,025,657	105,996,427	235,022,084	17,512,190	1,673,272	2,463,986	256,671,533
MEDICAL EXPENSES							
Provider Capitation	39,013,188	52,941,056	91,954,244	7,359,958	453,170		99,767,372
Facilities	23,824,439	23,945,922	47,770,361	4,850,798	(379,810)	256,249	52,497,597
Ancillary	-	-	-	726,876	29,129	-	756,006
Professional Claims	13,298,762	4,317,782	17,616,543	-	-	590,751	18,207,294
Prescription Drugs	17,940,150	20,242,333	38,182,483	5,263,138	483,418	220,519	44,149,558
MLTSS	32,172,633	2,634,653	34,807,286	1,537,284	8,795	51,427	36,404,793
Medical Management	3,664,510	1,171,722	4,836,232	1,113,348	15,552	822,013	6,787,146
Quality Incentives	(3,059,046)	(1,556,156)	(4,615,202)	(1,255,061)		(3,710)	(5,873,973)
Reinsurance & Other	2,019,470	2,332,772	4,352,241	264,492		131,624	4,748,358
Total Medical Expenses	128,874,105	106,030,083	234,904,188	19,860,834	610,255	2,068,874	257,444,151
Medical Loss Ratio	99.9%	100.0%	99.9%	113.4%	36.5%	84.0%	100.3%
GROSS MARGIN	**151,552**	**(33,656)**	**117,896**	**(2,348,644)**	**1,063,017**	**395,112**	**(772,618)**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,450,613	717,288	26,975	119,745	6,314,620
Professional fees			632,389	35,167	24,873	303	692,732
Purchased services			1,336,769	259,337	39,580	61,730	1,697,417
Printing & Postage			683,307	161,792	22,541	35,502	903,143
Depreciation & Amortization			418,926			2,092	421,018
Other expenses			1,975,851	170,838	(294)	(23,275)	2,123,121
Indirect cost allocation & Occupancy			(185,779)	493,059	61,300	28,679	397,258
Total Administrative Expenses			10,312,075	1,837,481	174,975	224,777	12,549,309
Admin Loss Ratio			4.4%	10.5%	10.5%	9.1%	4.9%
INCOME (LOSS) FROM OPERATIONS			(10,194,179)	(4,186,124)	888,042	170,336	(13,321,926)
INVESTMENT INCOME							4,884,574
OTHER INCOME			49				49
CHANGE IN NET ASSETS			**$ (10,194,130)**	**$ (4,186,124)**	**$ 888,042**	**$ 170,336**	**$ (8,437,303)**
BUDGETED CHANGE IN NET ASSETS			3,910,505	(375,363)	(68,394)	52,588	3,936,003
VARIANCE TO BUDGET - FAV (UNFAV)			$ (14,104,635)	$ (3,810,762)	$ 956,436	$ 117,747	$ (12,373,306)

Back to Agenda

CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: June 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	6,173,314	2,843,598	9,016,912	172,775	17,374	3,638	9,210,699
REVENUES							
Capitation Revenue	$ 1,743,278,470	$ 1,390,903,148	$ 3,134,181,617	$ 292,428,410	$ 20,613,605	$ 27,410,747	$ 3,474,634,378
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,743,278,470	1,390,903,148	3,134,181,617	292,428,410	20,613,605	27,410,747	3,474,634,378
MEDICAL EXPENSES							
Provider Capitation	455,697,333	630,340,812	1,086,038,145	141,354,378	5,774,092		1,233,166,615
Facilities	275,458,203	292,315,446	567,773,649	45,925,050	4,919,665	5,368,134	623,986,499
Ancillary	-	-	-	8,088,427	524,281	-	8,612,708
Professional Claims	209,561,209	83,962,682	293,523,892	-	-	5,774,943	299,298,835
Prescription Drugs	209,268,165	236,453,192	445,721,357	64,052,573	5,742,787	2,221,894	517,738,612
MLTSS	391,632,656	34,326,241	425,958,897	16,703,851	559,510	220,592	443,442,850
Medical Management	27,288,516	12,090,764	39,379,280	13,552,984	715,070	7,807,851	61,455,186
Quality Incentives	5,343,268	2,951,181	8,294,449	1,929,919		29,400	10,253,768
Reinsurance & Other	7,885,948	6,606,011	14,491,959	2,340,280	37,298	1,874,919	18,744,456
Total Medical Expenses	1,582,135,299	1,299,046,330	2,881,181,629	293,947,462	18,272,702	23,297,733	3,216,699,526
Medical Loss Ratio	90.8%	93.4%	91.9%	100.5%	88.6%	85.0%	92.6%
GROSS MARGIN	**161,143,170**	**91,856,818**	**252,999,988**	**(1,519,052)**	**2,340,902**	**4,113,013**	**257,934,852**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			73,345,063	9,006,984	382,445	1,273,933	84,008,424
Professional fees			2,700,775	273,473	186,207	7,164	3,167,619
Purchased services			9,735,234	2,032,332	198,182	214,722	12,180,470
Printing & Postage			4,163,448	828,461	111,430	109,325	5,212,665
Depreciation & Amortization			5,242,522			24,975	5,267,497
Other expenses			15,289,802	676,063	789	47,027	16,013,682
Indirect cost allocation & Occupancy			(3,532,455)	7,046,462	496,713	88,120	4,098,839
Total Administrative Expenses			106,944,388	19,863,775	1,375,766	1,765,267	129,949,196
Admin Loss Ratio			3.4%	6.8%	6.7%	6.4%	3.7%
INCOME (LOSS) FROM OPERATIONS			146,055,600	(21,382,827)	965,137	2,347,747	127,985,656
INVESTMENT INCOME							43,639,175
OTHER INCOME			928				928
CHANGE IN NET ASSETS			**$ 146,056,528**	**$(21,382,827)**	**$ 965,137**	**$ 2,347,747**	**$ 171,625,760**
BUDGETED CHANGE IN NET ASSETS			27,336,740	(8,702,531)	(725,086)	97,621	23,006,744
VARIANCE TO BUDGET - FAV (UNFAV)			$ 118,719,788	$ (12,680,296)	$ 1,690,223	$ 2,250,126	$ 148,619,017

Back to Agenda

CalOptima A Public Agency Better. Together.

Balance Sheet:
As of June 2019

CalOptima
Balance Sheet
June 30, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$347,627,784	Accounts Payable	$42,690,862
Investments	573,706,297	Medical Claims liability	744,669,961
Capitation receivable	302,964,503	Accrued Payroll Liabilities	11,007,473
Receivables - Other	48,977,264	Deferred Revenue	58,675,755
Prepaid expenses	5,782,878	Deferred Lease Obligations	44,512
		Capitation and Withholds	108,903,140
Total Current Assets	**1,279,058,726**	**Total Current Liabilities**	**965,991,703**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	5,559,034		
505 City Parkway West	50,464,989		
	93,110,388		
Less: accumulated depreciation	(46,485,498)		
Capital assets, net	46,624,889	Other (than pensions) post employment benefits liability	26,041,634
Other Assets		Net Pension Liabilities	23,602,064
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	60,000,000		
Board-designated assets:		**TOTAL LIABILITIES**	**1,015,635,400**
Cash and Cash Equivalents	12,711,832		
Long-term Investments	547,433,575	Deferred Inflows	
Total Board-designated Assets	560,145,408	Change in Assumptions	4,747,505
		Excess Earnings	156,330
Total Other Assets	620,445,408		
TOTAL ASSETS	**1,946,129,023**	Net Position	
		TNE	84,931,166
Deferred Outflows		Funds in Excess of TNE	851,193,072
		TOTAL NET POSITION	936,124,237
Pension Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,956,663,472**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,956,663,472**

Back to Agenda

CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of June 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	153,492,886				
	Tier 1 - Logan Circle	152,452,411				
	Tier 1 - Wells Capital	152,773,091				
Board-designated Reserve		458,718,387	311,302,029	481,116,256	147,416,358	(22,397,868)
TNE Requirement	Tier 2 - Logan Circle	101,427,020	84,931,166	84,931,166	16,495,854	16,495,854
	Consolidated:	**560,145,408**	**396,233,195**	**566,047,421**	**163,912,213**	**(5,902,014)**
	Current reserve level	*1.98*	*1.40*	*2.00*		

Back to Agenda

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

June 2019

Preliminary Report as of July 18, 2019
Subject to change following financial audit

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
759,923	782,612	(22,689)	(2.9%)	Member Months	9,210,699	9,406,376	(195,677)	(2.1%)
256,671,533	300,295,343	(43,623,810)	(14.5%)	Revenues	3,474,634,378	3,460,562,644	14,071,734	0.4%
257,444,151	284,033,294	26,589,144	9.4%	Medical Expenses	3,216,699,526	3,289,519,514	72,819,987	2.2%
12,549,309	12,742,712	193,404	1.5%	Administrative Expenses	129,949,196	153,036,387	23,087,191	15.1%
(13,321,926)	**3,519,336**	**(16,841,263)**	**(478.5%)**	**Operating Margin**	**127,985,656**	**18,006,743**	**109,978,913**	**610.8%**
4,884,623	416,667	4,467,957	1072.3%	Non Operating Income (Loss)	43,640,104	5,000,000	38,640,104	772.8%
(8,437,303)	**3,936,003**	**(12,373,306)**	**(314.4%)**	**Change in Net Assets**	**171,625,760**	**23,006,744**	**148,619,017**	**646.0%**
100.3%	94.6%	(5.7%)		Medical Loss Ratio	92.6%	95.1%	2.5%	
4.9%	4.2%	(0.6%)		Administrative Loss Ratio	3.7%	4.4%	0.7%	
(5.2%)	1.2%	(6.4%)		Operating Margin Ratio	3.7%	0.5%	3.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Twelve Months Ended June 30, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	743,936	766,071	(22,135)	(2 9%)
OneCare Connect	14,123	14,866	(743)	(5 0%)
OneCare	1,537	1,324	213	16 1%
PACE	327	351	(24)	(6 8%)
Total	759,923	782,612	(22,689)	(2 9%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (10,194)	$ 3,911	$ (14,105)	(360 6%)
OneCare Connect	(4,186)	(375)	(3,811)	(1016 3%)
OneCare	888	(68)	956	1405 9%
PACE	170	53	117	220 8%
505 Bldg	-	-	-	0 0%
Investment Income & Other	4,885	417	4,468	1071 5%
Total	$ (8,437)	$ 3,938	$ (12,375)	(314 2%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	99 9%	94 6%	(5 3)
OneCare Connect	113 4%	94 3%	(19 1)
OneCare	36 5%	96 1%	59 6

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,312	$ 10,561	$ 249	2 4%
OneCare Connect	1,837	1,873	36	1 9%
OneCare	175	131	(44)	(33 3%)
PACE	225	178	(47)	(26 6%)
Total	$ 12,549	$ 12,743	$ 193	1 5%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	913	1,126	213
OneCare Connect	201	234	33
OneCare	4	6	2
PACE	71	91	19
Total	1,189	1,457	268

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	815	680	134
OneCare Connect	70	64	7
OneCare	418	221	198
PACE	5	4	1
Total	1,308	968	339

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	9,016,912	9,208,308	(191,396)	(2 1%)
OneCare Connect	172,775	178,472	(5,697)	(3 2%)
OneCare	17,374	15,888	1,486	9 4%
PACE	3,638	3,708	(70)	(1 9%)
Total	9,210,699	9,406,376	(195,677)	(2 1%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 146,057	$ 27,337	$ 118,720	434 3%
OneCare Connect	(21,383)	(8,703)	(12,680)	(145 7%)
OneCare	965	(725)	1,690	233 1%
PACE	2,348	98	2,250	2295 9%
505 Bldg	-	-	-	0 0%
Investment Income & Other	43,640	5,000	38,640	772 8%
Total	$ 171,627	$ 23,007	$ 148,620	646 0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	91 9%	95 0%	3 1
OneCare Connect	100 5%	95 5%	(5 1)
OneCare	88 6%	95 6%	6 9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 106,944	$ 126,649	$ 19,705	15 6%
OneCare Connect	19,864	22,699	2,835	12 5%
OneCare	1,376	1,585	209	13 2%
PACE	1,765	2,103	338	16 1%
Total	$ 129,949	$ 153,036	$ 23,087	15 1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	11,533	12,956	1,424
OneCare Connect	2,632	2,809	176
OneCare	58	72	14
PACE	796	996	200
Total	15,018	16,833	1,815

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	782	711	71
OneCare Connect	66	64	2
OneCare	301	221	80
PACE	5	4	1
Total	1,153	999	154

Back to Agenda

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended June 30, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	759,923		782,612		(22,689)	
REVENUE						
Medi-Cal	$ 235,022,084	$ 315.92	$ 269,674,629	$ 352.02	$ (34,652,545)	$ (36.10)
OneCare Connect	17,512,190	1,239.98	26,449,267	1,779.06	(8,937,077)	(539.08)
OneCare	1,673,272	1,088.66	1,615,646	1,220.28	57,626	(131.62)
PACE	2,463,986	7,535.13	2,555,800	7,281.48	(91,814)	253.65
Total Operating Revenue	256,671,533	337.76	300,295,343	383.71	(43,623,810)	(45.95)
MEDICAL EXPENSES						
Medi-Cal	234,904,188	315.76	255,203,514	333.13	20,299,326	17.37
OneCare Connect	19,860,834	1,406.28	24,951,373	1,678.31	5,090,539	272.03
OneCare	610,255	397.04	1,552,805	1,172.81	942,550	775.77
PACE	2,068,874	6,326.83	2,325,602	6,625.65	256,728	298.82
Total Medical Expenses	257,444,151	338.78	284,033,294	362.93	26,589,144	24.15
GROSS MARGIN	(772,618)	(1.02)	16,262,048	20.78	(17,034,666)	(21.80)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	6,314,620	8.31	8,011,820	10.24	1,697,200	1.93
Professional fees	692,732	0.91	533,009	0.68	(159,723)	(0.23)
Purchased services	1,697,417	2.23	1,286,433	1.64	(410,984)	(0.59)
Printing & Postage	903,143	1.19	493,980	0.63	(409,163)	(0.56)
Depreciation & Amortization	421,018	0.55	464,166	0.59	43,147	0.04
Other expenses	2,123,121	2.79	1,581,071	2.02	(542,050)	(0.77)
Indirect cost allocation & Occupancy expense	397,258	0.52	372,235	0.48	(25,024)	(0.04)
Total Administrative Expenses	12,549,309	16.51	12,742,712	16.28	193,404	(0.23)
INCOME (LOSS) FROM OPERATIONS	(13,321,926)	(17.53)	3,519,336	4.50	(16,841,263)	(22.03)
INVESTMENT INCOME						
Interest income	3,155,214	4.15	416,667	0.53	2,738,548	3.62
Realized gain/(loss) on investments	441,620	0.58	-	-	441,620	0.58
Unrealized gain/(loss) on investments	1,287,740	1.69	-	-	1,287,740	1.69
Total Investment Income	4,884,574	6.43	416,667	0.53	4,467,907	5.90
OTHER INCOME	49	-	-	-	49	-
CHANGE IN NET ASSETS	**(8,437,303)**	**(11.10)**	**3,936,003**	**5.03**	**(12,373,306)**	**(16.13)**
MEDICAL LOSS RATIO	**100.3%**		**94.6%**		**-5.7%**	
ADMINISTRATIVE LOSS RATIO	**4.9%**		**4.2%**		**-0.6%**	

