NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, OCTOBER 3, 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

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. National Committee for Quality Assurance Health Plan Rating
   b. Strategic Planning
   c. Health Care Delivery System Study
   d. Orange County Community Indicators Report
   e. Homeless Health Initiatives
   f. California Advancing and Innovating Medi-Cal (CalAIM)
   g. Be Well OC Groundbreaking
   h. CalOptima Foundation Dissolution

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 September 5, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the August 8, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Appointments of OneCare Connect Member Advisory Committee Chair and Vice Chair

4. Consider Adopting Resolution No. 19-1003-01 Amending Resolution No. 12-0301-01 to Amend CalOptima Policy GA.3202: CalOptima Signature Authority

5. Consider Authorizing the Issuance of a Request for Proposal(s) for CalOptima Real Estate Related Services

6. Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating and Capital Budgets for Various Information Services Items

7. Consider Authorizing Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2020

8. Consider Approval of Reappointments to the Board of Directors' Investment Advisory Committee

9. Consider Revising the Membership of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS

10. Consider Accepting and Receiving and Filing the Fiscal Year 2019 CalOptima Audited Financial Statements

11. **Acting as the CalOptima Foundation Board of Directors:** Consider Accepting and Receiving and Filing the Fiscal Year 2019 CalOptima Foundation Audited Financial Statements

12. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards Community Grants for Access to Children's Dental Services

13. Consider Authorizing Supplemental Payments to Health Networks for Specific Home Health Agency Services

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

15. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Associated with AltaMed Health Services Corporation to include language for the Health Homes Program

16. Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services

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

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

19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

20. Consider Modifications to CalOptima Quality Improvement Policies and Procedures Related to Annual Policy Review

21. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model Program and Merit-based Incentive Payment System (MIPS) Payment Adjustment

22. Consider Authorizing Unbudgeted Operating Expenditures For Royalty Fees For Use Of The American Medical Association Current Procedural Terminology Codes

ADVISORY COMMITTEE UPDATES

23. OneCare Connect Member Advisory Committee Update

24. Provider Advisory Committee Update

INFORMATION ITEMS

25. Health Homes Program Update

26. August Financials

27. Compliance Report

28. Federal and State Legislative Advocates Report

29. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

MEMORANDUM

DATE:	October 3, 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

CalOptima Maintains High Quality Rating, Earning Recognition for the Sixth Year
For the past five years, September has brought CalOptima good news in the quality arena, and this year is no exception. Extending our track record as one of California's top rated Medi-Cal plans, CalOptima has earned a rating of 4 out of 5 in the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2019–2020. No other California Medi-Cal plan scored higher than a 4. Notably, we saw an improvement in the Consumer Satisfaction component of the rating to 2.5, with our Prevention rating at 4 and Treatment rating at 3.5. This comes on the heels of CalOptima's annual NCQA accreditation renewal at the Commendable level again. This level signifies that CalOptima meets or exceeds NCQA's rigorous requirements for clinical quality, member satisfaction and NCQA accreditation survey results. CalOptima's provider partners share in this recognition, and we thank them for serving our members with such a commitment to quality.

Strategic Planning Process Continues This Month With Advisory Committee Meeting
CalOptima is strengthening our 2020–22 strategic planning process by inviting feedback on the strategic priorities developed in August by the Board of Directors and executive team. On October 10, Chapman Consulting, CalOptima's strategic planning consultant, will lead a special joint session combining the membership of our four advisory committees: Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee. The group of up to 43 representatives will consider the current health care landscape in relation to the initial priority areas that pertain to members, value, stakeholders, sustainability and innovation. Chapman Consulting will integrate the community's feedback and bring a draft plan for Board review in November, with the intent of obtaining approval on a final plan in December.

CalOptima To Seek More Provider Feedback on Delivery System Study
At the Board's request, CalOptima is working on a comprehensive study of our health care delivery system, which is being conducted by Pacific Health Consulting Group. As part of the process, Pacific Health Consulting has made public presentations about the study background and methodology. However, CalOptima received considerable feedback from the provider community that more engagement is necessary to understand the study's analysis and possible recommendations that could affect physicians, hospitals and health networks. To address these concerns, we are working on an adjustment to our original project scope to allow for additional vetting by the provider community while still recognizing your Board's primary role as the

Back to Agenda

requestor of the study. To that end, Pacific Health Consulting has been invited to deliver an information item containing recommendations first at the November 7 Board meeting and then at the Provider Advisory Committee on November 14. Having presentations at both meetings will ensure that there is opportunity for all interested stakeholders to provide input before the Board considers taking action on the final report at its December meeting. While this may result in a slight increase in the cost of the overall engagement, ensuring provider inclusion and involvement now will mean better results and greater acceptance of any delivery system changes your Board may consider in the future.

Orange County Community Indicators Report Tracks Health Care Trends
The 2019–20 edition of the Orange County Community Indicators report was released on September 19. CalOptima is one of five report sponsors, alongside Orange County Business Council, United Way, Children and Families Commission, and Orange County Community Foundation. Access to an online version is available here. Starting on Page 89, the health section covers trends in Medi-Cal membership, health and fitness, chronic disease, mental health and substance abuse, as well as other topics.

Work on Homeless Health Initiatives Highlights Progress and Partnerships
CalOptima's ongoing dedication to improving homeless health is evident in our efforts to raise awareness and respond to community needs. Below are summaries of several recent activities.

- *Clinical Field Team (CFT) Statistics:* In the four weeks from August 23 to September 19, CalOptima dispatched 73 CFTs to provide urgent-care-type services to individuals experiencing homelessness. In that same time, nine were referred to recuperative care. CalOptima is proud of the progress made in the past five months since launching the CFT program, and we thank our community health center partners for their service.
- *Targeted City-Based Outreach:* CalOptima was asked to support efforts in two cities: San Clemente and Fullerton. CalOptima partnered with the Orange County Health Care Agency's Outreach and Engagement team at the San Clemente homeless encampment. Four CalOptima staff participated, calling out our South Orange County CFT partner, Families Together, to serve four patients on-site. Staff also assisted several CalOptima members with PCP changes, ID cards and transportation arrangements. Separately, CalOptima was present to support homeless individuals in need during Fullerton's process of cleaning up a sidewalk encampment on Gilbert Street.
- *Provider Workgroup:* With meetings on September 10 and 24, CalOptima continued the Outreach and Navigation Workgroup to keep health network and hospital leaders informed about our homeless health efforts and to collaborate on enhancing the delivery model. The September 10 meeting featured a presentation about the Orange County Social Services Agency, including Medi-Cal enrollment and redetermination as well as other programs, such as CalFresh and CalWORKs. The September 24 event worked to identify priority areas and opportunities to improve clinical services.
- *CFT Presentations:* Directors Sloane Petrillo (Case Management) and Debbie Kegel (Strategic Development) continued their series of in-services about our CFT services to potential referral sources at shelters. In September, they provided educational presentations to staff at the Homeless Multiservice Center in Santa Ana and the Costa Mesa Bridge Shelter.
- *Shelter Tours:* CalOptima staff toured four facilities serving the homeless in September. These include two facilities in Laguna Beach operated by Friendship Shelter. In Anaheim, staff visited Broadway Recuperative Care and a micro-community (6-bedroom house), both

operated by Illumination Foundation. The tours provided an opportunity to share information about CalOptima's resources for the homeless population.

State Regulators Preparing to Debut California Advancing and Innovating Medi-Cal (CalAIM)

This month, the Department of Health Care Services (DHCS) is expected to unveil CalAIM, a multiyear initiative to implement overarching policy changes across all Medi-Cal delivery systems. Key goals are to reduce variation and complexity, to apply population health management strategies, and to improve outcomes through value-based initiatives. DHCS plans to conduct stakeholder engagement for both CalAIM and the renewal of the 1115 waiver, which expires at the end of 2020. Five stakeholder workgroups are being formed to address the following topics: population health management and annual health plan open enrollment; NCQA accreditation; enhanced care management and in-lieu-of services; behavioral health; and full integration pilots. CalOptima will carefully track CalAIM and participate as appropriate.

Orange County to Celebrate New Mental Health Resource at Groundbreaking

A groundbreaking ceremony for the Be Well OC Regional Mental Health and Wellness Campus on Anita Drive in Orange is planned for October 16. CalOptima contributed $11.4 million toward services at the campus. Orange County supervisors and representatives from the sponsoring organizations, including CalOptima, have been invited to make brief remarks.

CalOptima Foundation Progressing Toward Dissolution by the End of 2019

The CalOptima Foundation Board approved dissolution of the Foundation on December 6, 2018. The dissolution is on track to be done by the end of 2019. CalOptima received a notice from the Attorney General's office on May 16 waiving objection to the dissolution of the Foundation assets. The notice, along with dissolution forms, were submitted to the California Secretary of State's office, and approval of dissolution is pending. Funds in the amount of $2,866,910.23 were transferred to CalOptima on May 31, 2019. Staff is facilitating activities to prepare for the review of the final tax returns and audited financials. Below are next steps:

- Staff receives complete preparation of the Foundation final tax returns and audited financials (anticipated early November)
- Foundation FAC reviews final tax returns (anticipated for the November meeting)
- CalOptima Board reviews Foundation's audited financials, along with CalOptima's consolidated financials (anticipated for the December meeting)
- Staff files final tax return
- CalOptima receives confirmation of dissolution from the Secretary of State and final audited financials filed with the Attorney General

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

September 5, 2019

A Regular Meeting of the CalOptima Board of Directors was held on September 5, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:08 p.m. Supervisor Do led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Ron DiLuigi

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 reordered the agenda to hear Agenda Item 14, CalOptima HealthCare Services Delivery Model Evaluation Update after the Consent Calendar.

Chair Yost also announced that Agenda Item 11 would be continued to a future meeting.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Schrader, CEO, highlighted several items from his CEO Report including the CalOptima Strategic Planning Session held on August 9, 2019, noting that based on Board discussion at the session, development of the Strategic Plan would include a focus on the following initial priority areas: members, value, stakeholders, sustainability, and innovation. Mr. Schrader added that the consultants from Chapman Consulting will be meeting with the Board's advisory committees in early October to solicit feedback. As currently planned, a draft Strategic Plan document will be brought to the November Board meeting.

Mr. Schrader mentioned that the state released an RFP on August 22, 2019 for a statewide pharmacy benefit manager that would implement the governor's Medi-Cal pharmacy benefit carve-out plan, and that a number of key stakeholders are calling for additional time for vetting stakeholder feedback and RFP responses.

Mr. Schrader shared that CalOptima's PACE center's enrollment continues to grow, noting we currently have 357 participants enrolled.

Back to Agenda

In addition, Mr. Schrader also provided a brief timeline of the meetings and presentations to the Board on the CalOptima HealthCare Services Delivery Model Evaluation which is ongoing, noting that we will receive another update from Pacific Health Consulting Group's Tim Reilly at today's meeting.

PUBLIC COMMENTS

1. Quynh Kieu, M.D. – Oral Re: Reimbursement for pediatric services (CHDP)
2. Le Dao, M.D. – Oral Re: Pediatric reimbursement
3. Peter Vu, M.D., Community Pediatrics – Oral Re: Pediatric reimbursement
4. Pamela Pimentel, R.N., MOMS Orange County – Oral Re: Breast Milk Drive
5. Mark Richard Daniels, Housing is a Human Right OC – Oral Re: Homeless Outreach
6. Mike Robbins, Peoples Homeless Task Force OC – Oral Re: Agenda Item 16, Consider Actions related to Homeless Health Care Delivery

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the August 1, 2019 Regular Meeting of the CalOptima Board of Directors and the August 9, 2019 Special Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the April 25, 2019 Regular Meeting of the OneCare Connect Member Advisory Committee; the June 13, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the June 13, 2019 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider authorizing Changes to Allowable Rates for Services Provided by Nurse Practitioners and Physician Assistants at the Program of All-Inclusive Care for the Elderly (PACE) Clinic

4. Consider Appointments of Member Advisory Committee Chair and Vice Chair

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 7-0-1; Director Schoeffel recused for Item 3 due to potential conflicts of interest; Supervisor Do abstained on Item 3 due to potential conflicts of interest under the Levine Act)***

INFORMATION ITEM

14. CalOptima HealthCare Services Delivery Model Evaluation Update

Tim Reilly of Pacific Health Consulting Group (PHCG) presented an update on progress on their review of CalOptima's healthcare delivery system. Mr. Reilly's presentation focused on describing network reimbursement models and how these various models can be used to influence provider behavior.

Mr. Reilly provided an overview of the various reimbursement models including fee-for-service (FFS), bundled payments, pay for performance (P4P), shared savings, shared risk (up-side and down-side), and capitation. He noted that nationally and in California, health plans use various reimbursement

Back to Agenda

models and that there are advantages and disadvantages to each approach depending on the desired outcome.

In terms of next steps, Mr. Reilly noted that PHCG would be attending the September 12, 2019 Provider Advisory Committee meeting to solicit feedback before presenting recommendations to the Board in November.

REPORTS

5. Consider Ratifying Revisions to CalOptima Financial Policies and Procedures Related to the Whole-Child Model Program

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors ratified revisions to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks, effective July 1, 2019. (Motion carried 8-0-0)***

6. Consider Authorizing Supplemental Payments to Health Networks for Specific Home Health Agency Services
This item was continued to a future meeting due to lack of a quorum.

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

Action: ***On motion of Vice Chair Khatibi, seconded and carried the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendment A08 to the PACE Agreement between the Department of Health Care Services and CalOptima regarding Calendar Year 2019 capitation rates and other changes to contractual requirements. (Motion carried; 8-0-0)***

8. Consider Actions Related to CalOptima's Health Homes Program
This item was continued to a future meeting due to lack of a quorum.

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
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 potential conflicts of interest based on his role as a physician anesthesiologist with CHOC. 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 Penrose, seconded and carried, the Board of Directors 1) Approved 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) Directed the Chief Executive Officer, 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. (Motion carried 5-0-1; Director Schoeffel absent; Chair Yost recused; Supervisor Do abstained)

10. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events
Supervisor Do recommended that the expenditure for the Vietnamese Physician Association of Southern California (VPASC) Foundation be increased from up to $3,000 to up to $10,000.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1.) Authorized expenditure for CalOptima's participation in the following events: a.) Up to $1,500 and staff participation at Somang Society Conference 2019 on Saturday, October 12, 2019 at Grace Ministries International in Fullerton; b.) Up to ~~$3,000~~ $10,000 and staff participation at the Vietnamese Physician Association of Southern California (VPASC) Foundation's 2019 OC Free Health Fair on Sunday, October 27, 2019 at Freedom Hall at Mile Square Park in Fountain Valley; c.) Up to $3,000 and staff participation at the Alzheimer's Orange County's 10th Annual Latino Conference on Saturday, November 16, 2019 at Templo Calvario Church in Santa Ana; 2.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3.) Authorized the Chief Executive Officer to execute agreements as necessary for events and expenditures. (Motion carried 8-0-0)***

11. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services
This item was continued to a future meeting.