Back to Agenda

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	9,210,699		9,406,376		(195,677)	
REVENUE						
Medi-Cal	$ 3,134,181,617	$ 347.59	$ 3,105,673,528	$ 337.27	$ 28,508,089	$ 10.32
OneCare Connect	292,428,410	1,692.54	308,598,939	1,729.12	(16,170,529)	(36.58)
OneCare	20,613,605	1,186.46	19,357,913	1,218.40	1,255,692	(31.94)
PACE	27,410,747	7,534.56	26,932,264	7,263.29	478,483	271.27
Total Operating Revenue	3,474,634,378	377.24	3,460,562,644	367.90	14,071,734	9.34
MEDICAL EXPENSES						
Medi-Cal	2,881,181,629	319.53	2,951,687,293	320.55	70,505,664	1.02
OneCare Connect	293,947,462	1,701.33	294,602,890	1,650.70	655,428	(50.63)
OneCare	18,272,702	1,051.73	18,497,977	1,164.27	225,275	112.54
PACE	23,297,733	6,403.99	24,731,353	6,669.73	1,433,620	265.74
Total Medical Expenses	3,216,699,526	349.24	3,289,519,514	349.71	72,819,987	0.47
GROSS MARGIN	257,934,852	28.00	171,043,130	18.19	86,891,722	9.81
ADMINISTRATIVE EXPENSES						
Salaries and benefits	84,008,424	9.12	97,406,402	10.36	13,397,978	1.24
Professional fees	3,167,619	0.34	5,333,200	0.57	2,165,581	0.23
Purchased services	12,180,470	1.32	15,040,115	1.60	2,859,645	0.28
Printing & Postage	5,212,665	0.57	6,232,746	0.66	1,020,081	0.09
Depreciation & Amortization	5,267,497	0.57	5,569,994	0.59	302,497	0.02
Other expenses	16,013,682	1.74	18,987,128	2.02	2,973,446	0.28
Indirect cost allocation & Occupancy expense	4,098,839	0.45	4,466,802	0.47	367,963	0.02
Total Administrative Expenses	129,949,196	14.11	153,036,387	16.27	23,087,191	2.16
INCOME (LOSS) FROM OPERATIONS	127,985,656	13.90	18,006,743	1.91	109,978,913	11.99
INVESTMENT INCOME						
Interest income	34,507,924	3.75	5,000,000	0.53	29,507,923	3.22
Realized gain/(loss) on investments	(1,013,900)	(0.11)	-	-	(1,013,900)	(0.11)
Unrealized gain/(loss) on investments	10,145,152	1.10	-	-	10,145,152	1.10
Total Investment Income	43,639,175	4.74	5,000,000	0.53	38,639,175	4.21
OTHER INCOME	928	-	-	-	928	-
CHANGE IN NET ASSETS	**171,625,760**	**18.63**	**23,006,744**	**2.45**	**148,619,017**	**16.18**
MEDICAL LOSS RATIO	**92.6%**		**95.1%**		**2.5%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.4%**		**0.7%**	

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended June 30, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,640	235,296	743,936	14,123	1,537	327	759,923
REVENUES							
Capitation Revenue	$ 129,025,657	$ 105,996,427	$ 235,022,084	$ 17,512,190	$ 1,673,272	$ 2,463,986	$ 256,671,533
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	129,025,657	105,996,427	235,022,084	17,512,190	1,673,272	2,463,986	256,671,533
MEDICAL EXPENSES							
Provider Capitation	39,013,188	52,941,056	91,954,244	7,359,958	453,170		99,767,372
Facilities	23,824,439	23,945,922	47,770,361	4,850,798	(379,810)	256,249	52,497,597
Ancillary	-	-	-	726,876	29,129	-	756,006
Professional Claims	13,298,762	4,317,782	17,616,543	-	-	590,751	18,207,294
Prescription Drugs	17,940,150	20,242,333	38,182,483	5,263,138	483,418	220,519	44,149,558
MLTSS	32,172,633	2,634,653	34,807,286	1,537,284	8,795	51,427	36,404,793
Medical Management	3,664,510	1,171,722	4,836,232	1,113,348	15,552	822,013	6,787,146
Quality Incentives	(3,059,046)	(1,556,156)	(4,615,202)	(1,255,061)		(3,710)	(5,873,973)
Reinsurance & Other	2,019,470	2,332,772	4,352,241	264,492		131,624	4,748,358
Total Medical Expenses	128,874,105	106,030,083	234,904,188	19,860,834	610,255	2,068,874	257,444,151
Medical Loss Ratio	99 9%	100 0%	99 9%	113 4%	36 5%	84 0%	100 3%
GROSS MARGIN	**151,552**	**(33,656)**	**117,896**	**(2,348,644)**	**1,063,017**	**395,112**	**(772,618)**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,450,613	717,288	26,975	119,745	6,314,620
Professional fees			632,389	35,167	24,873	303	692,732
Purchased services			1,336,769	259,337	39,580	61,730	1,697,417
Printing & Postage			683,307	161,792	22,541	35,502	903,143
Depreciation & Amortization			418,926			2,092	421,018
Other expenses			1,975,851	170,838	(294)	(23,275)	2,123,121
Indirect cost allocation & Occupancy			(185,779)	493,059	61,300	28,679	397,258
Total Administrative Expenses			10,312,075	1,837,481	174,975	224,777	12,549,309
Admin Loss Ratio			4 4%	10 5%	10 5%	9 1%	4 9%
INCOME (LOSS) FROM OPERATIONS			(10,194,179)	(4,186,124)	888,042	170,336	(13,321,926)
INVESTMENT INCOME							4,884,574
OTHER INCOME			49				49
CHANGE IN NET ASSETS			**$ (10,194,130)**	**$ (4,186,124)**	**$ 888,042**	**$ 170,336**	**$ (8,437,303)**
BUDGETED CHANGE IN NET ASSETS			3,910,505	(375,363)	(68,394)	52,588	3,936,003
VARIANCE TO BUDGET - FAV (UNFAV)			$ (14,104,635)	$ (3,810,762)	$ 956,436	$ 117,747	$ (12,373,306)

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	6,173,314	2,843,598	9,016,912	172,775	17,374	3,638	9,210,699
REVENUES							
Capitation Revenue	$ 1,743,278,470	$ 1,390,903,148	$ 3,134,181,617	$ 292,428,410	$ 20,613,605	$ 27,410,747	$ 3,474,634,378
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,743,278,470	1,390,903,148	3,134,181,617	292,428,410	20,613,605	27,410,747	3,474,634,378
MEDICAL EXPENSES							
Provider Capitation	455,697,333	630,340,812	1,086,038,145	141,354,378	5,774,092		1,233,166,615
Facilities	275,458,203	292,315,446	567,773,649	45,925,050	4,919,665	5,368,134	623,986,499
Ancillary	-	-	-	8,088,427	524,281	-	8,612,708
Professional Claims	209,561,209	83,962,682	293,523,892	-	-	5,774,943	299,298,835
Prescription Drugs	209,268,165	236,453,192	445,721,357	64,052,573	5,742,787	2,221,894	517,738,612
MLTSS	391,632,656	34,326,241	425,958,897	16,703,851	559,510	220,592	443,442,850
Medical Management	27,288,516	12,090,764	39,379,280	13,552,984	715,070	7,807,851	61,455,186
Quality Incentives	5,343,268	2,951,181	8,294,449	1,929,919		29,400	10,253,768
Reinsurance & Other	7,885,948	6,606,011	14,491,959	2,340,280	37,298	1,874,919	18,744,456
Total Medical Expenses	1,582,135,299	1,299,046,330	2,881,181,629	293,947,462	18,272,702	23,297,733	3,216,699,526
Medical Loss Ratio	90 8%	93 4%	91 9%	100 5%	88 6%	85 0%	92 6%
GROSS MARGIN	**161,143,170**	**91,856,818**	**252,999,988**	**(1,519,052)**	**2,340,902**	**4,113,013**	**257,934,852**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			73,345,063	9,006,984	382,445	1,273,933	84,008,424
Professional fees			2,700,775	273,473	186,207	7,164	3,167,619
Purchased services			9,735,234	2,032,332	198,182	214,722	12,180,470
Printing & Postage			4,163,448	828,461	111,430	109,325	5,212,665
Depreciation & Amortization			5,242,522			24,975	5,267,497
Other expenses			15,289,802	676,063	789	47,027	16,013,682
Indirect cost allocation & Occupancy			(3,532,455)	7,046,462	496,713	88,120	4,098,839
Total Administrative Expenses			106,944,388	19,863,775	1,375,766	1,765,267	129,949,196
Admin Loss Ratio			3 4%	6 8%	6 7%	6 4%	3 7%
INCOME (LOSS) FROM OPERATIONS			146,055,600	(21,382,827)	965,137	2,347,747	127,985,656
INVESTMENT INCOME							43,639,175
OTHER INCOME			928				928
CHANGE IN NET ASSETS			**$ 146,056,528**	**$ (21,382,827)**	**$ 965,137**	**$ 2,347,747**	**$ 171,625,760**
BUDGETED CHANGE IN NET ASSETS			27,336,740	(8,702,531)	(725,086)	97,621	23,006,744
VARIANCE TO BUDGET - FAV (UNFAV)			$ 118,719,788	$ (12,680,296)	$ 1,690,223	$ 2,250,126	$ 148,619,017

Back to Agenda

June 30th, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is ($8.4) million, $12.4 million unfavorable to budget
- Operating deficit is $13.3 million, with a surplus in non-operating income of $4.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $171.6 million, $148.6 million favorable to budget
- Operating surplus is $128.0 million, with a surplus in non-operating income of $43.6 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(10.2)	3.9	(14.1)	Medi-Cal	146.1	27.3	118.7
(4.2)	(0.4)	(3.8)	OCC	(21.4)	(8.7)	(12.7)
0.9	(0.1)	1.0	OneCare	1.0	(0.7)	1.7
0.2	0.1	0.1	PACE	2.3	0.1	2.3
(13.3)	**3.5**	**(16.8)**	**Operating**	**128.0**	**18.0**	**110.0**
4.9	0.4	4.5	Inv./Rental Inc, MCO tax	43.6	5.0	38.6
4.9	**0.4**	**4.5**	**Non-Operating**	**43.6**	**5.0**	**38.6**
(8.4)	**3.9**	**(12.4)**	**TOTAL**	**171.6**	**23.0**	**148.6**

CalOptima - Consolidated
Enrollment Summary
For the Twelve Months Ended June 30, 2019

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
65,454	66,234	(780)	(1.2%)	Aged	773,072	780,018	(6,946)	(0.9%)
579	620	(41)	(6.6%)	BCCTP	7,183	7,440	(257)	(3.5%)
47,558	44,161	3,397	7.7%	Disabled	564,815	547,578	17,237	3.1%
302,498	302,269	229	0.1%	TANF Child	3,684,884	3,713,871	(28,987)	(0.8%)
89,149	91,887	(2,738)	(3.0%)	TANF Adult	1,102,532	1,126,272	(23,740)	(2.1%)
3,402	3,569	(167)	(4.7%)	LTC	40,828	42,102	(1,274)	(3.0%)
235,296	244,830	(9,534)	(3.9%)	MCE	2,843,598	2,916,015	(72,417)	(2.5%)
-	12,502	(12,502)	(100.0%)	WCM*	-	75,012	(75,012)	(100.0%)
743,936	**766,071**	**(22,135)**	**(2.9%)**	**Medi-Cal**	**9,016,912**	**9,208,308**	**(191,396)**	**(2.1%)**
14,123	**14,866**	**(743)**	**(5.0%)**	**OneCare Connect**	**172,775**	**178,472**	**(5,697)**	**(3.2%)**
1,537	**1,324**	**213**	**16.1%**	**OneCare**	**17,374**	**15,888**	**1,486**	**9.4%**
327	**351**	**(24)**	**(6.8%)**	**PACE**	**3,638**	**3,708**	**(70)**	**(1.9%)**
759,923	**782,612**	**(22,689)**	**(2.9%)**	**CalOptima Total**	**9,210,699**	**9,406,376**	**(195,677)**	**(2.1%)**

* Whole Child Model (WCM) was budgeted based on initial implementation date. Enrollment for WCM was transferred from the other seven aid categories.

				Enrollment (By Network)				
164,025	166,527	(2,502)	(1.5%)	HMO	1,990,881	2,010,276	(19,394)	(1.0%)
212,464	221,666	(9,202)	(4.2%)	PHC	2,586,437	2,664,214	(77,777)	(2.9%)
190,105	185,277	4,828	2.6%	Shared Risk Group	2,304,142	2,276,557	27,585	1.2%
177,342	192,601	(15,259)	(7.9%)	Fee for Service	2,135,452	2,257,262	(121,810)	(5.4%)
743,936	**766,071**	**(22,135)**	**(2.9%)**	**Medi-Cal**	**9,016,912**	**9,208,308**	**(191,396)**	**(2.1%)**
14,123	**14,866**	**(743)**	**(5.0%)**	**OneCare Connect**	**172,775**	**178,472**	**(5,697)**	**(3.2%)**
1,537	**1,324**	**213**	**16.1%**	**OneCare**	**17,374**	**15,888**	**1486**	**9.4%**
327	**351**	**(24)**	**(6.8%)**	**PACE**	**3,638**	**3,708**	**(70)**	**(1.9%)**
759,923	**782,612**	**(22,689)**	**(2.9%)**	**CalOptima Total**	**9,210,699**	**9,406,376**	**(195,677)**	**(2.1%)**

CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	MMs
HMO													
Aged	3,844	3,866	3,841	3,841	3,854	3,842	3,837	3,821	3,783	3,760	3,780	3,801	45,870
BCCTP	1	1	1	1	1	1	1	1	1	1	1	1	12
Disabled	6,744	6,789	6,789	6,811	6,838	6,813	6,807	6,824	6,835	6,832	6,874	6,849	81,805
TANF Child	58,435	58,267	58,162	58,110	57,723	56,929	56,504	56,327	56,636	55,937	56,028	55,901	684,959
TANF Adult	29,473	29,373	29,404	29,529	29,392	29,131	28,926	28,716	28,656	28,084	28,183	28,165	347,032
LTC	2	2	3	4	1	1	2	2	3	3	2	3	28
MCE	68,597	68,602	68,919	69,646	69,547	69,385	69,020	69,207	70,003	69,476	69,468	69,305	831,175
WCM	-	-	-	-	-	-	-	-	-	-	-	-	-
	167,096	**166,900**	**167,119**	**167,942**	**167,356**	**166,102**	**165,097**	**164,898**	**165,917**	**164,093**	**164,336**	**164,025**	**1,990,881**
PHC													
Aged	1,600	1,621	1,620	1,673	1,673	1,645	1,593	1,565	1,535	1,528	1,517	1,541	19,111
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,243	7,239	7,230	7,212	7,226	7,231	7,190	7,187	7,225	7,190	7,227	7,211	86,611
TANF Child	157,157	156,755	157,444	158,169	157,483	156,497	155,299	154,625	155,297	153,634	154,475	154,590	1,871,425
TANF Adult	12,731	12,684	12,787	12,785	12,596	12,476	12,049	11,890	11,851	11,536	11,385	11,279	146,049
LTC	-	1	-	-	-	1	1	-	-	-	1	1	5
MCE	39,060	38,992	39,234	39,568	39,402	39,204	37,896	38,002	38,255	37,975	37,806	37,842	463,236
WCM	-	-	-	-	-	-	-	-	-	-	-	-	-
	217,791	**217,292**	**218,315**	**219,407**	**218,380**	**217,054**	**214,028**	**213,269**	**214,163**	**211,863**	**212,411**	**212,464**	**2,586,437**
Shared Risk Group													
Aged	3,593	3,605	3,621	3,642	3,610	3,589	3,635	3,614	3,632	3,613	3,617	3,575	43,346
BCCTP	-	-	-	-	-	-	-	-	-	1	-	-	1
Disabled	7,626	7,554	7,486	7,473	7,493	7,463	7,409	7,419	7,426	7,484	7,501	7,547	89,881
TANF Child	67,471	67,226	67,159	67,251	66,739	66,119	65,717	65,144	65,328	64,401	65,088	65,284	792,927
TANF Adult	30,936	30,567	30,622	30,670	30,417	30,217	29,947	29,702	29,756	29,163	28,997	28,878	359,872
LTC	2	-	1	1	-	2	-	-	1	2	1	1	11
MCE	83,554	83,443	84,008	85,253	85,270	84,916	85,218	85,265	86,207	85,185	84,965	84,820	1,018,104
WCM	-	-	-	-	-	-	-	-	-	-	-	-	-
	193,182	**192,395**	**192,897**	**194,290**	**193,529**	**192,306**	**191,926**	**191,144**	**192,350**	**189,849**	**190,169**	**190,105**	**2,304,142**
Fee for Service (Dual)													
Aged	49,903	50,943	50,657	50,741	51,018	51,265	51,130	51,194	51,296	51,058	51,291	51,565	612,061
BCCTP	16	15	18	14	13	11	11	10	11	13	13	15	160
Disabled	20,706	20,863	20,741	20,761	20,812	20,921	20,739	20,879	20,732	20,584	20,776	20,867	249,381
TANF Child	2	3	2	2	1	2	2	2	2	2	2	10	32
TANF Adult	1,081	1,083	1,064	1,055	1,038	1,029	1,028	992	1,014	993	998	986	12,361
LTC	3,025	3,019	3,007	3,077	3,079	3,096	3,062	3,027	3,054	3,059	3,033	3,079	36,617
MCE	2,327	2,367	2,416	2,388	2,237	2,141	2,086	2,141	2,216	2,111	2,128	2,159	26,717
WCM	-	-	-	-	-	-	-	-	-	-	-	-	-
	77,060	**78,293**	**77,905**	**78,038**	**78,198**	**78,465**	**78,058**	**78,245**	**78,325**	**77,820**	**78,241**	**78,681**	**937,329**
Fee for Service (Non-Dual)													
Aged	4,702	3,727	4,153	4,118	4,018	4,128	4,311	4,347	4,568	4,756	4,884	4,972	52,684
BCCTP	613	596	601	581	589	574	584	579	579	573	578	563	7,010
Disabled	4,802	4,672	4,617	4,678	5,209	4,676	4,068	4,686	4,822	4,811	5,012	5,084	57,137
TANF Child	30,166	31,801	28,765	26,649	25,545	26,010	27,672	26,188	28,242	29,921	27,869	26,713	335,541
TANF Adult	20,308	20,588	20,198	19,628	19,315	19,401	19,614	19,442	19,761	19,518	19,604	19,841	237,218
LTC	353	360	367	347	356	340	351	350	333	337	355	318	4,167
MCE	44,399	44,410	43,161	40,810	40,393	41,103	42,153	42,065	42,283	41,375	41,044	41,170	504,366
WCM	-	-	-	-	-	-	-	-	-	-	-	-	-
	105,343	**106,154**	**101,862**	**96,811**	**95,425**	**96,232**	**98,753**	**97,657**	**100,588**	**101,291**	**99,346**	**98,661**	**1,198,123**
MEDI-CAL TOTAL													
Aged	63,642	63,762	63,892	64,015	64,173	64,469	64,506	64,541	64,814	64,715	65,089	65,454	773,072
BCCTP	630	612	620	596	603	586	596	590	591	588	592	579	7,183
Disabled	47,121	47,117	46,863	46,935	47,578	47,104	46,213	46,995	47,040	46,901	47,390	47,558	564,815
TANF Child	313,231	314,052	311,532	310,181	307,491	305,557	305,194	302,286	305,505	303,895	303,462	302,498	3,684,884
TANF Adult	94,529	94,295	94,075	93,667	92,758	92,254	91,564	90,742	91,038	89,294	89,167	89,149	1,102,532
LTC	3,382	3,382	3,378	3,429	3,436	3,440	3,416	3,379	3,391	3,401	3,392	3,402	40,828
MCE	237,937	237,814	237,738	237,665	236,849	236,749	236,373	236,680	238,964	236,122	235,411	235,296	2,843,598
WCM	-	-	-	-	-	-	-	-	-	-	-	-	-
	760,472	**761,034**	**758,098**	**756,488**	**752,888**	**750,159**	**747,862**	**745,213**	**751,343**	**744,916**	**744,503**	**743,936**	**9,016,912**
OneCare Connect	16,399	13,137	14,681	14,665	14,610	14,301	14,287	14,209	14,128	14,178	14,057	14,123	172,775
OneCare	1,390	1,384	1,375	1,404	1,423	1,435	1,453	1,472	1,488	1,478	1,535	1,537	17,374
PACE	273	286	286	289	295	299	304	308	320	325	326	327	3,638
TOTAL	**778,534**	**775,841**	**774,440**	**772,846**	**769,216**	**766,194**	**763,906**	**761,202**	**767,279**	**760,897**	**760,421**	**759,923**	**9,210,699**

Back to Agenda

ENROLLMENT:

Overall June enrollment was 759,923

- Unfavorable to budget 22,689 or 2.9%
- Decreased 498 or 0.1% from prior month (May 2019)
- Decreased 20,354 or 2.6% from prior year (June 2018)

Medi-Cal enrollment was 743,936

- Unfavorable to budget 22,135 or 2.9%
  - Whole Child Model (WCM) unfavorable 12,502
    - WCM members will remain in their original aid codes until the program begins 7/1/19
  - Medi-Cal Expansion (MCE) unfavorable 9,534
  - Temporary Assistance for Needy Families (TANF) unfavorable 2,509
  - Long-Term Care (LTC) unfavorable 167
  - Seniors and Persons with Disabilities (SPD) favorable 2,577
- Decreased 567 from prior month

OneCare Connect enrollment was 14,123

- Unfavorable to budget 743 or 5.0%
- Increased 66 from prior month

OneCare enrollment was 1,537

- Favorable to budget 213 or 16.1%
- Increased 2 from prior month

PACE enrollment was 327

- Unfavorable to budget 24 or 6.8%
- Increased 1 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
743,936	**766,071**	**(22,135)**	**(2.9%)**	**Member Months**	**9,016,912**	**9,208,308**	**(191,396)**	**(2.1%)**
				Revenues				
235,022,084	269,674,629	(34,652,545)	(12 8%)	Capitation revenue	3,134,181,617	3,105,673,528	28,508,089	0 9%
-	-	-	0 0%	Other income	-	-	-	0 0%
235,022,084	**269,674,629**	**(34,652,545)**	**(12.8%)**	**Total Operating Revenue**	**3,134,181,617**	**3,105,673,528**	**28,508,089**	**0.9%**
				Medical Expenses				
87,339,042	95,353,206	8,014,164	8 4%	Provider capitation	1,094,332,594	1,080,231,441	(14,101,153)	(1 3%)
47,770,361	46,117,468	(1,652,893)	(3 6%)	Facilities	567,773,649	538,572,567	(29,201,082)	(5 4%)
17,616,543	29,126,139	11,509,596	39 5%	Professional Claims	293,523,892	345,312,249	51,788,357	15 0%
38,182,483	43,744,846	5,562,363	12 7%	Prescription drugs	445,721,357	498,951,794	53,230,436	10 7%
34,807,286	36,293,567	1,486,281	4 1%	MLTSS	425,958,897	436,340,691	10,381,794	2 4%
4,836,232	4,037,654	(798,578)	(19 8%)	Medical management	39,379,280	45,910,943	6,531,663	14 2%
4,352,241	530,634	(3,821,607)	(720 2%)	Reinsurance & other	14,491,959	6,367,608	(8,124,351)	(127 6%)
234,904,188	**255,203,514**	**20,299,326**	**8.0%**	**Total Medical Expenses**	**2,881,181,629**	**2,951,687,293**	**70,505,664**	**2.4%**
117,896	**14,471,115**	**(14,353,219)**	**(99.2%)**	**Gross Margin**	**252,999,988**	**153,986,235**	**99,013,753**	**64.3%**
				Administrative Expenses				
5,450,613	6,977,798	1,527,185	21 9%	Salaries, wages & employee benefits	73,345,063	84,796,468	11,451,405	13 5%
632,389	470,326	(162,063)	(34 5%)	Professional fees	2,700,775	4,581,000	1,880,225	41 0%
1,336,769	996,566	(340,203)	(34 1%)	Purchased services	9,735,234	11,561,714	1,826,480	15 8%
683,307	384,144	(299,163)	(77 9%)	Printing and postage	4,163,448	4,914,715	751,267	15 3%
418,926	462,075	43,149	9 3%	Depreciation and amortization	5,242,522	5,544,906	302,384	5 5%
1,975,851	1,493,292	(482,559)	(32 3%)	Other operating expenses	15,289,802	17,933,786	2,643,984	14 7%
(185,779)	(223,590)	(37,811)	(16 9%)	Indirect cost allocation, Occupancy Expense	(3,532,455)	(2,683,094)	849,361	31 7%
10,312,075	**10,560,610**	**248,535**	**2.4%**	**Total Administrative Expenses**	**106,944,388**	**126,649,495**	**19,705,107**	**15.6%**
				Operating Tax				
11,270,609	10,923,367	347,243	3 2%	Tax Revenue	136,596,585	130,244,985	6,351,600	4 9%
11,270,609	10,923,367	(347,243)	(3 2%)	Premium tax expense	136,596,585	119,460,847	(17,135,738)	(14 3%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
181,178	249,876	(68,698)	(27 5%)	Grant Revenue	646,750	2,998,490	(2,351,740)	(78 4%)
149,600	223,111	73,511	32 9%	Grant expense - Service Partner	464,738	2,677,288	2,212,551	82 6%
31,578	26,765	(4,813)	(18 0%)	Grant expense - Administrative	182,012	321,202	139,190	43 3%
0	-	0	**0.0%**	**Total Grant Income**	0	-	0	**0.0%**
49	**-**	**49**	**0.0%**	**Other income**	**928**	**-**	**928**	**0.0%**
(10,194,130)	**3,910,505**	**(14,104,635)**	**(360.7%)**	**Change in Net Assets**	**146,056,528**	**27,336,740**	**118,719,788**	**434.3%**
99.9%	***94.6%***	***(5.3%)***	***(5.6%)***	***Medical Loss Ratio***	***91.9%***	***95.0%***	***3.1%***	***3.3%***
4.4%	***3.9%***	***(0.5%)***	***(12.0%)***	***Admin Loss Ratio***	***3.4%***	***4.1%***	***0.7%***	***16.3%***

Back to Agenda

MEDI-CAL INCOME STATEMENT - JUNE MONTH:

REVENUES of $235.0 million are unfavorable to budget $34.7 million driven by:

- Unfavorable volume related variance of $7.8 million
- Unfavorable price related variance of $26.9 million due to:
  - ➢ $22.9 million of WCM revenue due to delay in program start
  - ➢ $11.5 million of prior year (PY) revenue
  - ➢ Offset by $4.7 million due to Proposition 56
  - ➢ $3.5 million of Coordinated Care Initiative (CCI) revenue