ADVISORY COMMITTEE UPDATES

12. Provider Advisory Committee Update
John Nishimoto, PAC Chair, noted that the report for the PAC's August 8, 2019 meeting was included in the meeting materials. Dr. Nishimoto also mentioned that the PAC will be recognizing long standing members Mary Pham and Steve Flood for their service on the PAC.

13. Member Advisory Committee Update
Christine Tolbert, newly appointed MAC Chair, thanked the Board for approving the recommended MAC Chair and Vice Chair appointments. Ms. Tolbert provided a brief update on the MAC's August 8, 2019 meeting.

INFORMATION ITEMS

Back to Agenda

14. CalOptima HealthCare Services Delivery Model Evaluation Update
This item was heard after the Consent Calendar

The following Information Items were accepted as presented:
15. July Financial Summary
16. Compliance Report
17. Federal and State Legislative Advocates Reports
18. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Nguyen announced that he has finished his residency and started a new position at the Veteran's Administration Hospital in Long Beach.

Director Penrose commented that he toured the facilities of Healthy Smiles for Kids and thanked Director Berger for arranging the tour. Director Penrose also mentioned a letter that the Board recently received from the provider community. The letter expresses concerns about the action taken at the Board's June 27, 2019 Special Meeting specific to providing health care services for homeless members, and about the importance of engaging CalOptima's provider partners as such decisions are being made. In light of these concerns, he asked that staff obtain input from Board members and other stakeholders, and return with recommendations on parameters and a framework the Board could apply in funding and approving specific homeless health initiatives.

Chair Yost commented that the Board members agree on much more than they disagree on, and emphasized the importance of working collaboratively.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 3:37 p.m.

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

Approved: October 3, 2019

Back to Agenda

MINUTES

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

August 8, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 8, 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. Member Patton led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anja Batra, M.D. (8:12 A.M); Donald Bruhns; Tina Bloomer, MHNP; John Kelly, M.D. (8:08 A.M); Junie Lazo-Pearson, Ph.D.; Craig Myers; Pat Patton, MSN, RN; Jacob Sweidan, M.D.; Loc Tran, Pharm.D.

Members Absent: Jena Jensen

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 Management; Tracy Hitzeman, Executive Director, Clinical Operations; Candice Gomez, Executive Director, Program Implementation; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant.

PAC members welcomed new members, John Kelly, M.D., as the Physician Representative and Loc Tran, Pharm.D., as the Pharmacy Representative. Dr. Kelly and Dr. Tran were both appointed by the CalOptima Board at its meeting on June 6, 2019. Chair Nishimoto notified the members of the passing of Dr. Theodore Caliendo, long time PAC member, and also noted the resignation of Brian Lee, L.Ac., Ph.D., PAC's Allied Health Representative. The PAC will begin an active recruitment for the Allied Health Representative.

Back to Agenda

MINUTES

Approve the Minutes of the June 13, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Patton, seconded and carried, the Committee approved the minutes of the June 13, 2019 meeting. (Motion carried 10-0-0; Members Batra and Jensen absent)***

PUBLIC COMMENTS

There were no requests for public comment.

REPORTS

Consider Recommendation for Long-Term Services and Supports Representative (LTSS)
Member Dr. Sweidan summarized the LTSS recommendation on behalf of the PAC Nominations Ad Hoc Committee. After discussion, it was recommended that the PAC reopen the recruitment for the LTSS Representative.

Action: ***On motion of Vice Chair Miranti, seconded and carried, the Committee directed Staff to continue recruitment of candidates for the LTSS Representative. (Motion carried 11-0-0; Member Jensen absent)***

CEO & MANAGEMENT REPORTS

Chief Executive Officer Update
Michael Shrader, Chief Executive Officer, notified the PAC that a Special Meeting of the CalOptima Board of Directors would be held on Friday, August 9, 2019. Mr. Schrader stated that no actions are expected to be taken at the special meeting, which will start the process of developing a three-year Strategic Plan for 2020-23.

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, provided an update on the July 1, 2019 Whole-Child Model (WCM) program implementation. Ms. Khamseh noted that the transition has been smooth to date with the help of the providers and health networks. She also mentioned that staff from CalOptima, California Children's Services (CCS), and health networks and providers, have daily calls to ensure continuity of care for members. Ms. Khamseh also informed the PAC that CalOptima continues to provide daily updates to the Department of Health Care Services (DHCS) on the transition of members into the WCM program. In addition, CalOptima communicates with members and providers on the benefits of the program and outreach continues to non-contracted providers for contracting opportunities.

Back to Agenda

Chief Financial Officer Update
Nancy Huang, Interim Chief Financial Officer, provided an overview of the June 2019 unaudited financials. She also provided an update on the Health Home Program's original rates, which CalOptima received from the state in April 2018, and noted that they had been updated by DHCS as of July 26, 2019.

Chief Medical Officer Update
David Ramirez, M.D. Chief Medical Officer, provided a verbal update on the Health Homes Program, noting that starting on January 1, 2020, CalOptima will manage the behavioral health benefit for the OneCare and OneCare Connect programs, which are currently managed by Magellan Health. Dr. Ramirez also updated the PAC on the Homeless Health Initiatives and noted that the Board approved additional funding for mobile clinics to provide care at shelters for all CalOptima members regardless of their network. Dr. Ramirez mentioned that the State is updating its quality measures and CalOptima will incorporate these changes into its programs. In addition, Dr. Ramirez informed the PAC that DHCS is in the process of updating policies related to its Telehealth program and that we are awaiting the release of the relevant All Plan Letter (APL) and updated provider manual.

Network Operations Update
Michelle Laughlin, Executive Director, Network Operations, provided an update on the July 2019 DHCS Network Adequacy requirement and the work currently underway to be ready for the March 2020 submission to the state. Ms. Laughlin noted that CalOptima is addressing deficiencies noted by DHCS specific to OB/GYN PCPs located in the South Orange County area and mentioned that Network Adequacy requirements are mandatory for the delegated health networks as well

INFORMATION ITEMS

Health Homes Program Update
Pallavi Patel, Director, Process Excellence, provided an update on the Health Homes Program (HHP). Ms. Patel noted the CalOptima anticipates a launch date of January 1, 2020 for members with chronic conditions, and July 1, 2020 for those with serious mental illness with or without a chronic medical condition. She also mentioned that the DHCS goal for the HHP is to ensure sufficient provider infrastructure and capacity to implement HHP as an entitlement benefit, and to ensure that HHP providers are appropriately serving members experiencing homelessness. Ms. Patel further advised the PAC that CalOptima and its delegated health networks would be expected to participate in HHP to provide HHP-related services to their respective assigned members.

New CalOptima Website Demonstration
Geoff Patino, Manager, Creative Branding and Rudy Huebner, Graphic Designer, Communications, provided a visual demonstration of CalOptima's updated website.

Back to Agenda

Federal and State Budget Update

Shamiq Hussain, Sr. Policy Advisory, Government Affairs, provided an update on the California state budget. Mr. Hussain discussed Proposition 56's (Tobacco Tax) new proposed supplemental payments and noted that the payments would remain in their current form and at current payment levels. Mr. Hussain also discussed the anticipated expansion of the full scope Medi-Cal to the undocumented population starting with ages 19-25. This expansion is anticipated to go into effect no sooner than January 1, 2020. Based on analysis from the California Legislature, it is anticipated that there could be 90,000 new enrollees across the state based on this expansion. Mr. Hussain also discussed the Pharmacy carve-out being put forward by Governor Newsom.

PAC Member Updates

Chair Nishimoto reminded PAC members to let Staff know if they had any agenda items for the September 12, 2019 meeting. Chair Nishimoto also reminded the PAC members of their upcoming annual compliance training obligation.

ADJOURNMENT

There being no further business, Chair Nishimoto adjourned the meeting at 10:20 a.m.

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

Approved: September 12, 2019

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Appointments of OneCare Connect Member Advisory Committee Chair and Vice Chair

Contact

Belinda Abeyta, Interim Executive Director, Operations, (714) 246-8400

Recommended Actions

The OneCare Connect Member Advisory Committee (OCC MAC) recommends:

A. Appointment of Patty Mouton as the Chair and the appointment of Gio Corzo as the Vice Chair, each for one-year terms ending June 30, 2020.

Background

The CalOptima Board of Directors welcomes community stakeholder involvement and benefits from their input in the form of advisory committees. The Center for Medicare & Medicaid Services (CMS) and the State of California Department of Health Care Services (DHCS) established requirements for the implementation of the Cal MediConnect program, including a requirement for the establishment of a Cal MediConnect Member Advisory Committee. The CalOptima Board of Directors established the OneCare Connect Member Advisory Committee (OCC MAC) by resolution on February 5, 2015 to provide input and recommendations to the CalOptima Board relative to the OneCare Connect program, the Cal MediConnect program administered by CalOptima.

The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or family of members. There are also four non-voting members representing Orange County agencies. OCC MAC voting members serve two-year terms, with no limit on the number of terms a representative may serve.

Pursuant to Resolution No. 15-0205, the CalOptima Board of Directors is responsible for the appointment of the Chair annually from among appointed members. The Chair may serve two consecutive one-year terms.

Pursuant to Resolution No. 16-0804, the CalOptima Board of Directors is responsible for the appointment of the Vice Chair annually from among appointed members. The Vice Chair may serve two consecutive one-year terms.

Discussion

In the month leading up to the August 22, 2019 meeting, members of the OCC MAC were asked to submit letters of interest for the Chair and Vice Chair positions to the Staff of the Advisory Committees. Prior to the August 22, 2019 meeting, OCC MAC members received information on the interested candidates for the Chair and Vice Chair positions. Patty Mouton submitted a letter of interest for the Chair and OCC MAC voted to recommend Patty Mouton. Gio Corzo also submitted a letter of interest for the Vice Chair.

Back to Agenda

Recommended candidates for Chair and Vice Chair are as follows:

OCC MAC Chair
Patty Mouton*

Ms. Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in health care for over thirty years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. Ms. Mouton is active in the community, speaking on many issues impacting seniors, including hospice, dementia and palliative care. Ms. Mouton is also the Medi-Cal Beneficiary representative on the Member Advisory Committee.

OCC MAC Vice Chair
Gio Corzo*

Mr. Corzo is the Vice President of Home & Care Services for SeniorServ. He has twenty years of health care experience and expertise in strategic planning, development and operations of multiple health facilities, including CBAS centers, Day Programs and residential long-term care facilities. Mr. Corzo was instrumental in working on the State transition of Adult Day Health Care (ADHC) to CBAS.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
An open nomination was held at the August 22, 2019 OCC MAC meeting based on the letters of interested received and there were no additional nominations from the floor. The OCC MAC forwards the recommended Chair and Vice Chair to the Board of Directors for consideration.

Concurrence
OneCare Connect Member Advisory Committee
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *9/25/2019*
Authorized Signature — **Date**

*Indicates OCC MAC recommendation

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Adopting Resolution No. 19-1003-01 Amending Resolution No. 12-0301-01 to Amend CalOptima Policy GA.3202: CalOptima Signature Authority

Contact

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

Recommended Actions

Adopt Resolution 19-1003-01 Amending Resolution No. 12-0301-01 to Amend CalOptima Policy GA.3202: CalOptima Signature Authority.

Background

The CalOptima Board of Directors is the legislative body of CalOptima and is responsible for making all fundamental policy determinations. Within the parameters of the legal framework in which CalOptima operates, the Board may delegate certain authority to staff or to Board committees to execute decisions on behalf of the Board, provided that these delegations are accompanied by adequate transparency and safeguards to guide the use of the delegated power and prevent abuse.

On March 1, 2012, the CalOptima Board of Directors adopted CalOptima Resolution No. 12-0301-01, which delegated authority to the CEO to make budget allocation changes within certain parameters, approve revisions to the Procurement Policy, adopt a Signature Authority Policy, and adopt other governance recommendations. Specifically, the Signature Authority Policy sets forth a clear delegation of authority for the execution of various types of documents binding CalOptima.

Discussion

Due to operational changes and efficiencies, Staff recommends revising CalOptima Policy GA.3202: CalOptima Signature Authority. The following provides a summary of the revisions.

- Under Section III.C.2.a.ii., revised procedure for signing authority for CalOptima Direct contracts that contain no changes from the standard boilerplate contract and are for rates that do not exceed the Board approved rates for healthcare goods and services. Specifically, due to changes to titles, revised the authorized signatory list from "CEO, Chief Operating Officer (COO), or the Executive Director, CalOptima Care Network" to "CEO, COO, or Executive Director, Network Operations;"

- Updated Section III.C.2.b., to reflect the change in name of the responsible department, "Purchasing" was revised to "Budget and Vendor Management"; and

- Under Section III.C.2.b.iv., updated signature authority for documents for $25,000 or less from "Director of Financial Compliance" to "Director of Budget and Procurement" to reflect the shift of procurement responsibilities as a result of organizational restructuring.

Back to Agenda

In addition to the proposed changes noted above, the attached red-lined version of the policy reflects other minor, non-substantive formatting revisions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended action will enhance the efficiency of CalOptima's operations and governance.

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

Attachments
1. Resolution No. 19-1003-01 Amending Resolution No. 12-0301-01 to Amend CalOptima Policy GA. 3202: CalOptima Signature Authority
2. Proposed Revised CalOptima Policy GA.3202, CalOptima Signature Authority Policy (redlined and clean)
3. Board Action dated March 1, 2012, Adopt Resolution No. 12-0301-01, Delegating Authority to the Chief Executive Officer to make Budget Allocation Changes Within Certain Parameters, Approve Revisions to the Procurement Policy, Adopt a Signature Authority Policy, and Adopt Other Governance Recommendations

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 19-1003-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

AMENDING RESOLUTION NO. 12-0301-01 TO REPLACE CALOPTIMA POLICY GA.3202: CALOPTIMA SIGNATURE AUTHORITY

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, purchasing and acquiring the use of equipment and supplies, and acquiring, constructing, and leasing real property and improvements; and

WHEREAS, the CalOptima Board of Directors adopted Resolution No. 12-0301-01 on March 1, 2012, delegating authority to make budget allocation changes to the Chief Executive Officer (CEO) within certain parameters, approving revisions to the Procurement Policy, adopting a Signature Authority Policy, and delegating authority to the CEO to manage CalOptima's Records Retention Policy; and

WHEREAS, the Board of Directors now wishes to update the CalOptima Signature Authority Policy to reflect operational changes and efficiencies.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the CalOptima Signature Authority Policy attached to Resolution No. 12-0301-01 is hereby amended by amending CalOptima Policy GA.3202: CalOptima Signature Authority Policy, as set forth in the attachment hereto and incorporated herein.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 3rd day of October 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

Back to Agenda

Policy ~~#~~: GA.3202
Title: **CalOptima Signature Authority**
Department: CalOptima Administrative~~Finance~~
Section: Finance~~Financial Affairs~~
CEO Approval: Michael Schrader ~~Michael Schrader~~

Effective Date: ~~3/1/12~~ 03/01/2012
~~Last~~ Revised Date: TBD ~~Revised: 7/1/12, 3/1/13~~

DRAFT 20190919FAC

I. PURPOSE

This policy sets forth the requirements for the execution of any document binding CalOptima in any manner.