MEDICAL EXPENSES of $234.9 million are favorable to budget $20.3 million driven by:

- **Professional Claims** expense is favorable to budget $11.5 million, due to:
  - ➢ $4.0 million of Incurred But Not Reported (IBNR) expenses
  - ➢ $1.9 million of Child Health and Disability Prevention (CHDP) expenses
  - ➢ $1.5 million of Behavioral Health Treatment (BHT) expenses
  - ➢ $1.5 million of Proposition 56 expenses
- **Provider Capitation** expense is favorable to budget $8.0 million due:
  - ➢ $12.0 million of WCM expense due to delay of program start
  - ➢ $5.9 million of prior year Quality Initiative (QI) expense
  - ➢ Offset by $6.7 million of Proposition 56 expense
- **Prescription Drug** expense is favorable to budget $5.6 million due to delay of WCM program start

ADMINISTRATIVE EXPENSES of $10.3 million are favorable to budget $0.2 million driven by:

- Salaries & Benefit expenses are favorable to budget $1.5 million due to open positions
- Other Non-Salary expenses are unfavorable to budget $1.3 million

CHANGE IN NET ASSETS is ($10.2) million for the month, unfavorable to budget $14.1 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Twelve Months Ending June 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,123	**14,866**	**(743)**	**(5.0%)**	**Member Months**	**172,775**	**178,472**	**(5,697)**	**(3.2%)**
				Revenues				
(4,484,145)	3,112,570	(7,596,715)	(244.1%)	Medi-Cal Capitation revenue	24,387,913	38,881,741	(14,493,828)	(37.3%)
17,631,157	18,490,648	(859,491)	(4.6%)	Medicare Capitation revenue part C	206,428,901	212,499,283	(6,070,382)	(2.9%)
4,365,179	4,846,049	(480,870)	(9.9%)	Medicare Capitation revenue part D	61,611,596	57,217,915	4,393,681	7.7%
-	-	-	0.0%	Other Income	-	-	-	0.0%
17,512,190	**26,449,267**	**(8,937,077)**	**(33.8%)**	**Total Operating Revenue**	**292,428,410**	**308,598,939**	**(16,170,529)**	**(5.2%)**
				Medical Expenses				
6,104,897	12,305,120	6,200,223	50.4%	Provider capitation	143,284,297	142,329,774	(954,523)	(0.7%)
4,850,798	3,728,051	(1,122,747)	(30.1%)	Facilities	45,925,050	43,892,992	(2,032,058)	(4.6%)
726,876	707,224	(19,652)	(2.8%)	Ancillary	8,088,427	8,120,194	31,767	0.4%
1,537,284	1,497,033	(40,251)	(2.7%)	Long Term Care	16,703,851	19,326,362	2,622,511	13.6%
5,263,138	5,295,132	31,994	0.6%	Prescription drugs	64,052,573	63,562,845	(489,728)	(0.8%)
1,113,348	1,273,102	159,754	12.5%	Medical management	13,552,984	15,647,519	2,094,535	13.4%
264,492	145,711	(118,781)	(81.5%)	Other medical expenses	2,340,280	1,723,204	(617,076)	(35.8%)
19,860,834	**24,951,373**	**5,090,539**	**20.4%**	**Total Medical Expenses**	**293,947,462**	**294,602,890**	**655,428**	**0.2%**
(2,348,644)	**1,497,894**	**(3,846,538)**	**(256.8%)**	**Gross Margin**	**(1,519,052)**	**13,996,049**	**(15,515,101)**	**(110.9%)**
				Administrative Expenses				
717,288	858,293	141,005	16.4%	Salaries, wages & employee benefits	9,006,984	10,519,013	1,512,029	14.4%
35,167	42,917	7,750	18.1%	Professional fees	273,473	515,000	241,527	46.9%
259,337	251,415	(7,922)	(3.2%)	Purchased services	2,032,332	3,016,981	984,649	32.6%
161,792	86,202	(75,591)	(87.7%)	Printing and postage	828,461	1,034,420	205,959	19.9%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
170,838	77,037	(93,801)	(121.8%)	Other operating expenses	676,063	924,438	248,375	26.9%
493,059	557,394	64,335	11.5%	Indirect cost allocation	7,046,462	6,688,728	(357,734)	(5.3%)
1,837,481	**1,873,257**	**35,776**	**1.9%**	**Total Administrative Expenses**	**19,863,775**	**22,698,580**	**2,834,805**	**12.5%**
(4,186,124)	**(375,363)**	**(3,810,762)**	**(1015.2%)**	**Change in Net Assets**	**(21,382,827)**	**(8,702,531)**	**(12,680,296)**	**(145.7%)**
113.4%	***94.3%***	***(19.1%)***	***(20.2%)***	***Medical Loss Ratio***	***100.5%***	***95.5%***	***(5.1%)***	***(5.3%)***
10.5%	***7.1%***	***(3.4%)***	***(48.1%)***	***Admin Loss Ratio***	***6.8%***	***7.4%***	***0.6%***	***7.6%***

Back to Agenda

ONECARE CONNECT INCOME STATEMENT - JUNE MONTH:

REVENUES of $17.5 million are unfavorable to budget $8.9 million driven by:

- Unfavorable volume related variance of $1.3 million
- Unfavorable price related variance of $7.6 million due to:
  - ➢ $6.9 million of prior year revenue
  - ➢ $5.7 million of calendar year (CY) 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) records adjustment
  - ➢ Offset by $6.6 million of PY 2017 Quality Withhold payback

MEDICAL EXPENSES of $19.9 million are favorable to budget $5.1 million driven by:

- Favorable volume related variance of $1.2 million
- Favorable price related variance of $3.8 million

ADMINISTRATIVE EXPENSES of $1.8 million are in line with budget at $1.9 million

C**HANGE IN NET ASSETS** is ($4.2) million, unfavorable to budget $3.8 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,537	**1,324**	**213**	**16.1%**	**Member Months**	**17,374**	**15,888**	**1,486**	**9.4%**
				Revenues				
1,157,067	1,117,778	39,288	3 5%	Medicare Part C revenue	14,118,494	13,377,000	741,495	5 5%
516,206	497,868	18,337	3 7%	Medicare Part D revenue	6,495,110	5,980,913	514,197	8 6%
1,673,272	**1,615,646**	**57,626**	**3.6%**	**Total Operating Revenue**	**20,613,605**	**19,357,913**	**1,255,692**	**6.5%**
				Medical Expenses				
453,170	443,664	(9,507)	(2 1%)	Provider capitation	5,774,092	5,397,291	(376,801)	(7 0%)
(379,810)	538,247	918,057	170 6%	Inpatient	4,919,665	6,293,695	1,374,030	21 8%
29,129	60,721	31,592	52 0%	Ancillary	524,281	690,035	165,754	24 0%
8,795	25,991	17,196	66 2%	Skilled nursing facilities	559,510	316,224	(243,286)	(76 9%)
483,418	440,543	(42,874)	(9 7%)	Prescription drugs	5,742,787	5,293,104	(449,683)	(8 5%)
15,552	33,864	18,312	54 1%	Medical management	715,070	409,629	(305,441)	(74 6%)
-	9,775	9,775	100 0%	Other medical expenses	37,298	98,000	60,702	61 9%
610,255	**1,552,805**	**942,550**	**60.7%**	**Total Medical Expenses**	**18,272,702**	**18,497,977**	**225,275**	**1.2%**
1,063,017	**62,841**	**1,000,176**	**1591.6%**	**Gross Margin**	**2,340,902**	**859,936**	**1,480,967**	**172.2%**
				Administrative Expenses				
26,975	39,156	12,181	31 1%	Salaries, wages & employee benefits	382,445	480,071	97,626	20 3%
24,873	19,600	(5,273)	(26 9%)	Professional fees	186,207	235,200	48,993	20 8%
39,580	17,425	(22,155)	(127 1%)	Purchased services	198,182	209,100	10,918	5 2%
22,541	13,206	(9,335)	(70 7%)	Printing and postage	111,430	158,471	47,041	29 7%
(294)	6,883	7,177	104 3%	Other operating expenses	789	82,600	81,811	99 0%
61,300	34,965	(26,335)	(75 3%)	Indirect cost allocation, occupancy expens	496,713	419,580	(77,133)	(18 4%)
174,975	**131,235**	**(43,740)**	**(33.3%)**	**Total Administrative Expenses**	**1,375,766**	**1,585,022**	**209,256**	**13.2%**
888,042	**(68,394)**	**956,436**	**1398.4%**	**Change in Net Assets**	**965,137**	**(725,086)**	**1,690,223**	**233.1%**
36.5%	***96.1%***	***59.6%***	***62.1%***	***Medical Loss Ratio***	***88.6%***	***95.6%***	***6.9%***	***7.2%***
10.5%	***8.1%***	***(2.3%)***	***(28.7%)***	***Admin Loss Ratio***	***6.7%***	***8.2%***	***1.5%***	***18.5%***

Back to Agenda

CalOptima
PACE
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
327	**351**	**(24)**	**(6.8%)**	**Member Months**	**3,638**	**3,708**	**(70)**	**-1.9%**
				Revenues				
1,916,453	1,963,873	(47,420)	(2 4%)	Medi-Cal capitation revenue	20,598,217	20,756,918	(158,701)	(0 8%)
458,084	478,006	(19,922)	(4 2%)	Medicare Part C revenue	5,396,409	4,978,763	417,646	8 4%
89,449	113,921	(24,472)	(21 5%)	Medicare Part D revenue	1,416,120	1,196,583	219,537	18 3%
2,463,986	**2,555,800**	**(91,814)**	**(3.6%)**	**Total Operating Revenue**	**27,410,747**	**26,932,264**	**478,483**	**1.8%**
				Medical Expenses				
822,013	792,358	(29,655)	(3 7%)	Medical Management	7,807,851	8,971,767	1,163,916	13 0%
256,249	554,853	298,604	53 8%	Claims payments to hospitals	5,368,134	5,678,881	310,747	5 5%
590,751	571,158	(19,593)	(3 4%)	Professional claims	5,774,943	5,976,692	201,749	3 4%
131,624	156,472	24,848	15 9%	Patient transportation	1,874,919	1,652,989	(221,930)	(13 4%)
220,519	208,539	(11,980)	(5 7%)	Prescription drugs	2,221,894	2,166,250	(55,644)	(2 6%)
51,427	38,972	(12,455)	(32 0%)	MLTSS	220,592	249,074	28,482	11 4%
(3,710)	3,250	6,960	214 2%	Other Expenses	29,400	35,700	6,300	17 6%
2,068,874	**2,325,602**	**256,728**	**11.0%**	**Total Medical Expenses**	**23,297,733**	**24,731,353**	**1,433,620**	**5.8%**
395,112	**230,198**	**164,914**	**71.6%**	**Gross Margin**	**4,113,013**	**2,200,911**	**1,912,102**	**86.9%**
				Administrative Expenses				
119,745	136,573	16,829	12 3%	Salaries, wages & employee benefits	1,273,933	1,610,850	336,917	20 9%
303	167	(137)	(82 0%)	Professional fees	7,164	2,000	(5,164)	(258 2%)
61,730	21,027	(40,704)	(193 6%)	Purchased services	214,722	252,320	37,598	14 9%
35,502	10,428	(25,074)	(240 4%)	Printing and postage	109,325	125,140	15,815	12 6%
2,092	2,091	(1)	(0 1%)	Depreciation & amortization	24,975	25,088	113	0 5%
(23,275)	3,859	27,133	703 2%	Other operating expenses	47,027	46,304	(723)	(1 6%)
28,679	3,466	(25,213)	(727 5%)	Indirect cost allocation, Occupancy Expense	88,120	41,588	(46,532)	(111 9%)
224,777	**177,610**	**(47,167)**	**(26.6%)**	**Total Administrative Expenses**	**1,765,267**	**2,103,290**	**338,023**	**16.1%**
170,336	**52,588**	**117,747**	**223.9%**	**Change in Net Assets**	**2,347,747**	**97,621**	**2,250,126**	**2305.0%**
84.0%	***91.0%***	***7.0%***	***7.7%***	***Medical Loss Ratio***	***85.0%***	***91.8%***	***6.8%***	***7.4%***
9.1%	***6.9%***	***(2.2%)***	***(31.3%)***	***Admin Loss Ratio***	***6.4%***	***7.8%***	***1.4%***	***17.5%***

Back to Agenda

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
37,559	22,981	(14,578)	(63.4%)	Purchase services	404,249	275,779	(128,470)	(46.6%)
164,493	162,934	(1,559)	(1.0%)	Depreciation & amortization	1,959,226	1,955,214	(4,012)	(0.2%)
17,476	15,916	(1,560)	(9.8%)	Insurance expense	194,772	191,000	(3,772)	(2.0%)
139,046	173,137	34,091	19.7%	Repair and maintenance	1,229,306	2,077,633	848,327	40.8%
34,238	1,635	(32,603)	(1994.1%)	Other Operating Expense	482,504	19,620	(462,884)	(2359.2%)
(392,814)	(376,603)	16,211	4.3%	Indirect allocation, Occupancy	(4,270,057)	(4,519,246)	(249,189)	(5.5%)
(0)	**-**	**0**	**0.0%**	**Total Administrative Expenses**	**(0)**	**-**	**0**	**0.0%**
0	**-**	**0**	**0.0%**	**Change in Net Assets**	**0**	**-**	**0**	**0.0%**

Back to Agenda

OTHER INCOME STATEMENTS - JUNE MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $888.0 thousand, $956.4 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $170.3 thousand, $117.7 thousand favorable to budget

CalOptima
Balance Sheet
June 30, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$347,627,784	Accounts Payable	$42,690,862
Investments	573,706,297	Medical Claims liability	744,669,961
Capitation receivable	302,964,503	Accrued Payroll Liabilities	11,007,473
Receivables - Other	48,977,264	Deferred Revenue	58,675,755
Prepaid expenses	5,782,878	Deferred Lease Obligations	44,512
		Capitation and Withholds	108,903,140
Total Current Assets	**1,279,058,726**	**Total Current Liabilities**	**965,991,703**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	5,559,034		
505 City Parkway West	50,464,989		
	93,110,388		
Less: accumulated depreciation	(46,485,498)		
Capital assets, net	46,624,889	Other (than pensions) post employment benefits liability	26,041,634
Other Assets		Net Pension Liabilities	23,602,064
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	60,000,000		
Board-designated assets:		**TOTAL LIABILITIES**	**1,015,635,400**
Cash and Cash Equivalents	12,711,832		
Long-term Investments	547,433,575	Deferred Inflows	
Total Board-designated Assets	560,145,408	Change in Assumptions	4,747,505
		Excess Earnings	156,330
Total Other Assets	620,445,408		
TOTAL ASSETS	**1,946,129,023**	Net Position	
		TNE	84,931,166
		Funds in Excess of TNE	851,193,072
Deferred Outflows		**TOTAL NET POSITION**	936,124,237
Pension Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,956,663,472**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,956,663,472**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of June 30, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
Board-designated Reserve	Tier 1 - Payden & Rygel	153,492,886				
	Tier 1 - Logan Circle	152,452,411				
	Tier 1 - Wells Capital	152,773,091				
		458,718,387	311,302,029	481,116,256	147,416,358	(22,397,868)
TNE Requirement	Tier 2 - Logan Circle	101,427,020	84,931,166	84,931,166	16,495,854	16,495,854
	Consolidated:	**560,145,408**	**396,233,195**	**566,047,421**	**163,912,213**	**(5,902,014)**
	Current reserve level	*1.98*	*1.40*	*2.00*		

Back to Agenda

CalOptima
Statement of Cash Flows
as of June 30, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(8,437,303)	171,625,760
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	585,512	7,226,723
Changes in assets and liabilities:		
Prepaid expenses and other	20,310	514,468
Catastrophic reserves		
Capitation receivable	(14,775,803)	(30,790,751)
Medical claims liability	35,367,576	(87,949,652)
Deferred revenue	(29,100,014)	(55,027,195)
Payable to providers	(3,219,164)	12,454,249
Accounts payable	14,489,096	35,041,244
Other accrued liabilities	114,412	(198,428)
Net cash provided by/(used in) operating activities	(4,955,378)	52,896,419
GASB 68 CalPERS Adjustments	-	2,173,056
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	2,866,910
Net cash provided by (used in) in capital and related financing activities	-	2,866,910
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(111,277,358)	6,592,651
Change in Property and Equipment	(5,804)	(3,093,363)
Change in Board designated reserves	(2,696,826)	(21,897,735)
Change in Homeless Health reserve	-	(60,000,000)
Net cash provided by/(used in) investing activities	(113,979,988)	(78,398,447)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(118,935,365)	(20,462,062)
CASH AND CASH EQUIVALENTS, beginning of period	466,563,150	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**347,627,784**	**347,627,784**

Back to Agenda

BALANCE SHEET - JUNE MONTH:

ASSETS of $2.0 billion increased $9.2 million from May or 0.5%

- **Operating Cash** decreased $118.9 million primarily due to the timing of cash flow needs, with an offsetting increase in Investments
- **Investments** increased $111.3 million with an offsetting decrease in operating cash based on the timing of cash flow needs
- **Capitation Receivables** decreased $8.6 million or 2.7% due to timing of Department of Healthcare Services (DHCS) capitation payments

LIABILITIES increased $17.7 million from May or 1.8%

- **Deferred Revenue** decreased $29.1 million due to timing of capitation payment from CMS
- **Medical Claims Liability** increased $35.4 million due to increase in overpayments due back to DHCS
- **Accounts Payable** increased $14.6 million due to the timing of the quarterly Managed Care Organization (MCO) tax payment
- **Capitation and Withholds** decreased $3.2 million due to release of prior year Qualitive Initiative liability

NET ASSETS total $936.1 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2019

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	**0**	**0**	**0.0%**	**Total Operating Revenue**	**0**	**0**	**0**	**0.0%**
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	74,210	74,210	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	35,818	35,818	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
0	229,841	229,841	100.0%	Other	12,000	2,758,078	2,746,078	99.6%
0	**239,010**	**239,010**	**100%**	**Total Operating Expenditures**	**12,000**	**2,868,106**	**2,856,106**	**99.6%**
0	**0**	**0**	**0.0%**	**Investment Income**	**35,771**	**0**	**35,771**	**0.0%**
0	**(239,010)**	**239,010**	**100.0%**	**Program Income**	**23,771**	**(2,868,106)**	**2,891,877**	**100.8%**

Back to Agenda

CalOptima Foundation
Balance Sheet
June 30, 2019

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	$0	Accounts payable-Current	$0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**0**	Grants-Foundation	0
		Total Current Liabilities	**0**
		Total Liabilities	0
		Net Assets	0
TOTAL ASSETS	**$0**	**TOTAL LIABILITIES & NET ASSETS**	**$0**

Back to Agenda

CALOPTIMA FOUNDATION FINANCIAL STATEMENTS – JUNE MONTH AND YTD:

OVERVIEW - CalOptima Foundation was formed as a not-for-profit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. The activities of the Foundation are presented in the financial statements.

CalOptima Foundation last date of operations was May 31, 2019

Homeless Health Initiatives and Allocated Funds As of June 30th, 2019

		Amount
Program Commitment		**$100,000,000**
Funds Allocation, approved initiatives:		
Be Well OC	11,400,000	
Recuperative Care	11,000,000	
Clinical Field Team Start-up & FQHC's	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	40,000,000
Funds Allocation Total		
Program Commitment Balance, available for new initiatives		**$60,000,000**

Back to Agenda

Budget Allocation Changes
Reporting Changes for June 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
November	Medi-Cal	Facilities - Capital Project (8th Floor HR Remodel)	Facilities - Capital Project (Replace Master Control Center)	$22,500	Reallocate $22,500 from Capital Project (8th Floor hr. Remodel) to Capital Project (Replace Master Control Center)	2019
December	Medi-Cal	Facilities - Office Supplies	Facilities - Computer Supply/Minor Equipment	$60,000	Reallocate $60,000 from Office Supplies to Computer Supplies/Minor Equipment to furniture needs of the staff	2019
December	Medi-Cal	Strategic Development - Professional Fees (Covered CA Consulting)	Strategic Development - Professional Fees (Strategic Planning Consulting)	$50,000	Repurpose $50,000 from Professional Fees (Covered CA Consulting) to Professional Fees (Strategic Planning Consulting)	2019
January	Medi-Cal	IS Application Development - Training & Seminars	IS Application Development - Maintenance HW/SW	$11,000	Reallocate $11,000 from training & seminars to maintenance HW/SW to pay for additional Tableau licenses	2019
June	Medi-Cal	Human Resources - Purchased Services (Electronic Files)	Human Resources - Purchased Services (Benefits Broker)	$16,500	Repurpose $16,500 from Purchased Services (Electronic Files) Purchased Services (Benefits Broker)	2019
June	Medi-Cal	Quality Analytics - Purchased Services (Practitioner Survey PCP Experience)	Quality Analytics - Purchased Services (Provider Coaching)	$30,000	Repurpose $30,000 from Purchased Services (Practitioner Survey PCP Experience) to Purchased Services (Provider Coaching)	2019
June	Medi-Cal	Facilities - Capital Project (8th Floor HR Remodel)	Facilities - Capital Project (Upgrade Card Access System)	$80,000	Reallocate $80,000 from Capital Project (8th Floor HR Remodel) to Capital Project (Upgrade Card Access System)	2019

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000. \
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors' Meeting
August 1, 2019

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- Notification of Three-Year Provider Network Adequacy Review:

  On January 15, 2019, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected for its three-year provider network adequacy review. On June 17, 2019, CMS requested that CalOptima upload its provider and facility network for the official formal review, which CalOptima completed on June 20, 2019. On June 29, 2019, CMS provided the results of the automated criteria check (ACC), which indicated that CalOptima passed with no deficiencies identified with the provider or facility files that were submitted.

- Medicare Data Validation Audit (OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to conduct a validation of all Medicare Parts C and D data reported for the prior calendar year. The virtual audit includes a review of source documentation for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medication Therapy Management Program
  - Special Needs Plan Care Management
  - Improving Drug Utilization Review Controls

  On June 26, 2019, CMS' audit contractor informed CalOptima that it received a score of 100% for all measures for both the OneCare and OneCare Connect programs.

Back to Agenda

- CY 2017 Medicare Part C National Risk Adjustment Data Validation (RADV) Audit:

  On December 28, 2018, CMS notified CalOptima that its OneCare program has been selected to participate in the CY 2017 Medicare Part C National Risk Adjustment Data Validation (RADV) audit. On February 28, 2019, CalOptima was notified that only one (1) enrollee with six (6) hierarchical condition categories (HCCs) was selected for validation. CalOptima submitted the medical records for the selected enrollee for five (5) of the six (6) HCCs on April 9, 2019, in advance of the June 20, 2019 deadline. There were no records for the sixth HCC. On June 4, 2019, CMS provided preliminary feedback that two (2) of the five (5) records did not support the sampled HCC. CalOptima expects to receive the final findings report from CMS later this year.

2. OneCare Connect

- CY 2019 Transition Requirements Analysis (TRA):

  On June 6, 2019, CMS selected CalOptima's OneCare Connect program for the CY 2019 TRA, which aims to investigate whether Part D sponsors are administering transition requirements appropriately. This analysis identifies beneficiaries who may have been eligible for a transition fill in January 2019, and verifies whether they received a transition through review of previously submitted prescription drug events. CalOptima submitted all deliverables by the July 8, 2019, regulatory deadline.

- CY 2018 Performance Measure Validation (PMV):

  On May 21, 2019, CMS provided Medicare-Medicaid Plans (MMPs) with an initial notification of upcoming PMV efforts for the 2018 measurement of the following:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
  - MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

  MMPs are required to report various monitoring and performance measures, as outlined in the MMP core and state-specific reporting requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures. On June 25, 2019, CMS held a kick-off call to provide an overview of the upcoming remote webinar review. The webinar review has been scheduled for September 18, 2019.

3. Medi-Cal

- 2019 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 4, 2019 through February 15, 2019. The

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

audit covered the review period of February 1, 2018 through January 31, 2019, and consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. On June 25, 2019, the DHCS issued its final audit report to CalOptima, which outlined three (3) findings in the areas of case management and coordination of care, access and availability of care, and quality management. The DHCS has requested a corrective action plan from CalOptima by July 26, 2019 deadline.

- CMS Medicaid Expansion Medical Loss Ratio (MLR) Examination:

  On April 1, 2019, CMS informed CalOptima that it will perform a comprehensive examination and validation of California Medicaid managed care plans' MLR reporting for the reporting periods January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. The overall purpose of the examination is to ensure that the financial information submitted by the Medicaid managed care plans and used by the DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed care plan's internal data and accounting systems. CMS expects that the review will be completed within six (6) months after all the data have been received by the reviewing contractor. The commencement date of the examination has yet to be established, but CalOptima expects to begin receiving data requests soon.

B. Regulatory Notices of Non-Compliance

1. On July 9, 2019, CalOptima received notification that DHCS had provided only partial approval of CalOptima's request for an Alternative Access Standard to account for a lack of obstetrics/gynecology (OB/GYN) providers, who are also primary care providers (PCPs), within time and distance standards of two (2) south Orange County zip codes. Via its corrective action plan (CAP) process, DHCS is requiring that CalOptima demonstrate evidence of contracting efforts with all such potential providers within time and distance standards, as well as to allow members to access out-of-network providers of this type within the time and distance standards. CalOptima has contacted all OB/GYN providers in our service area, and has not been able to identify any who are also eligible to be PCPs. On July 17, 2019, CalOptima had a conference call with DHCS to discuss this matter, and will submit a timely CAP response to address DHCS' concern.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2019	93%	100%	97%	100%
March 2019	100%	100%	100%	100%
April 2019	100%	100%	100%	100%

➢ For the March file review of Medi-Cal claims, CalOptima's Claims department received a 100% compliance score for the sixty (60) claims selected for a focused review as well as a 100% compliance score based on the overall universe of paid and denied claims.

➢ For the April file review of Medi-Cal claims, CalOptima's Claims department received a 100% compliance score for the sixty (60) claims selected for a focused review as well as a 100% compliance score based on the overall universe of paid and denied claims.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
February 2019	70%	60%	93%	90%	100%
March 2019	100%	98%	85%	100%	95%
April 2019	100%	100%	100%	100%	100%

➢ For the March file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 96% based on the overall universe of PDRs.

➢ The lower compliance score of 85% for accuracy of PDRs for March 2019 was due to multiple claims upheld in error based on a focused review of forty (40) PDRs.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of PDRs within regulatory requirements.

- For the April file review of Medi-Cal PDRs, CalOptima's Claims department received a score of 100% based on the overall universe of PDRs and a score of 100% for a focused audit of forty (40) claims selected for review.

- Medi-Cal Grievance & Appeals Resolution Services (GARS): Standard Grievances

Month	Classification Score	Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievances resolved ≤ 30 Calendar Days of Receipt
March 2019	100%	100%	100%	80%	100%
April 2019	Pending	Pending	Pending	Pending	Pending

- For the 2019 March file review of Medi-Cal standard grievances, CalOptima's GARS department:
  - Received a compliance score of 96% based on the overall universe of standard grievances.
  - Based on a focused review of ten (10) standard grievances, the lower compliance score of 80% for member notice content for March 2019 was due to an inaccurate resolution letter response.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of standard grievances within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- Medi-Cal Customer Service: Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	95%	100%

  - For the October – December 2018 file review of Medi-Cal inquiries, CalOptima's Customer Service department:
    - Received a compliance score of 98% based on the overall universe of inquiries.
    - Based on a focused review of nine (9) inquiries, the lower compliance score of 95% for the file review was due to a member's inquiry not being properly routed to the appropriate department for resolution.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of member inquiries received by the Customer Service department. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of member inquiries within regulatory requirements.