II. POLICY

A. A CalOptima officer or employee may not expend any funds, or take any other action on behalf of CalOptima, unless the Board of Directors (Board) has approved such expenditure or action, or delegated its power to that officer or employee, subject to an articulated standard.

B. No document of any type whatsoever that binds CalOptima to undertake or refrain from undertaking any action, or to expend any CalOptima funds, shall be entered into except pursuant to this policy.

C. In order for any document to bind CalOptima, the Board of Directors must have: (1) appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima representative, as identified in this policy.

D. Amendments or other changes to any document binding CalOptima must be approved and executed in the same manner as the original document, except for minor price deviations, as provided within this policy.

III. PROCEDURE

A. Board of Directors Appropriation: Except in emergency circumstances, as set forth CalOptima Policy GA.5002: Purchasing ~~Policy~~, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or

individual Board action, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in this policy.

B. Board of Directors Approval: No document binding CalOptima shall be entered into except pursuant to the approval of the CalOptima Board of Directors. In approving, the Board may delegate to a CalOptima officer the authority to enter into agreements that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action: To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements, as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement (contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget: To constitute an authorization through inclusion in CalOptima's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

   a. Healthcare goods and services (for the direct provision of Covered Services): The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

   b. Non-healthcare-related goods and non-professional services: To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The description of specific goods, services or other expenditure;

      ii. The number or duration of the goods, services or other expenditure items if available; and

      iii. The dollar amount of the expenditure.

   c. Non-medical professional services: Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation, etc.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer, etc.);

DRAFT 20190918AC

ii. The objective of the professional services; and

iii. The amount of the expenditure.

C. Signature Authority: Documents executed pursuant to Board Authority, as identified in Section III.B of this policy, may only be executed by the person expressly authorized to sign.

1. For authorizations that specify the signature authority in individual CalOptima Board Action Agenda Referral (COBARs), all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBARs, all related binding documents shall be executed as follows:

a. Healthcare goods and services: For binding documents (such as contracts, amendments, consents to assignment, and letters of agreement (LOAs)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima's lines of business, (e.g., those item budgeted under Section III.B.2.a):

i. Except as provided in subsection ii of this Section, execution shall be by the Chief ~~Executive~~ Executive Officer (CEO) or the Chief Operating Officer~~.~~ (COO).

ii. For CalOptima Direct (COD) contracts that contain no changes from the standard ~~boilerplate~~ contract, and are for rates that do not exceed the Board of ~~Directors~~ Director approved rates for the healthcare goods and services, execution may be by the ~~Chief Executive Officer, Chief Operating Officer~~CEO, COO, or the Executive Director, ~~CalOptima Care~~ Network~~.~~ Operations.

b. ~~Purchasing~~Budget and Vendor Management Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders), for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

i. ~~Chief Executive Officer~~CEO and the Chief Financial Officer~~,~~ (CFO), for documents involving an amount of two hundred fifty thousand dollars ($250,000) or more;

1. For those contracts of two hundred fifty thousand dollars ($250,000) or more, the COO shall have delegated signature authority in the absence of either the CFO or the CEO.

ii. ~~Chief Executive Officer~~ CEO for documents for less than two hundred fifty thousand dollars ~~(~~($250,000);

iii. ~~Chief Financial Officer~~CFO for documents for one hundred thousand dollars ($100,000) or ~~less~~less;

~~vi~~iv. Controller or the Director of ~~Financial Compliance~~ Budget and Procurement for documents for twenty-five thousand dollars ($25,000) or less; and

DRAFT 2019 OFAC

v. Purchasing Manager for documents for ten thousand dollars ($10,000) or less.

~~vi. For contracts of two hundred fifty thousand dollars ($250,000) or more, the Chief Operating Officer shall have delegated signature authority in the absence of either the Chief Financial Officer or the Chief Executive Officer.~~

~~vii~~vi. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed ten percent (10%) of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures, as defined in CalOptima Policy GA.5002: Purchasing ~~Policy,~~ shall be executed by the ~~Chief Executive Officer~~CEO or his or her ~~designee~~Designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. Employee reimbursements must be made, in accordance ~~to~~with the CalOptima Policy GA.5004: Travel Policy.

f. All Other ~~Binding Documents~~ binding documents (e.g., ~~MOUs,~~Memoranda of Understanding (MOU), Settlement Agreements, etc.) shall be executed by the ~~Chief Executive Officer~~CEO or Chair of the Board of Directors.

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

~~A. CalOptima Policy AA.1001: Glossary of Terms~~
~~B.~~A. CalOptima Policy GA.5002: Purchasing ~~Policy~~
~~C.~~B. CalOptima Policy GA.5004: Travel Policy

VI. ~~APPROVALS OR~~ REGULATORY APPROVAL(S)

None to Date

~~VI.~~VII. BOARD ACTION(S)

~~3/1/12: CalOptima Regular Board Meeting~~

Date	Meeting
03/01/2012	Regular Meeting of the CalOptima Board of Directors

~~VII.~~VIII. REVISION HISTORY

DRAFT_20190919FAC

A. 7/1/12: GA.3202: CalOptima Signature Authority
B. 3/1/12: GA.3202: CalOptima Signature Authority

VIII. KEYWORDS

Authority
Contract
Document
Payment
Purchasing
Signature

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	07/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	03/01/2013	GA.3202	CalOptima Signature Authority	Administrative
Revised	TBD	GA.3202	CalOptima Signature Authority	Administrative

DRAFT_20190909FAC

IX. GLOSSARY

Term	Definition
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
Covered Services	**Medi-Cal:** Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. **OneCare:** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. **OneCare Connect:** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). **PACE:** Those items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132 except those services specifically excluded under the contract with the Department of Health Care Services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Memorandum of Understanding (MOU)	An agreement between CalOptima and an external agency, which delineates responsibilities for coordinating care for Members.

DRAFT 20190508 AC

DRAFT_20190919FAC

Policy: GA.3202
Title: **CalOptima Signature Authority**
Department: CalOptima Administrative
Section: Finance

CEO Approval: Michael Schrader_____

Effective Date: 03/01/2012
Revised Date: TBD

I. PURPOSE

This policy sets forth the requirements for the execution of any document binding CalOptima in any manner.

II. POLICY

A. A CalOptima officer or employee may not expend any funds, or take any other action on behalf of CalOptima, unless the Board of Directors (Board) has approved such expenditure or action, or delegated its power to that officer or employee, subject to an articulated standard.

B. No document of any type whatsoever that binds CalOptima to undertake or refrain from undertaking any action, or to expend any CalOptima funds, shall be entered into except pursuant to this policy.

C. In order for any document to bind CalOptima, the Board of Directors must have: (1) appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima representative, as identified in this policy.

D. Amendments or other changes to any document binding CalOptima must be approved and executed in the same manner as the original document, except for minor price deviations, as provided within this policy.

III. PROCEDURE

A. Board of Directors Appropriation: Except in emergency circumstances, as set forth CalOptima Policy GA.5002: Purchasing, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or individual Board action, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in this policy.

B. Board of Directors Approval: No document binding CalOptima shall be entered into except pursuant to the approval of the CalOptima Board of Directors. In approving, the Board may delegate to a CalOptima officer the authority to enter into agreements that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action: To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring

DRAFT 20190919FAC

any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements, as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement (contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget: To constitute an authorization through inclusion in CalOptima's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

   a. Healthcare goods and services (for the direct provision of Covered Services): The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

   b. Non-healthcare-related goods and non-professional services: To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The description of specific goods, services or other expenditure;

      ii. The number or duration of the goods, services or other expenditure items if available; and

      iii. The dollar amount of the expenditure.

   c. Non-medical professional services: Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation, etc.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer, etc.);

      ii. The objective of the professional services; and

      iii. The amount of the expenditure.

C. Signature Authority: Documents executed pursuant to Board Authority, as identified in Section III.B of this policy, may only be executed by the person expressly authorized to sign.

1. For authorizations that specify the signature authority in individual CalOptima Board Action Agenda Referral (COBARs), all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBARs, all related binding documents shall be executed as follows:

DRAFT 20190919 FAC

a. Healthcare goods and services: For binding documents (such as contracts, amendments, consents to assignment, and letters of agreement (LOAs)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima's lines of business, (e.g., those item budgeted under Section III.B.2.a):

   i. Except as provided in subsection ii of this Section, execution shall be by the Chief Executive Officer (CEO) or the Chief Operating Officer (COO).

   ii. For CalOptima Direct (COD) contracts that contain no changes from the standard boilerplate contract, and are for rates that do not exceed the Board of Director approved rates for the healthcare goods and services, execution may be by the CEO, COO, or the Executive Director, Network Operations.

b. Budget and Vendor Management Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders), for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

   i. CEO and the Chief Financial Officer (CFO), for documents involving an amount of two hundred fifty thousand dollars ($250,000) or more;

      1. For those contracts of two hundred fifty thousand dollars ($250,000) or more, the COO shall have delegated signature authority in the absence of either the CFO or the CEO.

   ii. CEO for documents for less than two hundred fifty thousand dollars ($250,000);

   iii. CFO for documents for one hundred thousand dollars ($100,000) or less;

   iv. Controller or the Director of Budget and Procurement for documents for twenty-five thousand dollars ($25,000) or less; and

   v. Purchasing Manager for documents for ten thousand dollars ($10,000) or less.

   vi. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed ten percent (10%) of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures, as defined in CalOptima Policy GA.5002: Purchasing, shall be executed by the CEO or his or her Designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. Employee reimbursements must be made, in accordance with the CalOptima Policy GA.5004: Travel Policy.

DRAFT_20190919FAC

f. All Other binding documents (e.g., Memoranda of Understanding (MOU), Settlement Agreements, etc.) shall be executed by the CEO or Chair of the Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Policy GA.5002: Purchasing
B. CalOptima Policy GA.5004: Travel Policy

VI. REGULATORY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	07/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	03/01/2013	GA.3202	CalOptima Signature Authority	Administrative
Revised	TBD	GA.3202	CalOptima Signature Authority	Administrative

DRAFT 20190919FAC

IX. GLOSSARY

Term	Definition
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
Covered Services	**Medi-Cal:** Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. **OneCare:** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. **OneCare Connect:** Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). **PACE:** Those items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132 except those services specifically excluded under the contract with the Department of Health Care Services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Memorandum of Understanding (MOU)	An agreement between CalOptima and an external agency, which delineates responsibilities for coordinating care for Members.

DRAFT_20190910PAC

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2012
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. E. Adopt Resolution No. 12-0301-01, Delegating Authority to the Chief Executive Officer to Make Budget Allocation Changes Within Certain Parameters, Approve Revisions to the Procurement Policy, Adopt a Signature Authority Policy, and Adopt Other Governance Recommendations

Contact

Michael Engelhard, Chief Financial Officer, 714-246-8400

Recommended Actions

1. Delegate authority to make budget allocation changes to the Chief Executive Officer (CEO), within certain parameters;
2. Approve proposed revisions to the Procurement Policy;
3. Adopt the attached Signature Authority Policy; and
4. Delegate the authority to the CEO to manage CalOptima's records retention policy and ensure compliance with applicable State and Federal laws, regulations and contract requirements.

Background

The CalOptima Board is the legislative body of CalOptima and is responsible for making all fundamental policy determinations. Board members are also ultimately responsible for expenditures of public funds and may under certain circumstances be held personally liable for improper expenditures such as gift of public funds.

Within the parameters of the legal framework in which CalOptima operates, the CalOptima Board may delegate certain authority to staff or to Board committees to execute decisions on behalf of the CalOptima Board provided that these delegations are accompanied by adequate transparency and safeguards to guide the use of the delegated power and prevent abuse. The Bylaws of CalOptima describe committees, including the Quality Assurance and Finance and Audit Committees. These committees are subject to the Brown Act and other laws applicable to local public agencies. The Bylaws provide in part that, "All committees shall be advisory only to the Board unless otherwise specifically authorized to act by the Board." To date, the Board has not delegated to these committees the authority to act on behalf of the Board.

Recently, several Board members have inquired about the need for the Board to approve various items that appear on meeting agendas, including those items that have been analyzed and approved by either the Finance and Audit Committee or Quality Assurance Committee. With the 2010 enactment of the Patient Protection and Affordable Care Act (ACA) and the

Back to Agenda

changing healthcare environment, the Board faces many new challenges and opportunities during the short period between now and full implementation of the ACA.

The existing board approved Procurement Policy (GA.5002) was last revised in January 2004. This policy established the way that CalOptima procures goods and services. Key features of the policy are:

1. Setting the process for bidding and awarding of contracts (excluding provider contracts)
2. Established a fair and competitive approach to contracting
3. Provided for both budgeted and non-budgeted requisition limits
4. Established signature authority on contracts.

Certain language in the current policy, particularly around non-budgeted requisition authority, is vague, causing ambiguity in the policy and its application. A primary goal of the proposed action is to establish and clarify the policy's parameters to ensure efficient and transparent application.

Discussion

With input from legal counsel, the Ad Hoc Committee recommended changes that are summarized below:

1. Budget Allocation Change. Delegate authority to the Chief Executive Officer to authorize changes to the Board-approved Medical Services, Capital and Administrative budgets within parameters.