- Medi-Cal Customer Service: Exempt Grievances

Month	Log Requirements	Universe Accuracy	Classification of Exempt Grievances	Accurate Documentation of Exempt Grievances	Complete Resolution of Exempt Grievances	Resolution Timeliness
October – December 2018	100%	89%	100%	100%	100%	100%

  - For the October - December 2018 file review of Medi-Cal exempt grievances, CalOptima's Customer Service department:
    - Received a compliance score of 98% based on the overall universe of exempt grievances.
    - Based on a focused review of nine (9) exempt grievances, the lower compliance score of 89% was due to inaccuracies in the universe.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of exempt grievances. The A&O department continues to work with the Customer Service

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate universe submissions.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2019	100%	100%	100%	100%
March 2019	100%	100%	100%	100%
April 2019	100%	100%	100%	100%

➢ For the March file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of twenty (20) claims and a review of the overall universe of paid and denied claims.

➢ For the April file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of twenty (20) claims and a review of the overall universe of paid and denied claims.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
February 2019	100%	100%	100%
March 2019	Nothing to Report	Nothing to Report	Nothing to Report
April 2019	Nothing to Report	Nothing to Report	Nothing to Report

➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare GARS: Written Standard Grievances

Month	Classification Score	Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievances resolved ≤ 30 Calendar Days of Receipt
March 2019	100%	100%	100%	0%	100%
April 2019	Pending	Pending	Pending	Pending	Pending

  - For the March file review of OneCare standard grievances, CalOptima's GARS department:
    - Received a compliance score of 80% based on the overall universe of standard grievances.
    - The low compliance score of 0% for member notice content for March 2019 was due to multiple inaccurate resolution letter responses identified during a focused review of three (3) grievances.

  - CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of standard grievances within regulatory requirements.

- OneCare Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	89%	100%

  - For the October - December 2018 file review of OneCare Part C inquiries, CalOptima's Customer Service department:
    - Received a compliance score of 96% based on the overall universe of Part C inquiries.
    - Based on a focused review of nine (9) Part C inquiries, the lower compliance score of 89% was due to missing call recordings during the file review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of Part C inquiries. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of Part C inquiries within regulatory requirements.

- OneCare Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	89%	100%

- For the October - December 2018 file review of OneCare Part D inquiries, CalOptima's Customer Service department:
  - Received a compliance score of 96% based on the overall universe of Part D inquiries.
  - Based on a focused review of nine (9) Part D inquiries, the lower compliance score of 89% was due to missing call recordings during the file review.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Part D inquiries. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of Part D member inquiries within regulatory requirements.

- OneCare Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- For the October - December 2018 file review of OneCare oral grievances, CalOptima's Customer Service department received a compliance score of 100% based on a focused review of nine (9) oral grievances and a review of the overall universe of oral grievances.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2019	100%	90%	90%	70%
March 2019	100%	100%	100%	100%
April 2019	90%	100%	100%	90%

- For the March file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of twenty (20) claims and a review of the overall universe of paid and denied claims.

- For the April file review of OneCare Connect claims, CalOptima's Claims department:
  - Received a compliance score of 95% based on the overall universe of paid and denied claims.
  - Based on a focused review of twenty (20) claims:
    - The lower compliance score of 90% for paid claims timeliness was due to one (1) untimely claim.
    - The lower compliance score of 90% for denied claims accuracy was due to one (1) inaccurate claim.

- CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy	Check Lag
February 2019	100%	80%	100%	N/A
March 2019	100%	83%	100%	N/A
April 2019	100%	100%	100%	N/A

- For the March file review of OneCare Connect PDRs, CalOptima's Claims department:
  - Received a compliance score of 94% based on the overall universe of PDRs.
  - Based on a focused review of seven (7) PDRs, the lower compliance score of 83% for resolution timeliness was due to a claim not processing within thirty (30) days from the PDR receipt date.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of PDRs within regulatory requirements.

- For the April file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 100% based on a focused review of fourteen (14) PDRs and a review of the overall universe of PDRs.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare Connect GARS: Written Standard Grievances

Month	Classification Score	Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievances Resolved ≤ 30 Calendar Days of Receipt
March 2019	100%	100%	90%	30%	100%
April 2019	Pending	Pending	Pending	Pending	Pending

  - For the March file review of Medi-Cal written standard grievances, CalOptima's GARS department:
    - Received a compliance score of 84% based on the overall universe of standard grievances.
    - Based on a focused review of ten (10) grievances:
      - The lower compliance score of 90% for language preference was due to an acknowledgment and resolution letter not issued in the required primary language.
      - The lower compliance score of 30% for member notice content was due to multiple inaccurate resolution letter responses.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of standard grievances within regulatory requirements.

- OneCare Connect Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	78%	100%

  - For the October - December 2018 file review of OneCare Connect Part C inquiries, CalOptima's Customer Service department:
    - Received a compliance score of 93% based on the overall universe of Part C inquiries.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

  - Received a compliance score of 78% based on a focused review of nine (9) Part C inquiries due to missing call recordings.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Part C inquiries. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of Part C inquiries within regulatory requirements.

- OneCare Connect Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	77.78%	100%

➢ For the October - December 2018 file review of OneCare Connect Part D inquiries, CalOptima's Customer Service department:
  - Received a compliance score of 93% based on the overall universe of Part D inquiries.
  - Received a compliance score of 78% based on a focused review of nine (9) Part D inquiries due to missing call recordings.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the focused review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of Part D inquiries within regulatory requirements.

- OneCare Connect Customer Service: Part C Oral Grievances

Month	Misclassified Calls	File Review	Universe
October – December 2018	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- For the October - December 2018 file review of OneCare Connect Part C oral grievances, CalOptima's Customer Service department received a compliance score of 100% based on the overall universe of oral grievances and a focused review of nine (9) oral grievances.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
February 2019	100%	100%	100%	70%
March 2019	100%	100%	90%	100%
April 2019	100%	100%	100%	100%

➢ For the March file review of PACE claims, CalOptima's Claims department:
- Received a compliance score of 98% based on the overall universe of paid and denied claims.
- Received a compliance score of 90% for denied claims accuracy based on a focused review of twenty (20) claims.

➢ For the April file review of PACE claims, CalOptima's Claims department:
- Received a compliance score of 100% for timeliness and a compliance score of 95% for accuracy based on the overall universe of paid and denied claims.
- Received a compliance score of 100% for accuracy and timeliness based on a focused review of twenty (20) paid and denied claims.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for corrective action plan (CAP) for deficiencies identified during the focused review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
February 2019	100%	100%	100%	N/A
March 2019	100%	100%	100%	N/A
April 2019	100%	100%	100%	N/A

- For the March file review of PACE PDRs, CalOptima's Claims department received a compliance score of 100% based on the overall universe of PDRs and based on the focused review of two (2) PDRs.

- For the April file review of PACE PDRs, CalOptima's Claims department received a compliance score of 100% based on the overall universe of PDRs and based on the focused review of one (1) PDR.

5. Health Network Monitoring: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2019	76%	81%	83%	83%	66%	82%	82%	67%	84%	80%	53%	57%	65%
March 2019	68%	84%	85%	73%	74%	87%	86%	76%	84%	85%	71%	67%	73%
April 2019	87%	85%	85%	82%	88%	84%	85%	89%	84%	83%	100%	78%	80%

- Based on a focused review of select files, the lower scores for clinical decision making were due to the following reasons:
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision
  - Failure to cite criteria for decision

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- Based on a focused review of select files, the lower letter scores were due to the following reasons:
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Based on the overall universe of Medi-Cal authorizations for March 2019, CalOptima's health networks received a compliance score of 99% for timely processing of routine authorization requests and a compliance score of 98% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2019	98%	88%	99%	84%
March 2019	93%	82%	98%	69%
April 2019	99%	84%	98%	87%

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

- Based on the overall universe of Medi-Cal claims for March 2019, CalOptima's health networks received the following compliance scores for timely processing of claims:

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- 96% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
- 98% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
- 98% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

6. Health Network Monitoring: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
February 2019	80%	67%	81%	90%	79%	100%	74%	92%
March 2019	78%	100%	89%	88%	85%	50%	83%	83%
April 2019	98%	100%	90%	97%	92%	100%	78%	95%

- Based on a focused review of select files, the lower scores for clinical decision making were due to a failure to cite the criteria for the decision.

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for the month of March 2019, CalOptima's health networks received an overall compliance score of 100% for timely processing of standard Part C authorization requests and 81% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2019	97%	92%	99%	90%
March 2019	93%	96%	100%	92%
April 2019	98%	92%	100%	88%

  - Based on a focused review of select files, the compliance rate for paid claims accuracy decreased from 96% in March 2019 to 92% in April 2019 due to missing documents that are required for processing accurate payment on claims.

  - Based on a focused review of select files, the compliance rate for denied claims accuracy decreased from 92% in March 2019 to 88% in April 2019 due to missing documents that are required for processing accurate payment on claims.

  - Based on the overall universe of OneCare claims for CalOptima's health networks for the month of March 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
    - 93% for non-contracted clean claims paid or denied within 30 calendar days of receipt
    - 99% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

7. Health Network Monitoring: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
February 2019	71%	85%	82%	73%	89%	88%	77%	71%	100%	70%	48%
March 2019	78%	75%	81%	73%	91%	58%	78%	85%	55%	76%	75%
April 2019	83%	84%	84%	88%	87%	92%	85%	79%	94%	81%	78%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- Based on a focused review of select files, the lower letter scores were due to the following reasons:
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for March 2019, CalOptima's health networks received an overall compliance score of 99% for timely processing of routine authorization requests and 98% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2019	92%	93%	91%	94%
March 2019	96%	91%	100%	84%
April 2019	99%	94%	99%	89%

- Based on a focused review of select files, the compliance rate for denied claims timeliness decreased from 100% in March 2019 to 99% in April 2019 due to untimely processing of multiple claims.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for March 2019, CalOptima's health networks received the following overall compliance scores:

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.
Back to Agenda

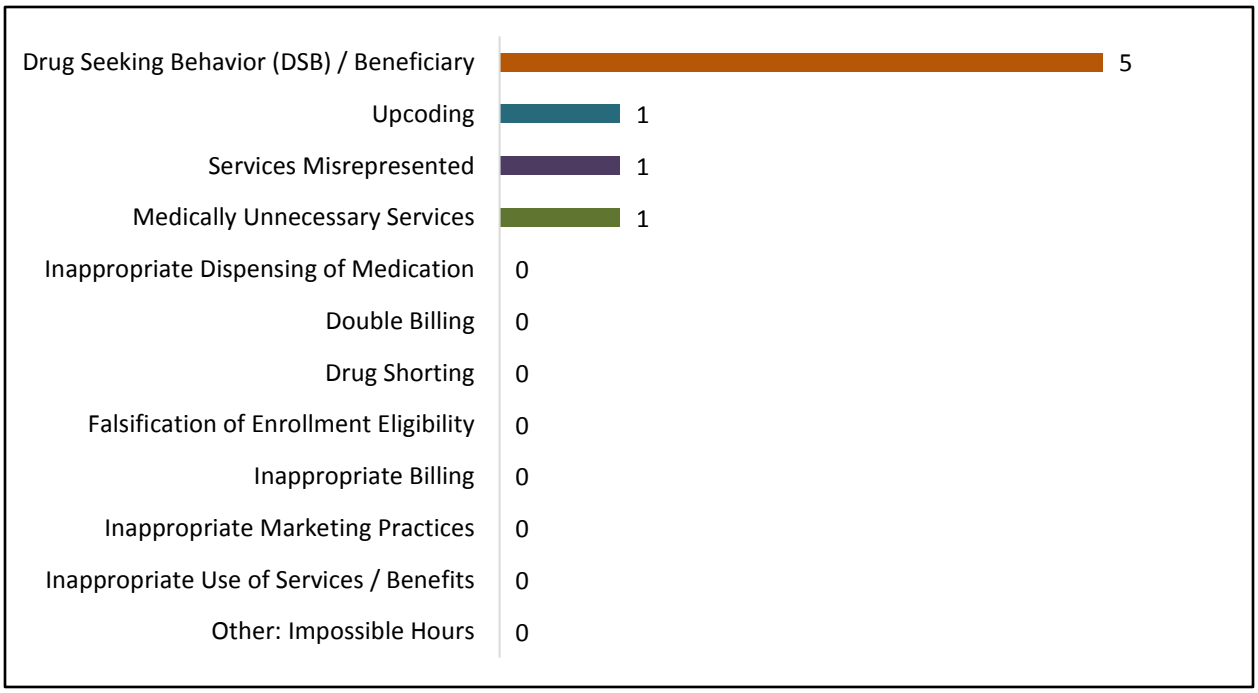
- 98% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt.
- 100% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt.
- 99% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt.