    A. Budget variances within Board-approved supplemental programs included in the Medical Services Budget. To the extent that there are unexpended budgeted funds approved for a specific supplemental program in the medical services budget (e.g., quality incentive programs), the CEO shall have authority to move up to a cumulative amount of $100,000 into or out of any supplemental program under the Medical Services Budget subject to the conditions and limitations set forth below. Any budget substitution of $100,000 or more is subject to the approval of the Board. Payments for supplemental programs are not for base rate payments (e.g. per diems, capitation rate, etc.), but are targeted to address a specific need or activity (e.g., quality incentives, incentive grants, etc.). Substitutions within the medical services budget the CEO may make shall be:
        i. For a program or activity that has been explicitly approved by the Board, either through the Medical Services Budget or previous Board action;
        ii. Limited to the same line of business, e.g., OneCare expenditure cannot be moved to Medi-Cal;

Back to Agenda

iii. Budget neutral in the context of the Medical Services Budget for that line of business, which establishes targets or estimates of the provider payment portion of the overall Budget; and
iv. Reported monthly to the Board as part of the Financial Report for the month in which the budget allocation change was made and reported to the Finance and Audit Committee with analysis on a quarterly basis, for the quarter in which the budget allocation change was made..

B. Capital Budget. Delegate to the CEO the authority to make a substitution of a capital item for a different capital item at a cost of less than $100,000 in the Board-approved Capital Budget subject to the conditions and limitations set forth below. Any budget substitution of $100,000 or more is subject to the approval of the Board. Substitutions within the Capital Budget that the CEO may make shall be:
   i. For a program, item or activity that has been explicitly approved by the Board, either through the Capital Budget or previous Board action;
   ii. Budget neutral in the overall Capital Budget;
   iii. Reported monthly to the Board as part of the Financial Report for the month in which the budget allocation change was made and reported to the Finance and Audit Committee with analysis on a quarterly basis, for the quarter in which the budget allocation change was made; and
   iv. Within the same capital expense category, which for purposes of the Capital Budget shall be defined as follows:
      - Information Systems Hardware
      - Information Systems Software, or
      - Furniture, Fixtures and Equipment (FF&E).

   For example, if the Board-approved I.S. Hardware budget includes $100,000 each for computer servers and computer printers, the CEO would have the authority to buy only $80,000 in printers and purchase a total of $120,000 in computer servers. In other words, based on a less than budgeted need for printers and a greater than budgeted need for servers, the CEO would be authorized to deploy the $20,000 in unexpended budgeted printer dollars to purchase servers.

C. Administrative Budget. Delegate to the CEO the authority to make a substitution of an approved administrative expense of less than $100,000 for another approved administrative expense subject to the conditions and limitations below. Any budget substitution of $100,000 or more is subject to the approval of the Board. Examples of included programs or activities would be: ICD-10, NCQA, MSI Transition, Health Care Reform analysis, Long-Term Care Integration, Behavioral Health integration, etc. The administrative portion of the Medical Services Budget (i.e., expenses for medical management, utilization management, etc.) shall have the same substitutions

Back to Agenda

policy as outlined for the Administrative Budget substitutions described in this section. Substitutions the CEO may make shall be:

i. For a program, activity, or item that has been explicitly approved by the Board, either through the Administrative Budget or previous Board action;
ii. Limited to the same line of business, e.g., OneCare expenditure cannot be moved to Medi-Cal;
iii. Budget neutral in the context of the Board-approved Administrative Budget for any specific fiscal year; and
iv. Reported monthly to the Board as part of the Financial Report for the month in which the budget substitution change was made and reported to the Finance and Audit Committee with analysis on a quarterly basis, for the quarter in which the budget substitution change was made.

2. Procurement Policy. Approve proposed changes to the CalOptima Procurement Policy, as attached and summarized below:

A. General Purchasing Issues
   i. Change references throughout from "Procurement" to "Purchasing."
   ii. Eliminate the "Non-budgeted requisition" section
   iii. Move signature authority to a separate Signature Authority Policy (attached)
   iv. Clarify that dollar limits apply on a per vendor, per fiscal year basis
   v. Clarify that the exceptions to the policy regarding grants applies only if the grant specifies a different set of Purchasing criteria
   vi. Add optional bidders conference to non-Public Works formal bid process
   vii. Change notice period for unsuccessful bidders from 72 hours to 10 business days
   viii. Require contracts to accompany all RFPs/RFQs for goods and services.
   ix. Add explicit reference to the requirement that all vendors comply with CalOptima's Code of Conduct

B. Goods and Non-Professional Services
   i. For contracts that are awarded through a formal bidding process, recommends a best practice for contracts not to exceed five years in duration.
   ii. Add non-professional services to the procurement of goods section

C. Professional Services
   i. Add licensure requirements (if applicable) to professional services description

ii. Clarify that the professional services section does not apply to medical professional services

D. Public Works
   i. Add Public Works requisition guidelines
   ii. Add Public Works to the goods and services exceptions
   iii. Add a Public Works procurement section
   iv. Add requirements for prevailing wage, in accordance with the California Labor Code

E. Special Situations
   i. Add cross-references for sole source and emergency purchases in goods and services exceptions

F. Real Property
   i. Add real property cross-reference to new section
   ii. Add real property section (Board-directed process)

G. Information Systems/Telecommunications
   i. Increase competitive means threshold for IS/Telecom procurement to $100,000

3. Signature Policy. Adopt a Signature Authority Policy to provide clear delegation of authority to bind CalOptima through various types of documents. The proposed policy (attached) can be summarized as follows:

   A. Describes means of Board approval for expenditures (individual Board action or explicit description in the Board-approved budget), consistent with the June 3, 2010, Board action, allowing for authorization of expenditure through budget adoption, subject to certain details being presented in the budget
   B. Clarifies that Contingency-based-payment contracts require separate Board approval
   C. Defines signature authority, by purchasing type:
      i. Healthcare goods and services (for the direct provision of Covered Services)—CEO, COO (supersedes EE.1126: Authority to Sign Provider Operations Department Contracts and Letters of Agreement). Also allows Executive Director for CCN to execute standard COD contracts.
      ii. Purchasing Policy Goods and Services

Back to Agenda

- CEO, CFO
- Director of Finance and Purchasing (up to $25,000)
- Purchasing Manager (up to $10,000)

iii. Emergency Expenditures—CEO

iv. Government Program and Real Estate Documents—Board Chair

v. All Others—CEO, Board Chair

4. Records Retention. Delegate authority to the CEO to manage CalOptima's records retention policies, in accordance with all applicable state and federal laws and contract requirements. Currently, CalOptima's records retention policy is a Board of Directors-approved policy, which adds a Board of Directors approval process for changes, complicating ensuring continuous compliance with state and federal requirements.

Fiscal Impact
None

Rationale for Recommendation
Enhance the efficiency of CalOptima's operations and governance.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Governance Ad Hoc Committee

Attachments
Resolution No. 12-0301-01
Proposed Revised CalOptima Policy GA.5002, Purchasing Policy
Proposed CalOptima Signature Authority Policy

/s/ Richard Chambers 2/24/12
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 12-0301-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY

d.b.a. Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

DELEGATE AUTHORITY TO MAKE BUDGET ALLOCATION CHANGES TO THE CHIEF EXECUTIVE OFFICER (CEO) WITHIN CERTAIN PARAMETERS; APPROVE REVISIONS TO THE PROCUREMENT POLICY; ADOPT SIGNATURE AUTHORITY POLICY; DELEGATE AUTHORITY TO THE CEO TO MANAGE CALOPTIMA'S RECORDS RETENTION 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, purchasing and acquiring the use of equipment and supplies, and acquiring, constructing, and leasing real property and improvements; and,

WHEREAS, the CalOptima Board of Directors adopted a Procurement Policy (GA.5002) in 1996 and amended said policy in 1997, 2000, and 2004; and,

WHEREAS, the Board of Directors now wishes to further update CalOptima's processes to ensure streamlined operations;

NOW, THEREFORE, BE IT RESOLVED:

That the Board of Directors hereby:

I. Delegates authority to make budget allocation changes to the CEO, within the attached parameters;

II. Approves the attached revised version of the Procurement Policy;

III. Adopts the attached Signature Authority Policy; and

IV. Delegates the authority to the CEO to manage CalOptima's records retention policy and ensure compliance with applicable State and Federal laws, regulations and contract requirements.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 1st day of March, 2012.

Back to Agenda

AYES: Bui, Kacic, McAleer, Nguyen, Penrose, Refowitz, Riley

NOES: None

ABSENT: Foo, Pereyda

ABSTAIN: None

/s/ _____
Title: Chair, Board of Directors
Printed Name and Title: Edward B. Kacic, Chair, CalOptima Board of Directors

Attest:

/s/ _____
Suzanne Turf, Clerk of the Board

Back to Agenda

Policy #: GA. 5002
Title: **Purchasing Policy**
Dept.: Finance
Section: Financial Affairs
Board of Directors/CEO: Richard Chambers_____
Effective Date: 9/96 Revised 10/97; 01/00; 01/04; 02/11

I. PURPOSE

This policy establishes the organization and administration of a unified, fair and effective process for the procurement of goods and services essential to the operations of CalOptima, and may be amended from time to time in order that it remains consistent with current best business practices.

II. POLICY

A. Unless exempted by this policy herein and/or applicable law, the Chief Financial Officer or designee, with the assistance of the Purchasing Department, is charged with the authority and responsibility for the following:

1. Acquiring equipment, supplies and services for all departments in an economical, expeditious and reasonable manner in accordance with this policy;

2. Identifying qualified vendors and developing and promoting good vendor relationships;

3. Educating and training employees and vendors on this policy and the purchasing process;

4. Providing assistance to departments in preparing specifications and in analysis of bids received; and

5. Awarding contracts and assuring vendor performance through contract administration.

B. A requisition for purchase of supplies, equipment or services, including Public Works projects, shall be approved only by a person who has been properly authorized in accordance with this policy. The Board of Directors has delegated requisition authority to the Chief Executive Officer. The Chief Executive Officer has further delegated that authority and in the amounts provided below. Any person in a position delegated authority below may appoint a designee, in writing, to act in his or her stead when that person is ~~away from CalOptima for one or more days~~unavailable. The Purchasing Department shall have full authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

C. Requisition Approval Limits – Goods and Services except as specified in D. and E. below

Employee Position	Authority Limit
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
Chief Executive Officer	Over 100,000

D. Requisition Approval Limits – Public Works Projects

752121.1

Back to Agenda

Employee Position	Authority Limit
Facilities Manager	$ 10,000
Chief Administrative Officer	100,000
Chief Executive Officer	Over 100,000

E. Requisition Approval Limits – Computer Hardware, Software and Services
Telecommunications Goods and Services

Employee Position	Authority Limit
I.S. Manager	$ 10,000
I.S. Director	$ 50,000
I.S. Executive Director, Chief Information Officer	100,000
Chief Executive Officer	Over 100,000

F. Funding for all requisitions shall be approved by the Board of Directors through:
   a. The annual operating or capital budget,
   b. Specific Board action, or
   c. A Budget Allocation Change, in accordance with CalOptima Policy GA.5003: Budgets and Operations Forecasting

G. To enable the Board of Directors to consider approval through the operating and capital budgets, the budget submission must meet the requirements of Section III.B.2. of Policy XX.YYYY: Signature Authority Policy.

H. Signature authorization for contracts, agreements, leases, and/or purchase orders resulting from this policy is addressed in CalOptima Policy XX.YYYY: Signature Authority. For all CalOptima contracts requiring the vendor's signature, CalOptima authorized signature representatives shall sign the contract documents only after the contract documents have been signed by the vendor.

I. Informal Bidding

Set forth below are the generally accepted methods of purchasing, which may be adjusted from time to time for CalOptima's Best Interest and to reflect current best business practices. All formal and informal requests for prices in the form of bids, quotations or proposals for all materials, services and equipment purchased, must be made by the Purchasing Department, unless otherwise delegated by the Purchasing Department in writing. Pre-qualified vendor relationships shall be reviewed periodically, at least every five (5) years, to ensure consistency in quality, service and competitive pricing. For the purposes of this policy, the response to any request for prices, requests for quotations or invitations for bids shall collectively be referred to as a "bid" or "bids".

1. Purchases of Goods and Services as specified in Section II. C., Public Works projects as specified in Section II. D. and Computer Hardware, Software and Services and Telecommunications Goods and Services as specified in Section II.E. above, valued at under ten thousand dollars ($10,000) per vendor per fiscal year, not including applicable taxes and freight charges, referred to as small procurements, may be made on a discretionary basis without solicitation of bids. The Purchasing Department may establish pre-qualified vendor relationships for common small purchases to leverage pricing to the maximum extent practicable.

2. Purchases of Goods and Services as specified in Section II. C. above valued from ten thousand

dollars ($10,000) ~~-~~to fifty thousand dollars ($50,000) per vendor per fiscal year, or between ten thousand dollars ($10,000) and one hundred thousand dollars ($100,000) per vendor per fiscal year for computer equipment and telecommunications goods and services, not including applicable taxes and freight charges, require solicitation of at least two (2) informal bids and/or quotations from known suppliers.

3. Purchases for Public Works projects and Computer Hardware, Software and Services and Telecommunications Goods and Services specified in Section II.D. and Section II. E. above valued from ten thousand dollars ($10,000) or more per vendor per fiscal year, or one hundred thousand dollars or more for computer equipment and telecommunications goods and services to $100,000, excluded taxes and freight charges, shall be made in accordance with this policy under Section(s) II. M., or L. as applicable. Such purchases require solicitation of at least two (2) informal bids and/or quotations from known suppliers. Contracts for software licenses or software maintenance agreements, or computer equipment purchases must be approved in writing by the Information Services Department.

4. Public Works Projects shall be procured in accordance with the limits and procedures of Section II.M

5. Contracts for the provision of healthcare services must be coordinated by the Provider Operations Department with approval of ~~the contracts by the Chief Executive Office~~an appropriate signing party under~~r~~ Policy XX.YYYY: Signature Authority, within limits delegated by the Board of Directors, and with approval of the contract template and any deviations therefrom~~documents~~ by the Legal Counsel.

J. Formal Bidding

Provisions Applicable to Purchasing of Goods, and Non-Professional Services shall be made by Request for Quotations (RFQ), Request for Proposals (RFP) or Invitations for Bid (IFB).

a. Unless exempted in Section II.J.2 below, or by applicable law, purchases of items under Section II.C., including any purchase of goods, material, supplies or non- professional services (e.g., printing, graphic design, mail processing, janitorial, or hard copy file storage, etc.) to be furnished, sold, or leased to CalOptima, involving an expenditure of more than fifty thousand dollars ($50,000). shall be procured using a formal request for bids in the form of formal Request for Quotations, Requests for Proposal and/or Invitations for Bid

Unless exempted in Section II.J.2 below or by applicable law, Public Works projects under Section II.D. and the purchase of Computer Hardware, Software and Services and Telecommunications Goods and Services under Section II.E. valued at more than one hundred thousand dollars ($100,000) shall be procured using a formal request for bids in the form of a formal RFQ, RFP or IFB, as provided in Sections II.M. and II.L., respectively Public Works involving construction or demolition, including tenant improvements, shall include detailed plans and specifications prepared by an architect, engineer or other licensed professional acting within the scope of his or her license. Formal requests for bids for Public Works projects sent to Offerors will include a construction contract template, and any deviations therefrom, approved by Legal Counsel.

b. Exceptions to Bidding

a. Contracts for non-medical professional services, including special services and advice in financial, economic, accounting, engineering, legal, medical consulting and administrative matters, if such persons have the necessary experience, training, competence, and licensure (if applicable) to perform the special services required, may be made without soliciting or securing bids, but shall be awarded according to the guidelines in Section II.K. of this policy.

b. Contracts for the acquisition of computer hardware, software, and other peripheral equipment and related services (referred to as "computer equipment"), and telecommunications goods and services may be made without soliciting bids, but shall be awarded according to the guidelines specified in Section II.L. of this policy.

c. Contracts for the undertaking of Public Works Projects, which shall be awarded according to the provision of Section II.M. of this policy.

d. Contracts for the provision of health care and related services.

e. Sole source or emergency purchases, which shall only be undertaken in accordance with Sections II.O. and II.P. respectively.

f. Acquisitions or transfers of real property, which shall only be undertaken in accordance with Section II.Q.

g. Subcontracts and other agreements entered into by CalOptima in fulfilling its obligations under a federal, state, local or private grant, if the grant requires that an alternative set of procurement policies, rules, or regulations be used (e.g., the Federal Acquisition Regulation (FAR).

c. Bid Procedures for formal bidding for goods and non-professional services

a. Preparation.
Before entering into any contract which requires formal bidding, CalOptima shall prepare or cause to be prepared a bid package. The bid package may take the form of a RFQ, RFP or IFB. To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications, giving such direction as will enable any competent vendor to ascertain and carry out the contract requirements.

b. Notice of formal bids.
All prospective bidders who have not been suspended or debarred by any regulatory agency within the last three years, have notified CalOptima in writing or via the CalOptima website that they desire to bid on contracts, and all prospective bidders which CalOptima would like to bid on contracts, shall be furnished with an automated e-mail announcement that there is a request for quotation, request for proposal or invitation for bids (as applicable) posted on the CalOptima website for them to download. The RFQ, RFP or IFB shall include information as to the type, quality, quantity, date, location and other bid requirements. The notice shall specify the place bids are to be received and the time by which they are to be received. Notice may also be made by telephone, telegram, personal contact, letter, or other informal means. Any bids received after the due date and specified time shall be returned unopened, except as otherwise provided herein.

c. Advertising/Publication.
Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given via the automated e-mail system. The RFQ, RFP or IFB will be posted on the Website from the issue date until the date the proposal is due.

Methods of publicizing of the bids shall include at least two of the following:

i. RFQ's, RFP's or IFB's will appear on the Supplier tab of CalOptima's Web Site on the date the documents will be issued; or

ii. In a newspaper of general circulation once a week for two consecutive weeks published in such places most likely to reach prospective bidders; or

iii. In trade journals or papers of general circulation as the Chief Financial Officer, or designee, deems proper.

iv. The Chief Executive Officer or designee may waive any irregularity or informality in the publication procedures.

d. Bid Form.
The bid package shall furnish to each prospective bidder an appropriate bid form and bid package prepared by CalOptima for the type of contract being let. Bids not presented on forms so furnished shall be disregarded as non-responsive. All bids must be accompanied by a non-collusion affidavit.

e. Presentation of Bids under Sealed Cover.
All bids shall be presented under sealed cover on or before the bid deadline. After receipt, the bid shall be date-stamped.

f. Withdrawal of Bids.
Bids may be withdrawn at any time prior to the time fixed in the notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of the bids does not prejudice the right of the bidder to timely file a new bid. No bidder may withdraw his bid after opening for at least a period of forty-five (45) days thereafter.

g. Bidder's Conference.
CalOptima may hold a bidders' conference or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice of formal bid.

d. Award of Contracts
a. Opening of Bids.

On the day named in the bid notice, CalOptima shall open the sealed bids. Award of the contract shall be to the ~~lowest qualified~~lowest-price qualified and responsive bidder, if at all, as determined in CalOptima's sole discretion. Award shall be made within forty-five (45) days after opening, unless the bid package specifies otherwise or the Chief Executive Officer or designee extends the time. All bidders shall have complied with the foregoing bid procedures, except as otherwise provided herein. After a bid is opened it shall be deemed irrevocable for the period specified in the invitation to bid. Bids shall be irrevocable for a minimum of forty-five (45) days after the opening thereof.

c. Awards to the Second and Third Lowest Price Qualified Bidders.
If it is deemed to be in CalOptima's Best Interest, CalOptima may, on refusal or failure of the successful bidder to execute the contract or comply with other bid requirements, award it to the second lowest price qualified bidder. If the second ~~lowest qualified~~lowest-price qualified bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima may likewise award it to the third lowest price qualified bidder.

d. Only One Bid or Proposal Received.
If only one bid or proposal is received in response to the RFQ, RFP or IFB, an award may be made to the sole bidder provided that CalOptima finds that the price or proposal submitted is fair, reasonable and in CalOptima's Best Interest.

e. Qualified Bidder
CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

5. Contract Renewal.
For contracts that are awarded through a formal bidding process, it is recommended to follow the industry best practice for which contracts ~~shall~~ not exceed five years in duration, the goods or services must be rebid~~, unless the Board approves continuation beyond five years for good cause (e.g., it may not be reasonable to rebid a proprietary information system, such as FACETS, given the training and productivity costs of having to train a large number of employees on a new system)~~.

6. Negotiated Purchase
CalOptima reserves the right and at its sole discretion, to informally solicit one or more alternative proposals from one or more qualified vendor(s), in the event that a procurement solicitation results in no acceptable vendor responses based on the criteria set forth in the solicitation package. The Chief Financial Officer or designee may use a procedure to select a vendor by "competitive means." This would include one or more the following methods when deemed by the CFO or designee as an appropriate means under the circumstances to permit CalOptima's Best Interests to be served:

a. The preparation and circulation of an RFP or RFQ to an adequate number of qualified sources. An adequate number shall be defined as two or more qualified sources, as determined by the

Chief Financial Officer or designee based on the number of qualified sources believed to be capable of submitting a satisfactory proposal after reasonable inquiry.

b. Posting to the Website, publishing, communicating telephonically or otherwise publicizing the RFP or RFQ in a manner intended to disseminate the RFP or RFQ to an adequate number of qualified sources.

c. Soliciting comparable rates charged by other vendors for similar services to ensure a competitive price.

d. Any other means determined by the Chief Financial Officer or designee as reasonably expected to disseminate the RFQ or RFP to an adequate number of qualified sources.

7. Criteria for Award of Contract via Negotiated Purchase
   a. Contracts shall be awarded based on the determination of which vendor has the most cost effective and beneficial solution. In making this determination, the following evaluation tools shall apply as appropriate:

      i. Price.

      ii. Payment or financial terms offered by contractor.

      iii. The extent to which the proposal meets or exceeds CalOptima's technical requirements and, if purchased, can be expected to accomplish the specified goals.

      iv. Offeror's relevant experience in the area of purchase/project.

      v. A demonstrated quality, dependability and responsiveness of the Offeror and any subcontractors providing installation, integration, consulting maintenance or other goods and services including Public Works.

      vi. For capital equipment, the anticipated salvage or resale value of the components, if any, based upon its anticipated useful life.

      vii. For Computer Hardware, Software and Services and Telecommunications Goods and Services, the anticipated expense and disruption to CalOptima facilities and services involved in upgrading or integrating additional components to the system and/or maintaining the system which may be necessary to accommodate the expansion of CalOptima facilities, keep pace with technology, provide for system back-up or obtain necessary parts and service.

      viii. Offeror's familiarity with CalOptima.

      ix. Offeror's reputation in the community.

      x. Special expertise in the area of purchase.

xi. Such other criteria, consistent with this policy and the goal of achieving the most cost-effective solution to CalOptima's requirements, as the Chief Financial Officer or designee may establish.

b. These criteria shall be applied by the Chief Financial Officer or designee using a scoring or other system designed to determine which of the proposals submitted provides the most viable solution to CalOptima's requirements. The basis for such determination shall be documented by the Purchasing Department in a manner which permits the Board, the Chief Financial Officer or designee to reasonably evaluate compliance with this policy.

8. Waiver and Rejection Rights
CalOptima reserves the right to reject any and all bids or proposals or to waive any informality or non-substantive defects in bids or proposals to serve CalOptima's Best Interest. Only those bids or proposals which are deemed by CalOptima to be responsive to the RFP or RFQ shall be considered. The Purchasing Department shall ensure maximum protection of CalOptima's Best Interest consistent with ensuring an equal opportunity and fair and equitable treatment for all bidders and Offerors.

9. Notice to Bidders Not Awarded the Contract
Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by regular mail within ten (10) business days after the award of the contract to another bidder.

10. Qualified Bidder
CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

11. Extensions
The granting of an extension to the contractor is not a new contract. If a contractor makes an application for an extension in writing, CalOptima shall consider matters germane to the particular contract and shall not grant or deny the extension arbitrarily. However, in any contract which includes provisions for liquidated damages, CalOptima's decision to extend the contract without charge to the contractor shall be made only when the failure to complete the contract on time is not attributable to the contractor's unreasonable delay or default.

12. Contract Documents
Contract documents shall be prepared in advance, with the approval of Legal Counsel and shall be incorporated into the bid package.

13. Flexibility
In recognition of the fact that the contracting and purchasing needs of CalOptima may from time to time render certain procedures herein impracticable, the Chief Financial Officer or designee are authorized to permit or waive deviations from this policy, to the extent permitted by law, upon making a written finding that such deviation is in CalOptima's Best Interests. Additionally,

provisions required to be included in Public Works and construction contracts (e.g. requirements for performance bonds, insurance, etc.) may be included in other contracts if appropriate.

K. Provisions Applicable to Procurement of Non-Medical Professional Services.

1. Except as otherwise provided for in this policy, all procurements for professional services shall be made in accordance with limits as set forth in the Board-approved annual operating budget.

2. Exceptions
Contracts for professional services, including special services and advice in financial, economic, accounting, engineering, legal, or administrative matters, if such persons have the necessary experience, training, competence, and licensure (if applicable) to perform the special services required, may be made without soliciting or securing competitive offers, but shall be awarded according to Section II.K. of this policy. If proposals are solicited, the procedure set forth herein, modified as the Chief Executive Officer or designee shall determine to be in CalOptima's best interest, shall be followed.

3. The Chief Executive Officer or designee may use a procedure to select a vendor involving an expenditure of more than fifty thousand dollars ($50,000) by "competitive means." This would include one or more the following methods when deemed by the CEO or designee as an appropriate means under the circumstances to permit reasonable conclusion that the proposed contract is beneficial to CalOptima.

a. Preparation and circulation of a request for proposal (RFP) to an adequate number of qualified sources.

b. Posting, publishing, communicating telephonically or otherwise publicizing RFP in a manner intended to disseminate the RFP to an adequate number of qualified sources.

c. Soliciting comparable rates charged by other vendors for similar services to ensure a competitive price.

4. Criteria for Award of Contract
Contracts for professional services shall be awarded based on the determination of which vendor has the most cost-effective and beneficial solution to CalOptima's requirements. In making this determination, the following evaluation tools shall apply as appropriate:

a. Price.

b. Payment or financial terms offered by contractor.

c. The relevant experience in the area of purchase.

d. A demonstrated quality, dependability and responsiveness.

e. Familiarity with type of business CalOptima is operating.

f. Familiarity with CalOptima.

g. Reputation in the community.

h. Special expertise in the area of purchase.

i. Other selection criteria as may be deemed appropriate.

j. These criteria shall be applied by the Board, Chief Executive Officer or designee in selecting the vendor.

k. Exception: Pursuant to 40 U.S.C. §§ 1101-1104 and California Government Code §§ 4525-4529.5, any RFP or RFQ for architectural or engineering services shall not, for the purposes of ranking firms, be evaluated primarily on the basis of price. Once firms are determined to have the requisite technical capabilities to meet the services required (e.g. experience, proposal, technical expertise) CalOptima may then use price as a factor for the purposes of final ranking determinations. CalOptima then shall seek to negotiate a fair and reasonable price with the top ranked firm. If agreement on a fair and reasonable price cannot be reached, CalOptima shall cease negotiations and move to the second ranked firm and seek to negotiate a fair and reasonable price. This process shall continue until agreement with a firm is reached.

L. Provisions Applicable to Procurement of Computer Hardware, Software, and Other Peripheral Equipment and Related Services (collectively "computer equipment"), and Telecommunications Goods and Services.

1. CalOptima shall acquire computer equipment, and telecommunications goods and services involving an expenditure of more than one hundred thousand dollars ($100,000) or such other amount as may be specified by law, through "competitive means", except when the Chief Executive Officer or designee determines either that (a) the goods and services proposed for acquisition are the only goods and services which can meet CalOptima's needs, or (b) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare and safety.

2. As used in this policy, "competitive means" includes any one or more of the following methods, when deemed by the Chief Executive Officer or designee as an appropriate means under the circumstances to permit reasonable competition consistent with the nature and requirements of the proposed acquisition:

a. The preparation and circulation of a request for quotations (RFQ) or request for proposals (RFP) to an adequate number of qualified sources. An "adequate number" shall be defined as two or more qualified sources, as determined by the Chief Executive Officer or designee based upon the number of qualified sources believed to be capable of submitting a satisfactory proposal, after reasonable inquiry.

b. Posting, publishing, communicating telephonically or otherwise publicizing the RFP in a manner intended to disseminate the RFP to an adequate number of qualified sources.

c. Any other means determined by the Chief Executive Officer or designee as reasonably expected to disseminate the RFP to an adequate number of qualified sources.