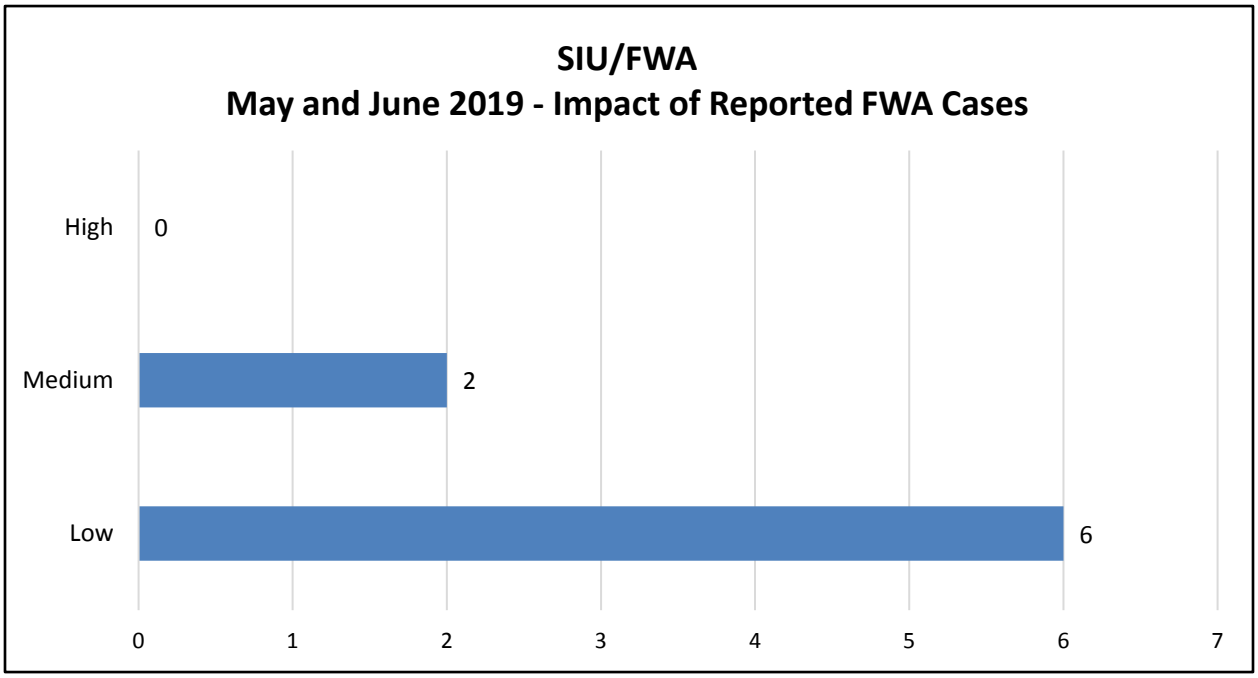
- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.
Back to Agenda

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in May and June 2019)

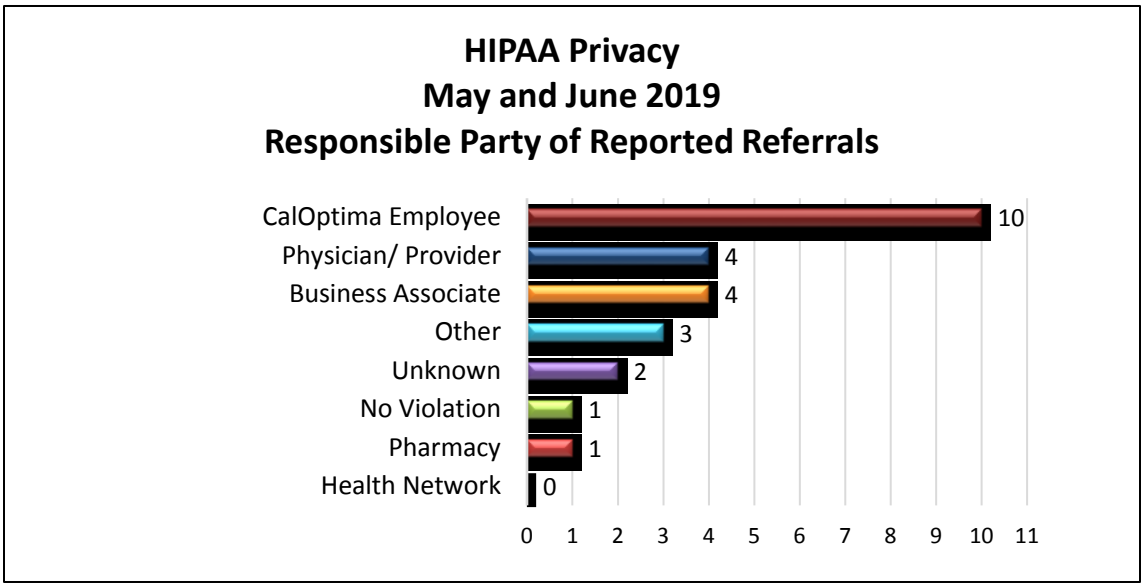


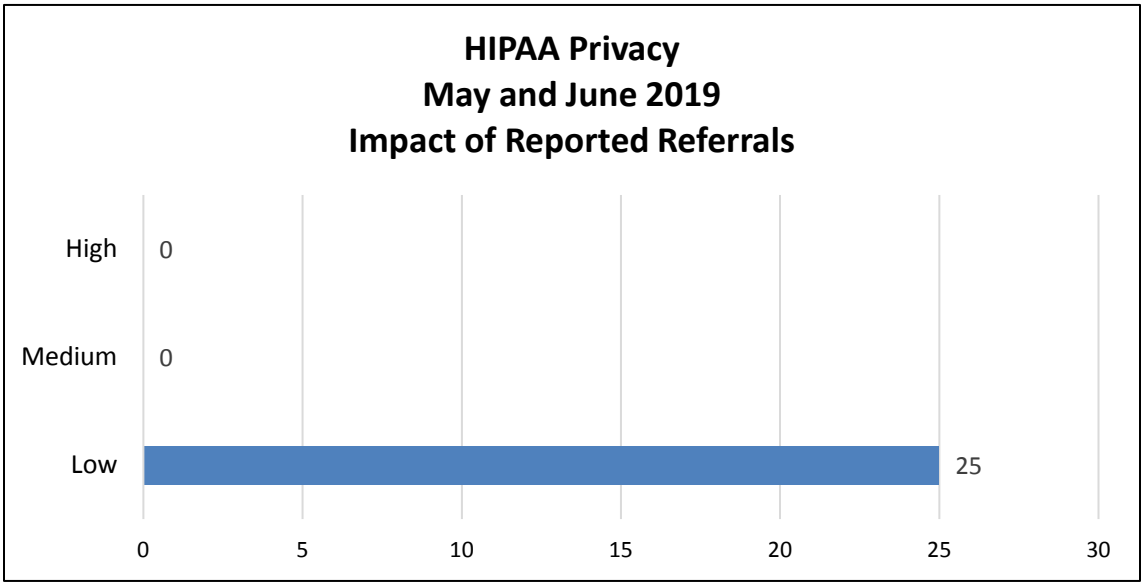


a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

E. Privacy Update (May and June 2019)





Total Number of Referrals Reported to DHCS (State)	25
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**25**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
August 1, 2019

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

May 13, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: May Board of Directors Report

House Democrats are moving forward with appropriations, even as a broad spending caps deal remains out of reach. Meanwhile, committees continue to advance bipartisan drug pricing legislation while previewing the next steps on "surprise billing." This report provides an update on legislative activities through May 13, 2019.

FY 2020 Budget and Appropriations

With no bipartisan agreement on spending levels for Fiscal Year (FY) 2020, House Democrats are nonetheless moving ahead with individual appropriations bills for the coming fiscal year. Appropriations Chairwoman Nita Lowey (D-NY) is following the $664 billion defense limit and $631 billion non-defense limit in legislation (H.R. 2021) she authored with House Budget Chairman John Yarmuth (D-KY). Plans to bring that legislation to the floor before the April recess were scrapped due to objections by members of the Progressive Caucus. However, House Democrats adopted an informal "deeming resolution" (H.Res. 293) to set spending targets that correspond to the total levels in H.R. 2021.

The House Appropriations Committee is proceeding with markups, with the hope that the quick start will give Democrats some leverage in spending cap negotiations. The Senate has yet to settle on overall spending targets, meanwhile, pending action on a disaster aid package. While the Senate Budget Committee approved a budget resolution last month, Senate Republican leaders do not plan to bring the measure to the floor.

On May 8, the House Appropriations Committee voted 30-23 to approve its Fiscal Year (FY) 2020 Labor, Health and Human Services, Education, and Related Agencies spending bill. The measure passed on a party-line vote and includes $189.9 in discretionary funding, an increase of $11.8 billion over the 2019 enacted level and $48 billion higher than the President's FY 2020 budget request. The bill increases funding for the Department of Health and Human Services (HHS) by 9 percent and includes other policy riders to address Democrats' concerns related to Title X family planning grants, exchange plan enrollment outreach, and unaccompanied migrant

Back to Agenda

children. The Labor-HHS Appropriations Subcommittee previously marked up the bill on April 30.

Negotiations between House and Senate leaders and appropriators will likely continue for several months, with the hope of reaching a deal before the Treasury Department's "extraordinary measures" are exhausted around the end of September. While the White House has called for swift passage of a spending agreement, the President is urging Senate Majority Leader Mitch McConnell (R-KY) not to agree to any measure that raises the budget caps. If Congress and the White House were unable to reach agreement on new budget caps before the deadline, automatic sequestration spending cuts would take effect in January.

Drug Pricing Legislation

House committees continue to advance legislation on drug pricing issues. The House Ways and Means Committee advanced a package of drug pricing transparency bills on April 9. The legislation, known as the Prescription Drug Sunshine, Transparency, Accountability and Reporting (STAR) Act, contains several proposals related to price disclosures, rebate transparency, and inpatient hospital drug costs.

On April 30, the House Judiciary Committee advanced several drug pricing bills with bipartisan support, including the CREATES Act, legislation to prohibit "pay-for-delay" settlements, a bill to prevent abuse of the Food and Drug Administration (FDA) citizen petition process, and a measure to require that the Federal Trade Commission (FTC) study the role of pharmacy benefit managers (PBMs) in the drug supply chain.

The full House on May 8 passed two bills to support generic and biosimilar drug competition. The Orange Book Transparency Act (H.R. 1503), sponsored by Rep. Robin Kelly (D-IL), and the Purple Book Continuity Act (H.R. 1520), sponsored by Rep. Anna Eshoo (D-CA), would ensure timely and accurate updates to the Food and Drug Administration's (FDA) list of patents for approved drug and biological products. H.R. 1503 and H.R. 1520 passed by votes of 422-0 and 421-0, respectively. The House will vote the week of May 13 on a legislative package (H.R. 987) that combines three committee-approved drug pricing bills with four Affordable Care Act-related measures. The drug pricing bills are H.R. 965, the CREATES Act; H.R. 1499, the Protecting Consumer Access to Generic Drugs Act; and H.R. 938, the BLOCKING Act. While the prescription drug pricing bills have bipartisan support, Republicans are likely to oppose the package over the inclusion of the ACA bills.

Back to Agenda

On the Senate side, five PBMs testified before the Finance Committee on April 9. Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR) sent a letter to several PBMs the week prior, questioning whether they "are appropriately leveraging their power for the benefit of taxpayers and patients, especially patients who take multiple or high-cost medications." Additional action on drug pricing legislation is expected in the coming months in the Finance Committee and the Health, Education, Labor and Pensions (HELP) Committee. HELP Committee Chairman Lamar Alexander (R-TN) has indicated that drug pricing reforms could move as part of a broader Senate package focused on consumer health care costs.

Policymakers are also awaiting the release of a final regulation from the Centers for Medicare and Medicaid Services (CMS) that would effectively ban drug manufacturers from providing rebates under Medicare Part D plans and Medicaid managed care unless they are offered directly to patients at the pharmacy counter. Recent projections from the Congressional Budget Office (CBO) indicate about $177 billion in savings could be achieved if Congress were to repeal the regulation once it is finalized.

Surprise Billing

President Trump spoke on surprise billing at a White House event on May 9, announcing four principles to guide Congress in developing legislation on the issue:

1. Out-of-network balance billing should be prohibited for emergency care;
2. Patients should be given prices and out-of-pocket costs in advance of scheduled, non-emergency care;
3. Patients should not receive bills from out-of-network providers that they did not choose themselves; and
4. Legislation should protect patients without increasing federal expenditures or reducing patient choice.

The President was joined by Secretary Azar, several Members of Congress, patients, and physicians. Several individuals who had been subject to surprise billing practices shared their experiences and gave their support for a legislative effort to address the problem. Sen. Lamar Alexander (R-TN) said he hopes to send the President legislation in July. The President also previewed a major announcement on health care transparency in the next few weeks, though he did not offer additional details.

A report released by the Congressional Research Service (CRS) on April 15 identified a number of legal and policy issues for Congress to address in surprise billing legislation, including potential preemption of existing state laws.

Opioid Crisis

Sen. Elizabeth Warren (D-MA) and House Oversight Chairman Elijah Cummings (D-MD) on May 8 unveiled their sweeping plan to combat the opioid epidemic. The bill, an updated version of the CARE Act that was introduced in the last Congress, would provide $100 billion over 10 years to fund treatment programs, training for behavioral health providers, public health surveillance, and increased access to naloxone. Notably, the plan includes $500 million to fund projects to increase the capacity of substance use providers under the Medicaid program, such as providing technical assistance, increasing reimbursement for Medicaid providers that prescribe medication-assisted treatment (MAT), and conducting ongoing assessments of state behavioral health treatment needs. Sen. Warren said the bill would be paid for with a 2-percent tax on wealthy earners. The plan would also impose criminal penalties on executives who "deliberately hurt people through criminal negligence," Warren stated.

Fellow 2020 presidential candidate Sen. Amy Klobuchar (D-MN) also outlined her plans to combat addiction and boost mental health services, calling for investments in addiction prevention and treatment as well as repeal of the Institutions for Mental Diseases (IMD) exclusion that bars federal Medicaid reimbursement for those receiving mental health or substance abuse care at facilities with more than 16 beds. Sen. Klobuchar proposes to pay for the plan in part with a two cent-per-milligram fee on active opioid ingredients in prescription medications.

Meanwhile, Rep. Paul Tonko (D-NY) told reporters that he expects the House Energy and Commerce Committee will take up opioid legislation later this year. Rep. Tonko recently introduced the Mainstreaming Addiction Treatment Act (H.R. 2482), which aims to expand access to medication-assisted treatment by removing the requirement that providers obtain a special Drug Enforcement Administration (DEA) waiver in order to prescribe buprenorphine.

CMS Final Rule on Reassignment of Medicaid Provider Payments

CMS on May 2 released a final rule that would remove states' ability to make payments to third parties on behalf of individual Medicaid providers for benefits such as health insurance, skills training, and other benefits. CMS concluded that this provision is not authorized by statute. Democrats including House Education and Labor Committee Chairman Bobby Scott (D-VA) and

Senate HELP Committee Ranking Member Patty Murray (D-VA) criticized the rule and its potential impact on home health workers, who would no longer be able to deduct union fees and benefit payments from Medicaid provider payments. The House Labor-HHS spending bill that passed out of committee on May 8 includes a rider that would block implementation of the rule.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

CALOPTIMA
LEGISLATIVE UPDATE
By Don Gilbert and Trent Smith
July 15, 2019

On July 12 the Legislature adjourned for its month long summer recess. Policy committees have finished their work for the year but the fiscal committees, which review bills to evaluate their financial impact on the state, will have large agendas when the Legislature reconvenes on August 12. The Legislature will work until September 13, when they will adjourn for the year.