3. Criteria for Award of Contract

a. Contracts for computer equipment or telecommunications goods and services subject to this policy shall be awarded based on a determination of which responsive proposal provides the most cost-effective and beneficial solution to CalOptima's requirements. In making this determination, the following evaluation criteria shall apply, as applicable:

i. The price of the components, installation and any related consulting, maintenance or other services.

ii. The payment and financing terms offered by the contractor.

iii. The extent to which the components meet or exceed CalOptima's technical requirements and can be expected to accomplish the specified goals.

iv. The demonstrated quality, dependability, and responsiveness of the contractor and any subcontractors providing installation, integration, consulting, maintenance or other services.

v. The anticipated expense and disruption to CalOptima services and facilities involved in integrating additional components or upgrades into the system which may be necessary to accommodate the expansion of CalOptima facilities or needs.

vi. The anticipated expense and disruption to CalOptima facilities and services involved in integrating upgrades or retrofits into the system as necessary to keep pace with technological improvements or refinements to the system.

vii. The anticipated expense and disruption to CalOptima facilities and services involved in maintaining or repairing the system, including but not limited to implementing back-up procedures while the system is down, and obtaining necessary parts and service.

viii. The quality and comprehensiveness of the warranty offered.

ix. The anticipated salvage or resale value of the components, if any, based upon its anticipated useful life to CalOptima.

x. Such other criteria, consistent with this policy and the goal of achieving the most cost-effective solution to CalOptima's requirements, as the Chief Executive Offer or designee may establish.

b. These criteria shall be applied by the Chief Executive Officer or designee using a scoring or other system designed to determine which of the proposals submitted provides the most viable solution to CalOptima's requirements. The basis for such determination shall be documented by the Purchasing Department in a manner which permits the Board, the Chief Executive Officer or designee to reasonably evaluate compliance with this policy.

M. Provisions Applicable to Public Works Projects

1. CalOptima is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, qualified bidder. This policy establishes the generally accepted methods of procurement, which may be adjusted from time to time in order to serve CalOptima's Best Interests or to reflect current best business practices. All formal and informal requests for prices in the form of bids for all materials, services and equipment purchased, must be made by the Purchasing Department, unless otherwise delegated by the Purchasing Department in writing.

   a. Purchases for less than ten thousand dollars ($10,000) not including applicable taxes and freight charges, referred to as small procurements, may be made on a discretionary basis without solicitation of bids.

   b. Purchases for ten thousand dollars ($10,000) or more, but not exceeding one hundred thousand dollars ($100,000), require informal solicitation of bids and shall be made in accordance with this policy, including the procedures described in Section II.M.2.

   c. Purchases amounting to over one hundred thousand dollars ($100,000) require formal solicitation of bids, and shall be made in accordance with this policy, including the procedures described in Section II.M.2.

   d. All requests and contracts shall be based on forms approved by CalOptima's Legal Department.

2. Procurement of Alterations to and Maintenance of Real Property and Other Public Works Projects

   a. This section II.K.2. shall apply to any acquisition of goods and services for the physical construction, alteration, demolition, installation or repair of real property, including fixtures, painting, wiring, carpeting and other things incorporated into or permanently affixed to real property.. CalOptima may elect to pre-qualify contractors to participate in informal and formal bids.

   b. No alteration to real property requiring a building permit, including tenant improvements in leased spaces, shall be undertaken, except pursuant to detailed plans and specifications, prepared by an architect, engineer, or other California-licensed professional acting within the scope of her or his license. Any such alterations to CalOptima's leased spaces shall be consistent with the terms and conditions of the lease, if any.

   c. Purchases/Projects valued at less than $10,000 shall be made in accordance with Section II.M.1.

   d. Purchases/Projects valued between $10,000 and $100,000 shall be made in accordance with Section II.M.2.h.

   e. Purchases/Projects valued at $100,000 or more shall be made in accordance with Section II.M.2.i.

f. Projects where the architect's or engineer's estimate is over $100,000 must be bid through the formal bidding process set forth in Section II.M.2.g.

g. All bids must be accompanied by a non-collusion affidavit.

h. Informal Bid Procedures

i. Preparation.
A written request shall be prepared which shall, at a minimum, contain: (i) appropriately detailed plans and specifications or scope of work considering the value and technical complexity of the goods and/or services to be procured; (ii) the CalOptima staff person to whom the bid must be addressed; (iii) the date and time by which CalOptima must receive the bid; (iv) a statement that the bid must be firm for a period of not less than ninety (90) days from receipt by CalOptima; and (v) a copy of the construction contract.

ii. Evaluation.
The criteria for evaluating bids will be determined on a case-by-case basis, and will be stated in the written request.

iii. Bidder Pre-qualification
CalOptima may pre-qualify contractors for projects to be bid through this informal bid procedure, and may limit distribution of informal bid packets to pre-qualified contractors.

i. Formal Bid Procedures

i. Preparation.
CalOptima shall prepare or cause to be prepared a bid package. To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications and estimates of cost, giving such directions as will enable any competent contractor to ascertain and carry out the contract requirements. The bid package shall also include a statement of the date and time by which CalOptima must receive bids, the criteria upon which the bids will be evaluated; and a copy of the construction contract.

ii. Notice/Request for Bids.
All prospective bidders who have notified CalOptima in writing that they desire to bid on contracts, and all prospective bidders which CalOptima would like to bid on contracts, shall be furnished with notice and a request for bids, including information as to the type, quality, quantity, date, location and other bid requirements. In addition to notifying all such persons, the notice shall specify the place bids are to be received and the time by which they are to be received.

iii. Advertising/Publication.
Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and

specifying the place bids are to be received and the time by which they are to be received, shall be given by publication once a week for at least two (2) consecutive weeks, as follows:

(A) In a newspaper of general circulation published in such places as are most likely to reach prospective bidders; or

(B) In trade journals or papers of general circulation as the Chief Executive Officer, or designee, deems proper; or

(C) Electronic media may be used in lieu of newspaper advertisements if and when it is believed this media will better serve the needs of CalOptima.

(D) The Chief Executive Officer or designee may waive any irregularity or informality in the publication procedures.

iv. Bidders' Conference

CalOptima may hold a bidders' conference or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice.

v. Bid Form.

CalOptima shall furnish to each prospective bidder a bid package, including an appropriate bid form, prepared by CalOptima for the type of contract being let. Bids not presented on forms so furnished shall be disregarded.

vi. Presentation of Bids Under Sealed Cover.

All bids shall be presented under sealed cover. Upon receipt of each, the bid shall be date-stamped. The bid shall be accompanied by a copy of the construction contract duly executed by the bidder, but which will not be executed by CalOptima until completion of the bid process and CalOptima Board approval, as necessary and appropriate.

vii. Withdrawal of Bids.

Bids may be withdrawn at any time prior to the deadline for submitting bids fixed in the notice only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of the bids does not prejudice the right of the bidder to timely file a new bid. No bidder may withdraw his bid after opening for at least a period of ninety (90) days thereafter.

viii. Opening of Bids and Award of Contract.

At the scheduled date and time, CalOptima shall open the sealed bids. Award of the contract shall be to the ~~lowest qualified~~lowest-price qualified and responsive bidder, if at all, within ninety (90) days after opening, unless the bid package specifies otherwise or the Chief Executive Officer or designee extends the time. All bidders shall have complied with the foregoing bid procedures, except as otherwise provided herein. After a bid is opened it shall be deemed irrevocable for the period specified in the

request for bids. Bids shall be irrevocable for a minimum of ninety (90) days after the opening thereof.

ix. Awards to the Second and Third Lowest Price Qualified Bidders.
If CalOptima deems it is in its best interest, it may, on refusal or failure of the successful bidder to execute the contract or comply with other bid requirements, award it to the second ~~lowest qualified~~lowest-price qualified bidder. If the second lowest price qualified bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima may likewise award it to the third lowest price qualified bidder.

x. Only One Bid or Proposal Received.
If only one bid or proposal is received in response to the request for bids, an award may be made to the sole bidder, provided that CalOptima finds that the price submitted is fair and reasonable.

xi. Notice to Bidders Not Awarded the Contract
Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by regular mail within seventy-two (72) hours after the award of the contract to another bidder.

xii. Qualified Bidder
CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

xiii. Contract Documents
Contract documents shall be prepared in advance, with the approval of Legal Counsel, and shall be incorporated into the bid package as indicated above.

j. Waiver and Rejection Rights
CalOptima reserves the right to reject any and all bids, or to waive any informality or non-substantive defects in bids, as the interest of CalOptima may require. Only those bids shall be considered that are deemed by CalOptima to be responsive to the Request for Bid (RFB) or Request for Quotations (RFQ). The Purchasing Department shall ensure maximum protection of CalOptima's interest consistent with ensuring an equal opportunity and fair and equitable treatment for all bidders.

k. Extensions
The granting of an extension to the contractor is not a new contract. If a contractor makes an application for an extension in writing, CalOptima shall consider matters germane to the particular contract, and shall not grant or deny the extension arbitrarily. However, in any contract which includes provisions for liquidated damages, CalOptima's decision to extend the contract without

charge to the contractor shall be made only when the failure to complete the contract on time is not attributable to the contractor's unreasonable delay or default.

l. Provisions of the policy may be waived by the CalOptima Board.

m. All contractors contracted by CalOptima for the performance of Public Works Projects , as defined in California Labor Code Section 1720, shall pay not less than the required prevailing wages, as provided in Section 1771 of the California Labor Code, if the total payments under that contract are more than $1,000.

n. Payment Bonds – Pursuant to California Civil Code § 3247, for any Public Works project in excess of $25,000, the prime contractor shall submit a payment bond, in a form approved by the Chief Financial Officer and from a surety authorized to do business in the State of California, in the amount of 100% of the contract price.

N. Cooperative Purchases

When it is in CalOptima's Best Interest, the Purchasing Department may enter into or use pre-existing cooperative purchasing agreements for acquisition of goods and services with any entity or group and execute respective contracts under those agreements.

O. Sole Source Purchases

Sole source purchases are not competitively bid and shall not be used unless there is clear and convincing evidence that only one (1) acceptable source exists to fulfill CalOptima's requirements. Sole source purchases involve goods or services that are unique or novel to only one (1) supplier, or products and/or services that are designed to match others already in use.

P. Emergency Purchases

1. The Chief Executive Officer, or designee, may authorize emergency purchases in cases that have or could impose significant provable loss to CalOptima or where human life or property is endangered. When an emergency condition arises, and the need cannot be met through normal procurement methods, the emergency purchase shall be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements shall be executed in accordance with the requirements of CalOptima Policy XX.YYYY: CalOptima Signature Authority.

2. The person responsible for the emergency purchase shall provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor. A written account of the emergency circumstances shall be sent promptly to the Chief Executive Officer and the Board of Directors. Normal purchasing procedures shall be followed as soon as the emergency is over.

Q. Real Property Transactions

CalOptima shall not enter into any transaction for the purchase, sale, lease (including any sublease or lease assignment, whether CalOptima is the lessor, lessee, sublessor, sublessee, assignor or assignee),

or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board of Directors, pursuant to a Board action addressed solely to the transaction or set of related transactions , and setting forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima shall be carried out exclusively by the person or persons designated by the Board of Directors.

R. Ethics

1. CalOptima employees shall conduct themselves in such a manner as to foster public confidence in the integrity of the CalOptima procurement process.

2. CalOptima employees shall perform their duties impartially to ensure that vendors have fair and competitive access to do business with CalOptima.

3. Employees, officers or agents of CalOptima shall be subject to the Conflict of Interest Laws of the State of California and the CalOptima Code of Conduct. Employees, officers or agents of CalOptima who violate these standards shall be subject to the penalties, sanctions or other disciplinary actions provided for therein.

4. Gratuities, Kickbacks, and Contingency Fees
   a. No CalOptima employee shall solicit, demand, or accept from any person anything of monetary value for, or because of, any action taken, or to be taken, in the performance of his/her duties. An employee failing to adhere to the above shall be subject to any disciplinary proceeding deemed appropriate by CalOptima, including possible dismissal.

   b. CalOptima employees shall adhere to all provisions of the CalOptima Policy AA.1204 Gift, Honoraria, and Travel Payment.

5. Confidential Information
   a. No CalOptima employee shall use confidential information for his or her actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima employee by blood, marriage, or by common commercial or financial interest. An employee failing to adhere to this requirement shall be subject to any disciplinary proceeding deemed appropriate by CalOptima, up to and including dismissal.

   b. CalOptima employees shall not divulge confidential information to any vendor, consultant, or contractor.

6. Vendor Relations
   a. CalOptima employees may discuss, on an informal basis, non-financial requirements with contractors, consultants, and vendors. Employees may also solicit information such as brochures and other descriptive material from vendors, consultants, and contractors.

   b. CalOptima employees shall not meet with vendors, consultants, and/or contractors regarding specific financial requirements unless a representative of the Purchasing Department is present at the meeting.

c. CalOptima employees shall not bind, or appear to bind, CalOptima in any way, financially, or otherwise, except as provided for in CalOptima Policy XX.YYYY: Signature Authority. Only the Board, Chief Executive Officer or his/her designee, and those staff designated as signing authorities in Policy XX.YYYY: CalOptima Signature Authority may financially or contractually bind CalOptima.

d. No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have a foreseeable impact on a vendor if a conflict of interest, real or implied, exists. Such a conflict arises when any one of the following has a financial or other interest in the firm selected for award:

i. A CalOptima employee, officer, or agent;

ii. The employee, officer or agent's spouse or dependent children;

iii. The employee, officer or agent's domestic or business partner;

iv. An organization that employs or has made an offer of employment to any of the above.

III. PROCEDURE

Not Applicable

IV. REFERENCE

A. California Fair Political Practices Commission Form 700 - Statement of Economic Interests
B. CalOptima Compliance Program
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Code of Conduct
E. CalOptima Conflict of Interest Code.
F. CalOptima Signature Authority Policy.

DEFINITIONS

A. Public Works: Public Works means any work of improvement contracted for by a public entity (such as CalOptima). Work of improvement includes, but is not restricted to, the construction, alteration, addition to, or repair, in whole or in part, of any building, whether owned or leased by a public entity.

B. RFQ: Request for Quotation: A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specifications of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.

C. RFP: Request for Proposal: The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendors advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms,

including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. It may be a single or multi-step process.

D. IFB: Invitation for Bids: The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.

D. CalOptima's Best Interest:– The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.

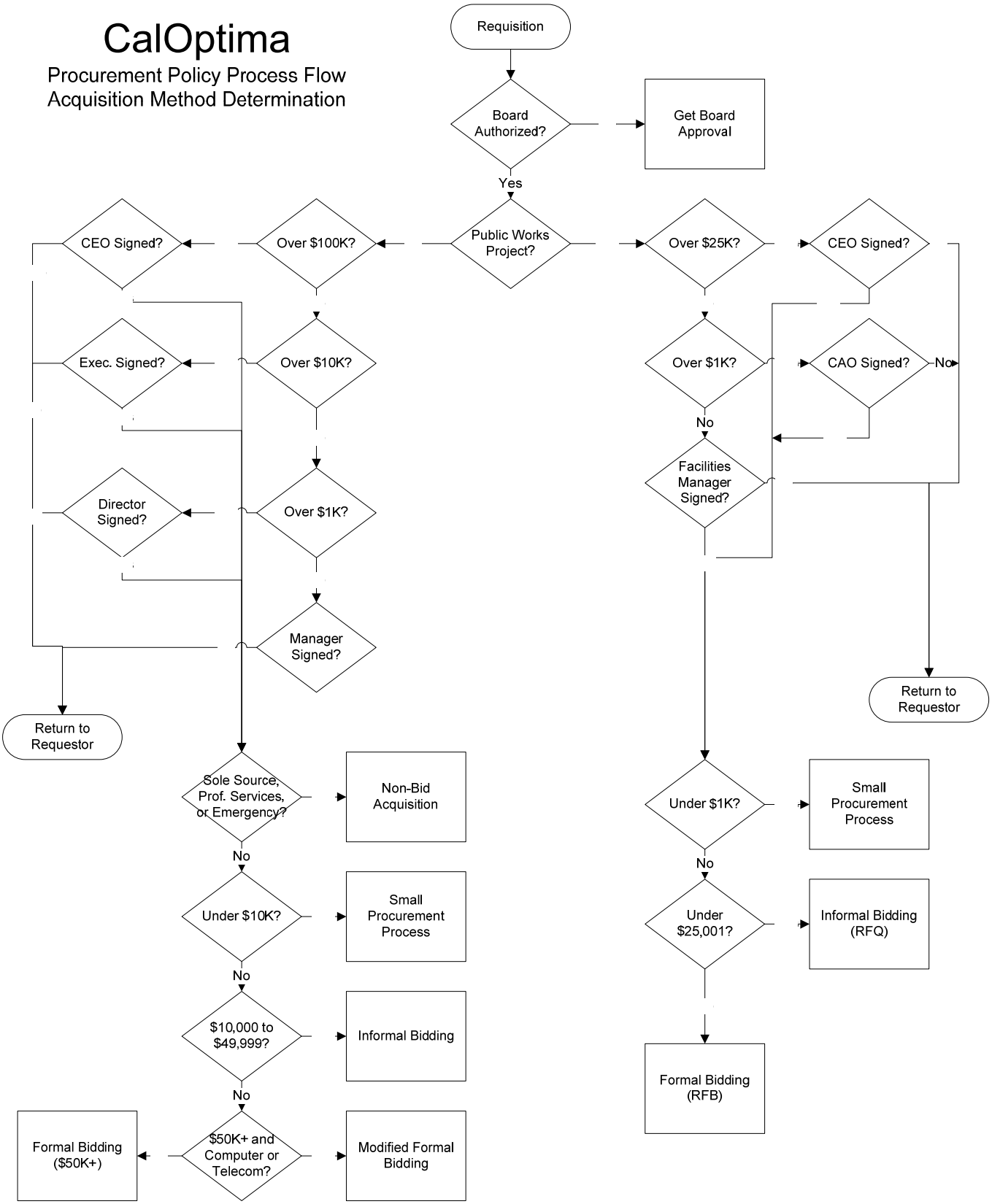
E. Pre-Qualification (of bidders):– The screening of potential vendors in which such factors as financial capability, reputation, and management are considered in order to develop a list of qualified businesses who may then be allowed to submit bids.

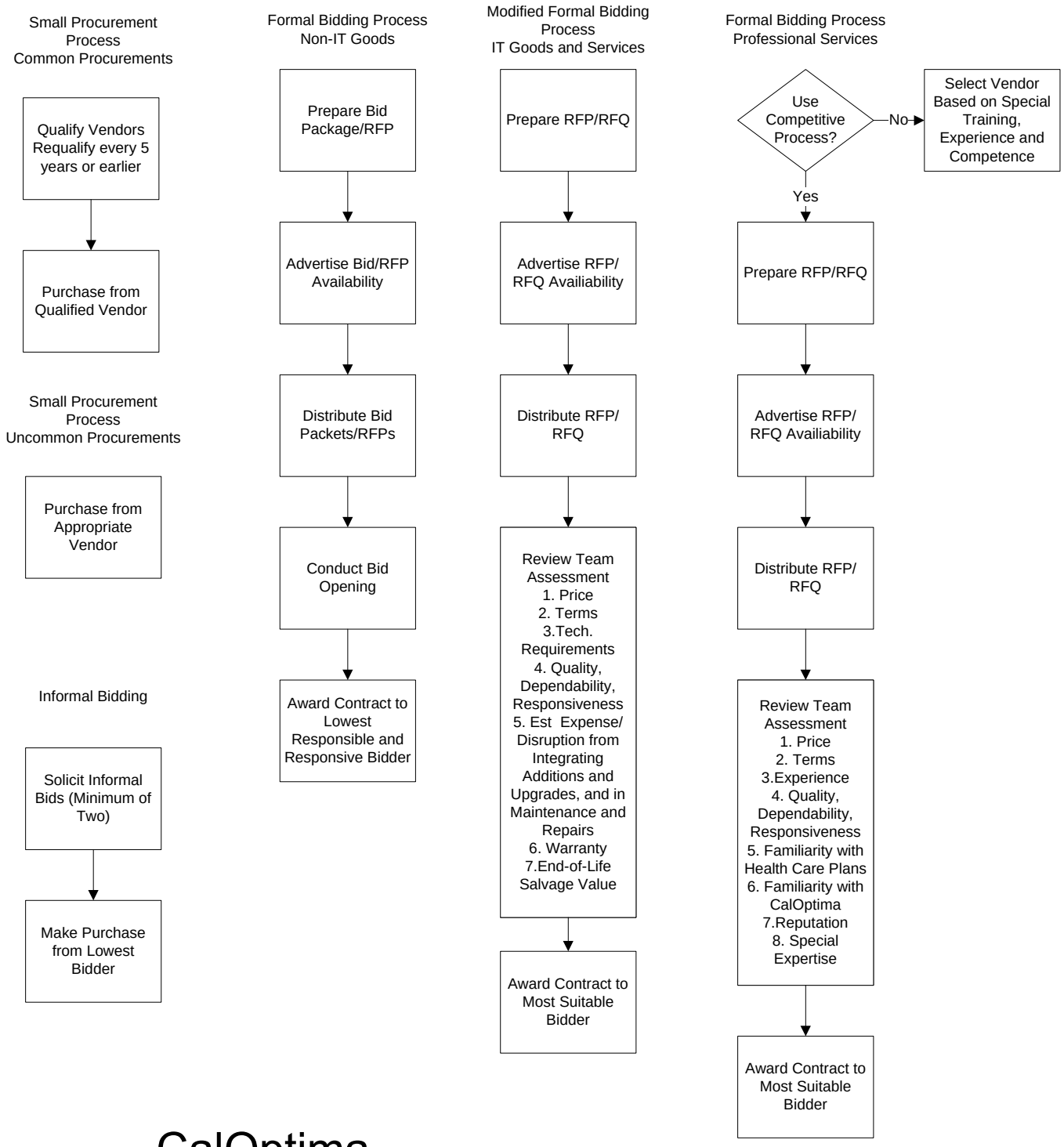
F. Bidder's Conference:– A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.

G. Offeror:– The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.

H. Scope of Work: (SOW): A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes:

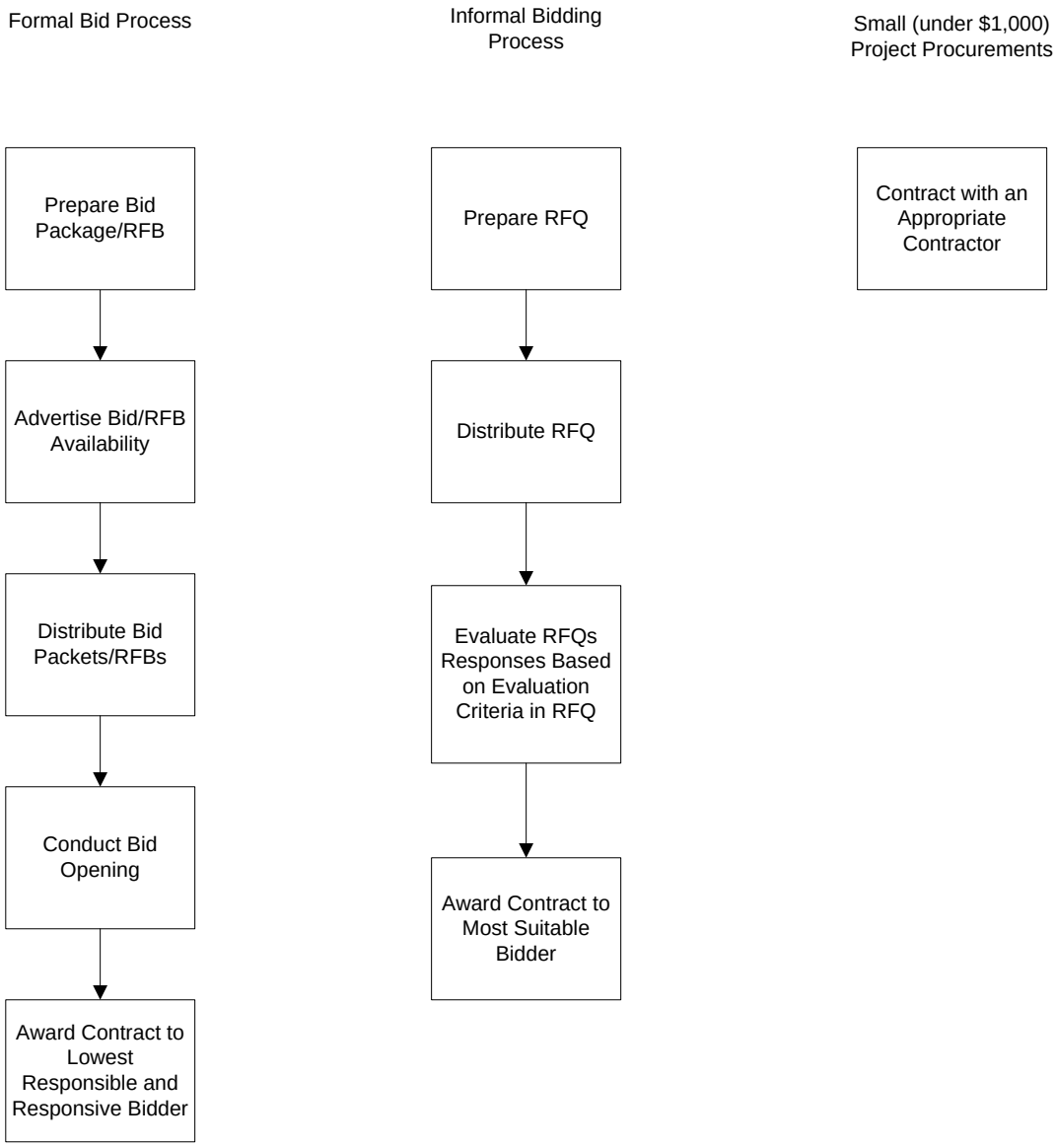
- Establishes clear understanding of what is needed;
- Encourages competition in the marketplace and promotes economic stimulus;
- Satisfies a critical need of government; and
- Obtains the best value for the taxpayer.


CalOptima
Procurement Policy Process Flow
Acquisition Method Determination
Requisition
Board Authorized?
Get Board Approval
Yes
Public Works Project?
Over $25K?
CEO Signed?
Over $1K?
CAO Signed?
No
Facilities Manager Signed?
Return to Requestor
Under $1K?
Small Procurement Process
No
Under $25,001?
Informal Bidding (RFQ)
Formal Bidding (RFB)
Over $100K?
CEO Signed?
Over $10K?
Exec. Signed?
Over $1K?
Director Signed?
Manager Signed?
Return to Requestor
Sole Source, Prof. Services, or Emergency?
Non-Bid Acquisition
No
Under $10K?
Small Procurement Process
No
$10,000 to $49,999?
Informal Bidding
No
$50K+ and Computer or Telecom?
Modified Formal Bidding
Formal Bidding ($50K+)



CalOptima

Procurement Policy
Acquisition Method Flows
Non-Public Works



CalOptima

Procurement Policy
Acquisition Method Flows
Public Works

Policy #:
Title: CalOptima Signature Authority
Dept.:
Section:
Board of Directors/CEO: Richard Chambers _____
Effective Date:

I. PURPOSE

This policy sets forth the requirements for the execution of any document binding CalOptima in any manner.

II. POLICY

A. A CalOptima officer or employee may not expend any funds, or take any other action on behalf of CalOptima, unless the Board has approved such expenditure or action, or delegated its power to that officer or employee, subject to an articulated standard.

B. No document of any type whatsoever that binds CalOptima to undertake or refrain from undertaking any action, or to expend any CalOptima funds, shall be entered into except pursuant to this Policy.

C. In order for any document to bind CalOptima, (1) the Board of Directors must have appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima representative, as identified in this Policy.

D. Amendments or other changes to any document binding CalOptima must be approved and executed in the same manner as the original document, except for minor price deviations as provided within this Policy.

III. PROCEDURE

A. Board of Directors Appropriation—Except in emergency circumstances, as set forth CalOptima Policy GA.5002: Procurement Policy, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or individual Board action, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in Section III.B. of this Policy.

B. Board of Directors Approval—No document binding CalOptima shall be entered into except pursuant to the approval of the CalOptima Board of Directors. In approving, the Board may delegate to a CalOptima officer the authority to enter into agreements that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action—To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement

(contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget—To constitute an authorization through inclusion in CalOptima's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

a. Healthcare Goods and Services (for the direct provision of Covered Services). The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

b. Non-Healthcare-Related Goods and Non-Professional Services—To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

i. The description of specific goods, service or other expenditure;

ii. The number or duration of the goods, service or other expenditure item if available; and,

iii. The dollar amount of the expenditure.

c. Non-Medical Professional Services—Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation, etc.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer, etc.);

ii. The objective of the professional services; and,

iii. The amount of the expenditure.

d. Limitation on Budgetary Authorizations—Authorizations made under this Section III.B.2. only apply to the particular purchase or contract identified in the budget, and do not convey authority for the undertaking of any program, project, or operation to which the contract or purchase relates. Such programs, projects, or operations must be approved through individual Board action as provided above in Section III.B.1.