Of the bills still pending in the Legislature, the most interesting bill for CalOptima is AB 1642 by Assemblyman Jim Wood. This measure proposes a number of changes to the Medi-Cal program intended to improve the delivery and utilization of services, including changes related to time and distance standards and preventive services and outreach. AB 1642 also codifies the Department of Health Care Services' (DHCS) authority to impose administrative and financial sanctions on Medi-Cal managed care plans (MCP). Many of the proposals in AB 1642 come from recommendations made in the Bureau of State Audits audit focused on Medi-Cal MCP provisions of pediatric preventive services and access to care. The author's stated goal is to improve timely access to medically necessary services, preventative care, and to improve accountability in Medi-Cal MCP performance.

AB 1642 is supported by the Western Center on Law and Poverty, as well as the California Pan-Ethic Health Network, both of which have been consistent critics of Medi-Cal MCP. These organizations argue that AB 1642 outlines steps managed care plans have to take to ensure beneficiaries have access to care within their geographic area or can have transportation provided to access network providers. They also support the greater oversight and accountability of Medi-Cal MCPs through increased sanction authority and alignment of sanctions across the different delivery systems.

The California Association of Health Plans (CAHP) is opposed to AB 1642, unless amended. With regards to the financial penalties, CAHP requests amendments to require, rather than authorize, the director of DHCS to consider certain factors when determining whether -- and what amount of -- sanctions are justified. CAHP also requests amendments to require DHCS to provide a Medi-Cal MCP with advance written notice prior to any formal decision by the DHCS to sanction a plan. CAHP is also requesting language allowing any Medi-Cal MCP response be published alongside the sanction letter on DHCS's website, if requested by the MCP. CAHP is also opposed to the requirement for Medi-Cal MCPs to assist beneficiaries obtain appointments when the Medi-Cal MCP has an alternative access standard. The Local Health Plans of California (LHPC) also opposes the bill, unless it is amended, for reasons similar to those outlined by CAHP.

It should be noted that AB 1642 is authored by Assemblyman Wood, Chairman of the Assembly Health committee. He also represents an area of the state served by Partnership Healthplan, a County Organized Health System (COHS) like CalOptima. Assemblyman Wood is very familiar

with the COHS model and is very supportive of the care Partnership provides his constituents. It is doubtful that Assemblyman Wood is pursuing AB 1642 because of any concerns with COHS. However, LHPC, which CalOptima is a member, is justified to have some concerns with AB 1642. If AB 1642 becomes law, DHCS will have greater authority to impose fines. Meanwhile health plans will have new guidelines in which they are expected to meet. While COHS are likely already meeting these new standards there is no way of predicting how DHCS will interpret or enforce the new policies created under AB 1642. We predict AB 1642 will pass and be signed into law by the Governor. However, amendments could still be adopted in the final month of session.

Another bill of interest to CalOptima is AB 1122, Assemblywoman Jackie Irwin. This bill authorizes Ventura County to conduct a three-year "super user" pilot project, to predict which Medi-Cal beneficiaries are likely to become "super users." The measure requires Gold Coast Health Plan, the COHS serving Ventura County, to report data to the county as part of the pilot project. The county is required to report to the Legislature by July 1, 2023.

"Super-utilizer" or "Super User" is a term used to describe individuals with complex, unaddressed physical, behavioral, and social needs who have frequent encounters with the health care system. Super-utilizers constitute a very small percentage of the population but account for a disproportionally high amount of health care utilization.

This bill is sponsored by Govern for California, which states that this pilot project will provide the state with valuable information in its efforts to improve citizen health while also reducing costs. It will also build on other state efforts to use data to inform public policy decisions, and if successful, could provide a valuable model for other counties, such as Orange County, and for the state.

Ventura County is also in support of this bill. Ventura County states, "The bill will allow better sharing of state-level data with the county and could assist the County in better identifying individuals at risk of complex medical and social service needs. Ventura County supports investing in services and supports earlier intervention in order to avoid higher-cost services later, which promises to result in better health and socio-economic outcomes for individuals."

Back to Agenda

Board of Directors Meeting
August 1, 2019

CalOptima Community Outreach Summary — June and July 2019

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

On June 18, 2019, the Community Relations department and Community Alliances Advisory Committee hosted a Community Alliances Forum at the Delhi Center in Santa Ana. The forums are events designed to bring together our community partners to discuss health care issues impacting our county and serve as a platform to share information, resources and support. The June 18 Forum highlighted results from the 2019 Orange County Point in Time Count and provided an overview of countywide efforts to serve homeless individuals in Orange County.

CalOptima CEO Michael Schrader opened the forum by providing an update on CalOptima's Homeless Health Initiatives, which include the Clinical Field Team Pilot, CalOptima's Homeless Response Team and support for Homeless Navigators in hospitals, Be Well OC and Recuperative Care.

Melissa Tober-Beers, Manager of Strategic Projects, Health Policy, Research and Communication at the Orange County Health Care Agency (OC HCA) provided a comprehensive presentation on the Whole Person Care Program (WPC). Tober-Beers shared information for the county's multi-faceted program that involves multiple agencies working together to expand Orange County's homeless services. WPC ensures coordination of

Back to Agenda

targeted specialized services reach the people in need. To date, the WPC program has served nearly 7,500 unduplicated enrollees.

We were pleased to have Susan Price, the first Director of Care Coordination from Orange County's Chief Executive Office as the featured speaker. Price gave a special presentation on results from the 2019 Orange County Point in Time Count, which detailed information on populations, sub-populations, demographics and community ties for homeless individuals in Orange County. In her presentation, Price highlighted initiatives in the areas of health care, behavioral health, community corrections, housing and benefit and support services. Price is working with cities and community-based organizations to strengthen regional capacity to prevent and address homelessness, coordinate resources to meet the needs of the homeless population in Orange County and promote integration of services throughout the community that improve the countywide response to homelessness.

CalOptima is committed to working with community partners to serve our members and individuals who are homeless. We will continue to provide information and updates on our Homeless Health Initiatives as we continue and expand this work.

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During June and July 2019, CalOptima participated in 43 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
6/03/19	• Parent and Family Supportive Services Faire hosted by Orange County Department of Education
6/04/19	• Collaborative to Assist Motel Families Meeting
6/05/19	• Orange County Aging Services Collaborative Meeting • Orange County Aging Services Initiatives Meeting
6/06/19	• Orange County Homeless Providers Forum
6/10/19	• Fullerton Collaborative Meeting
6/12/19	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting • Orange County Strategic Plan for Aging – Health Care Subcommittee Meeting • Orange County Communication Workgroup Meeting
6/13/19	• Garden Grove Collaborative Meeting • Orange County Women's Health Project Advisory Meeting
6/19/19	• Orange County Communication Workgroup Meeting

Back to Agenda

6/26/19	• Disability Coalition of Orange County Meeting
6/27/19	• Orange County Care Coordination for Kids Meeting • Orange County Care Coordination for Kids Stakeholders Meeting
7/08/19	• Orange County Strategic Plan for Aging – Social Engagement Committee Meeting
7/10/19	• Orange County Strategic Plan for Aging – Health Care Subcommittee Meeting • Orange County Communication Workgroup Meeting
7/11/19	• State Council on Developmental Disabilities Regional Advisory Committee Meeting
7/16/19	• North Orange County Senior Collaborative Meeting • Orange County Cancer Coalition Meeting
7/17/19	• Orange County Communication Workgroup Meeting
7/18/19	• Covered Orange County Quarterly Meeting
7/25/19	• Orange County Care Coordination for Kids Meeting • Orange County Care Coordination for Kids Stakeholders Meeting
7/26/19	• Community Health Research Exchange Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
6/01/19	1	• Annual Life Options Expo hosted by the Garden Rain Foundation
6/03/19	2	• Parent and Family Support Services Faire hosted by Orange County Department of Education (Registration Fee: $50 included one table for outreach during the event)
6/04/19	1	• Living with Aphasia Resource Fair hosted by St. Jude Center for Rehabilitation and Wellness
6/06/19	2	• Orange County Wraparound Resource Fair hosted by Family Support Network
	2	• 17th Anniversary Celebration hosted by Buena Clinton Youth and Family Center
6/07/19	2	• Annual Orange County Hiring Fair hosted by Korean American Chamber of Commerce Foundation (Sponsorship Fee: $1,000 included agency's logo on website and social media promotion, agency's name listed in event program booklet and one table for outreach during event)

Back to Agenda

6/08/19	2	• Clinic in the Park at the Boys and Girls Club of Santa Ana
6/14/19	1	• World Elder Abuse Awareness Day hosted by North Orange County Senior Collaborative (Sponsorship Fee: $1,000 included company's logo on promotional materials [flyers, social media and e-communications], recognition on presentation slides and event programs, recognition and acknowledgement during welcoming remarks, and one resource table for outreach during the event)
	1	• Annual Picnic and Health Fat the Woodbridge Manor Apartment hosted by Living Opportunities Management Company
6/15/19	2	• SoCal Spring Health Fair hosted by Syrian American Medical Society (Registration Fee: $250 included one table for outreach during the event)
6/18/19	2	• Fourteenth Annual Senior Expo at Founders Village Senior Center hosted by the City of Fountain Valley (Sponsorship Fee: $750 included reserved booth location at the event, company's name and logo displayed on inside of banner and on website, announcement of sponsorship during event, door prize and health screening opportunity)
6/22/19	2	• Family Fun Day Community Resource Center hosted by Rancho Santiago Community College District
7/20/19	2	• Health Fair hosted by River Church
7/27/19	2	• Back to School Outreach Event hosted by Collaborative to Assist Motel Families (Sponsorship Fee: $1,500 included company's name and logo on banner and one table for outreach during the event)
	2	• TransPride 2019 Resource Fair hosted by LGBT Center Orange County (Sponsorship Fee: $1,000 included one table for outreach during the event, company's logo on fliers and social media promotion)
	2	• Carnival for Kids and Resource Fair hosted by Illumination Foundation (Sponsorship Fee: $1,000 included recognition in all printed materials, social media platforms and website and one table for outreach)

CalOptima organized or convened the following six community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
6/07/19	• Community-based Organization Presentation for Santa Ana Unified School District FACES staff — Topic: CalOptima: Medi-Cal in Orange County
6/18/19	• Community Alliance Forum — Topic: 2019 Orange County Point in Time Count

Back to Agenda

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
6/06/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center Topic: Healthy Weight Healthy You (English and Spanish)
6/13/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center Topic: Healthy Weight Healthy You (English and Spanish)
6/20/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center Topic: Healthy Weight Healthy You (English and Spanish)
6/27/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center Topic: Healthy Weight Healthy You (English and Spanish)

CalOptima provided one endorsement during this reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Provide a Letter of Support for Central City Community Health Center's application for 2019 Oral Health Infrastructure.

Back to Agenda

CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

August

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Thursday 8/1 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Thursday, 8/1 5:30-7pm	* Health Education Workshop Healthy Weight, Healthy You	Community Presentation Open to the Public Registration Required	N/A	Ponderosa Park Family Resource Center 320 E. Orangewood Ave. Anaheim
Friday, 8/2 10-11am	++Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Monday, 8/5 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 8/6 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 8/7 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 8/7 10am-12pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 8/7 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Thursday, 8/8 11:30am-12:30pm	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 8/8 12:30-1:30pm	++Kid Health Advisory Committee Mtg	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC 1901 E. Fourth St. Santa Ana
Thursday, 8/8 2:30-4:30pm	++OC Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana

Thursday, 8/8 5:30-7pm	* Health Education Workshop Healthy Weight, Healthy You	Community Presentation Open to the Public Registration Required	N/A	Ponderosa Park Family Resource Center 320 E. Orangewood Ave. Anaheim
Saturday, 8/10 10am-1pm	+City of Fullerton Health and Wellness Fair	Health/Resource Fair Open to the public	2 Staff	Fullerton Community Center 340 W. Commonwealth Ave. Fullerton
Monday, 8/10 1-2:30pm	+OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 8/10 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 8/13 9-10:30am	++Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 8/14 10-11:30am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 8/14 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 8/14 3-4:30pm	++OC Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 8/15 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana

Thursday, 8/15 2:30-4:30pm	++Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center Central Park 18041 Goldenwest St. Huntington Beach
Thursday, 8/15 5:30-7pm	* Health Education Workshop Healthy Weight, Healthy You	Community Presentation Open to the Public Registration Required	N/A	Ponderosa Park Family Resource Center 320 E. Orangewood Ave. Anaheim
Saturday, 8/17 9am-1pm	+City of Buena Park Super Senior Saturday	Health/Resource Fair Open to the Public	2 Staff	Buena Park Senior Center 8150 Knott Ave. Buena Park
Tuesday, 8/20 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 8/20 10-11:30am	++OC Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	American Cancer Society 1940 E. Deere Ave. Santa Ana
Wednesday, 8/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 8/21 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 8/21 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Thursday, 8/22 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana

Thursday, 8/21 5:30-7pm	* Health Education Workshop Healthy Weight, Healthy You	Community Presentation Open to the Public Registration Required	N/A	Ponderosa Park Family Resource Center 320 E. Orangewood Ave. Anaheim
Saturday, 8/25 11am-4pm	+Depression and Bipolar Support Alliance Ridiculous Goodness Event	Health/Resource Fair Open to the Public	2 Staff	Tri-City Park - 2301 Kraemer Blvd. Placentia
Monday, 8/26 9-11am	++Community Health Research and Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Tuesday, 8/27 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Wednesday, 8/28 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St., Anaheim
Thursday, 8/29 10am-1pm	+Saddleback College Annual Veterans Resource Fair	Health/Resource Fair Open to the Public	2 Staff	Saddleback College Student Quad 28000 Marguerite Pkwy Mission Viejo
Thursday, 8/29 5:30-7pm	* Health Education Workshop Healthy Weight, Healthy You	Community Presentation Open to the Public Registration Required	N/A	Ponderosa Park Family Resource Center 320 E. Orangewood Ave. Anaheim