C. Signature Authority—Documents executed pursuant to Board Authority, as identified in Section III.B. of this policy, may only be executed by the following authorized signers:

1. For authorizations that specify the signature authority in individual COBARs, all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBARs, all related binding documents shall be executed as follows:

   a. Healthcare goods and services For binding documents (such as contracts, amendments, consents to assignment, and letters of agreement (LOAs)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima's lines of business, (e.g., those item budgeted under Section III.B.2.a.):

      i. Except as provided in subsection ii of this Section, execution shall be by the Chief Executive Officer or the Chief Operating Officer.

      ii. For COD contracts that contain no changes from the standard boilerplate contract, and are for rates that do not exceed the Board of Directors-approved rates for the healthcare goods and services, execution may be by the Chief Executive Officer, Chief Operating Officer, or the Executive Director, CalOptima Care Network.

   b. Purchasing Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders),for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

      i. Chief Executive Officer and the Chief Financial Officer, for documents involving an amount of two hundred fifty thousand dollars ($250,000) or more;

      ii. Chief Executive Officer for documents for less than two hundred fifty thousand dollars ($250,000);

      iii. Chief Financial Officer for documents for one hundred thousand dollars ($100,000) or less;

      iv. Director of Finance and Purchasing for documents for twenty-five thousand dollars ($25,000) or less; and,

      v. Purchasing Manager for documents for ten thousand dollars ($10,000) or less.

      vi. For contracts of two hundred fifty thousand dollars ($250,000) or more, the Chief Operating Officer shall have delegated signature authority in the absence of either the Chief Financial Officer or the Chief Executive Officer.

      vii. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed ten percent (10%) of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures as defined in CalOptima Policy GA.5002: Procurement Policy, shall be executed by the Chief Executive Officer or designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. All Other Binding Documents (e.g., MOUs, Settlement Agreements, etc.) shall be executed by the Chief Executive Officer or Chair of the Board of Directors.

IV. FORMS

None

V. REFERENCE

None

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Authorizing the Issuance of a Request for Proposal(s) for CalOptima Real Estate Related Services

Contact

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

Recommended Action

Authorize the issuance of a Request for Proposal(s) for CalOptima real estate related consultant services.

Background

At the January 6, 2011, Special Meeting of the CalOptima Board of Directors, the Board authorized the purchase of an office building located at 505 City Parkway West, Orange, California (505 Building), and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to 10 stories and 200,000 square feet of office space, and a parking structure of up to 5 levels and 1,528 spaces (605 Building Site). The initial expiration date for the Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the Board authorized an amended and restated Development Agreement with the City of Orange to extend the development rights for 6 years, until October 28, 2020. The City of Orange Planning Commission approved the extension on September 15, 2014, and the Orange City Council approved it on November 25, 2014.

At the April 2, 2015, meeting, the Board authorized the identification and negotiation of interim office space leasing options for approximately 40,000 square feet for a term not to exceed five years and at a monthly cost per square foot not to exceed $2.75. In addition, the Board authorized the expansion of the Telework program from 180 staff to no more than 30% of the total budgeted head count at any given time. These actions were taken to address increasing staffing levels.

At the August 6, 2015, meeting, the Board authorized the execution of a 66 month lease agreement with 333 City Tower located at 333 W City Blvd., Orange, California, valued at $6,621,867, and authorized a supplemental budget of $5,464,099 for expenditures on tenant improvements and other space planning options for 41,480 square feet of leased space.

At the March 3, 2016, meeting, the Board authorized the negotiation and execution of a lease agreement with City Plaza located at 1 City Boulevard West, for 66 months and up to 20,000 square feet of office space at a price per square foot not to exceed $2.55 per month. The Board authorized a supplemental budget of up to $2.8 million for expenditures for associated furnishings.

At the August 4, 2016, and December 1, 2016, meeting, the Board authorized a contract with real estate consultant, Newport Real Estate Services, Inc., to provide market research, evaluate development and

Back to Agenda

financial feasibility, make recommendations for Board consideration on the development rights, and develop a site plan.

At the March 2, 2017, meeting, the Board authorized the issuance of a request for information to solicit responses on potential interest and options for CalOptima's development rights.

At the December 7, 2017, meeting, the Board received the results from the Property and Associated Development Rights RFI dated April 21, 2017, authorized exploring the extension of the existing development rights for as long as possible, broadening the development rights from commercial/office to include urban mixed use (including transitional housing). Upon confirming the City of Orange is amenable to the proposed changes, the Board authorized an RFI process on development options that assume no use of Medi-Cal dollars and includes a parking structure and instructed Management to seek assistance from the County of Orange Real Estate Department, as appropriate.

Staff conducted exploring additional leased space, pursuant to Board direction. However, after additional review of short-term capacity in the 505 Building, the departure of former 505 Building tenants, and the delay in implementation of new programs, management determined that space was not needed in the short term due to current building inventory.

Separate from the 505 Building, on February 3, 2011, the Board authorized the CEO to enter into a lease agreement for the CalOptima Program of All-Inclusive Care (PACE) building located at 13300 Garden Grove Boulevard in Garden Grove. The term of the lease for the PACE building is for a period of 10 years, which will expire in 2021.

Discussion

505 Building Capacity

The following provides a summary of the space capacity at the 505 Building. Staff anticipates that after the completion of the 10th floor improvements projected for December 1, 2019, the 505 Building will have a surplus of just 3 open cubes or offices by the end of June 2020.

	Total Cubes/Offices
505 Building Space Capacity	1,042
10th Floor (available for occupancy on December 1, 2019)	85
Total 505 Building Capacity	**1,127**
Occupied Space (as of August 20, 2019)	
Head count	860
Temporary Employees	49
Consultants	13
Subtotal	922
Budgeted head count in the Fiscal Year (FY) 2019-20 Operating Budget (includes current vacant positions, new approved positions, and staffing related to new programs)	202
Projected 505 Building Head Count by June 30, 2020	**1,124**
Total Shortfall/Surplus	**+3**

Back to Agenda

The total head count does not include budgeted PACE employees, Teleworkers or Community Workers.

Considering the 10th floor improvements and the FY 2019-20 budgeted head count, the 505 Building will likely reach full occupancy within the next 12-month period. At that time CalOptima will have no additional space to accommodate future growth.

Parking Supply

The following provides a summary of on-site parking spaces. The existing on-site parking for the 505 Building is 738 spaces.

The following table provides an overview of available parking spaces by type.

Type	**Total**
Regular	691
Visitor	15
Reserved	17
Handicap	15
Total*	**738**

* Total includes 65 overflow parking spaces from the 500/600 Building shared lot.

In addition, CalOptima has a reciprocal parking easement with neighboring properties located at 500 and 600 City Parkway West, which provides access to the non-exclusive use of 725 additional parking spaces.

	Total
Projected 505 Building Head Count by June 30, 2019	1,124
Total Regular On-Site Parking Capacity	691
Total Shortfall/Surplus On-Site (not factoring in reciprocal parking easement)	**-433**

*The total head count does not include budgeted PACE employees, Teleworkers or Community Workers.

Based on the head count of 922 individuals occupying current space in the 505 Building as of August 20, 2019, the number of regular on-site parking spaces available, depending on the time and day of the week, at the 505 Building, may be a shortfall of as many as 231 regular on-site spaces. Staff projects that once budgeted FTE's in the FY 2019-20 Operating Budget are filled, the shortfall may increase to 433 as many as regular on-site spaces by the end of June 2020. Because the reciprocal parking easement provides for non-exclusive use of the neighboring parking lots, tenants of the neighboring properties will be competing with CalOptima employees and visitors for parking spaces in the reciprocal parking easement area. Furthermore, the neighboring property owner is planning to build a housing development and parking structure in the reciprocal parking easement area, which may limit availability of parking spaces during construction.

PACE

In addition to real estate related activities at the 505 Building, staff is also focused on the PACE site and addressing the current lease term which ends in 2021.

Back to Agenda

Recommendation

In light of the anticipated office space issues and parking needs at the 505 Building, Management recommends that the Board authorize the issuance of an RFP for CalOptima real estate related consulting services. Obtaining the expertise of a real estate consultant(s) to help gather data and evaluate the options below, along with development of a strategic real estate plan will provide decision support to the Board. Specifically, the RFP(s) would include the following scope(s) of work items:

- Review the North Orange County commercial real estate market to determine the availability of space for lease;
- Review the North Orange County commercial real estate market to determine the availability of buildings to be purchased;
- Provide a financial analysis comparing lease options to purchase options;
- Create a parking map of available local parking for rent;
- Develop different options for a strategic real estate plan to meet CalOptima's needs
- Continue negotiations with the City of Orange to extend and potentially modify the Development Agreement to best meet the needs of CalOptima, possibly in two steps (e.g., extend existing agreement first, then work to broaden the scope of the Development Agreement as a possible second step); and
- Represent CalOptima in negotiations and exploration of real estate options for the PACE program (including but not limited to reviewing the possibility of extending the lease at the current PACE site and examining the local commercial real estate market to ascertain the proper renewal rate for the PACE lease renewal at fair market value).

Management plans to return to the Board to request funding authorization for the selected vendor and anticipates presenting a report to the Finance and Audit Committee at the November 21, 2019, meeting and to the full Board at its December 5, 2019 meeting.

Fiscal Impact

The recommended action to authorize the issuance of an RFP for CalOptima real estate related services does not have a fiscal impact. Management will return to the Board to request authorization for funding upon completion and recommendation of a vendor identified through the RFP process.

Rationale for Recommendation

Management anticipates that CalOptima's space needs will continue to grow in the short-term. In order to ensure such growth is adequately met in the future, and to assist the Board in determining next steps with the existing Development Agreement with the City of Orange, and the PACE program, Management recommends engaging a real estate consultant(s).

Concurrence

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

Back to Agenda

Attachments

1. Board Action dated January 6, 2011, Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a purchase and sale agreement, and to execute all documentation necessary to complete the transaction
2. Minutes of Board meeting dated February 3, 2011, Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a lease agreement consistent with the terms of the Letter of Intent located at 13300 Garden Grove Blvd., Garden Grove, California
3. Board Action dated October 2, 2014, Consider Authorizing Extension of CalOptima Headquarters Building Site Development Agreement with the City of Orange
4. Board Action dated April 2, 2015, Consider Interim Office Space Leasing Options and Adjustment to Current Limitation on Telework Participation to Reflect Increasing Staffing Levels
5. Board Action dated August 6, 2015, Consider Authorizing Execution of Lease Agreement for Office Space, Expenditures on Tenant Improvements and Other Space Planning Options
6. Board Action dated March 3, 2016, Authorize Staff to Negotiate a Lease Agreement for Office Space, Expend Funds on Furnishings and Evaluate and Pursue Other Space Planning Options
7. Board Action dated August 4, 2016, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
8. Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
9. Board Action dated March 2, 2017, Consider Options for Development Rights at 505 City Parkway West, Orange, California Site
10. Board Action dated December 7, 2017, Consider Actions Related to CalOptima's Development Agreement with the City of Orange

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

Real Estate

Special Board of Directors Meeting
January 6, 2011

Kim Cunningham, Chief Administrative Officer
Michael Engelhard, Chief Financial Officer

Back to Agenda

Background

- Developed a real estate strategy over past 18 months due to approaching lease expirations in current building
- Contracted with Jones Lang LaSalle brokerage firm to assist in evaluation of real estate options – lease vs. buy
- Established certain criteria for any real estate action including:
  - economic feasibility,
  - future space needs, and
  - location
- Considered a number of lease and purchase options
- Worked closely with the Board of Directors to fully vet options

Background (Continued)

- Decline in the Orange County commercial real estate market created opportunities to economically purchase or lease office space

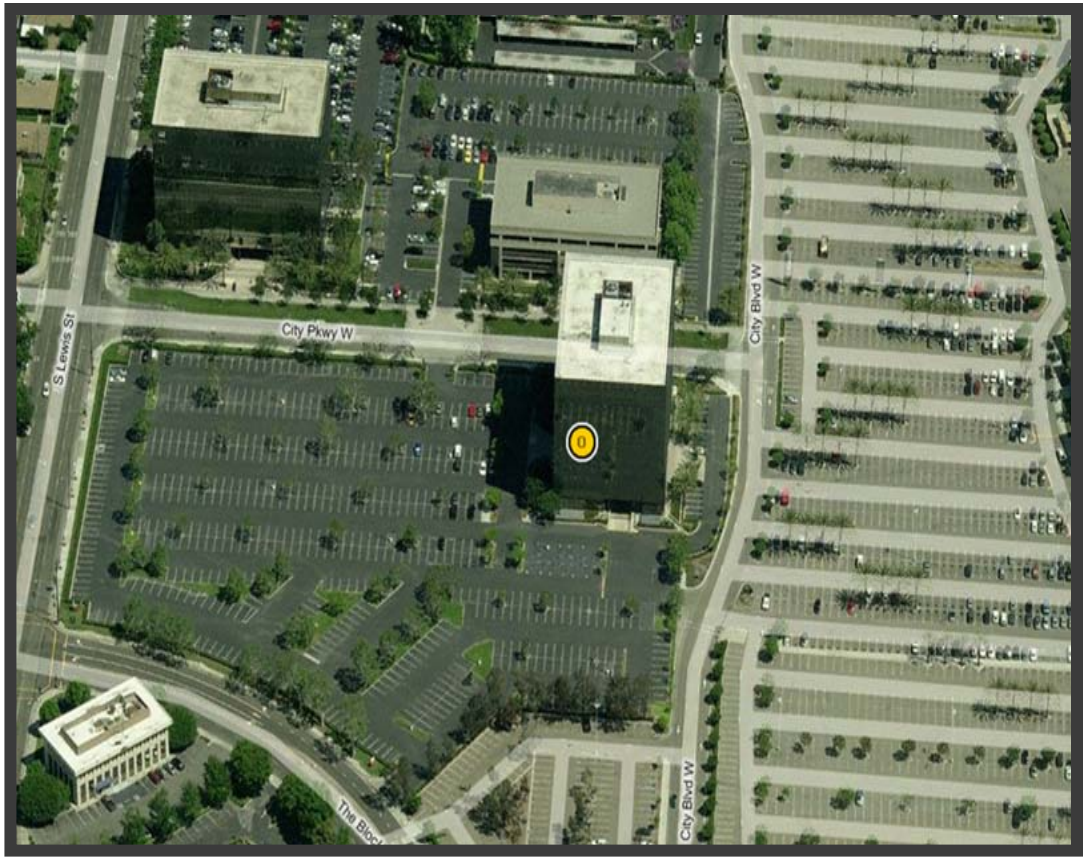
- Major concerns about current location:
  - Out of space today (without telework implementation, we would have had to lease more space elsewhere)
  - Current location cannot accommodate anticipated future growth up to 125,000-130,000 rentable square footage (RSF) by 2014
  - Parking is constrained; need to seek opportunities to improve
  - Space for community and Board meetings is limited

- Considered a number of properties before identifying the building at 505 City Parkway West in Orange as a match for our needs

505 City Parkway West Building Specifics

- 203,000 RSF
- 10-story building
- Built in 1976
- 55,000 square feet currently leased by three tenants
- Remaining square footage provides more than adequate room for future CalOptima expansion needs
- Located in Orange next to The Block shopping center
- Excellent location for members – 1 mile from current location and good access to public transit

505 City Parkway West



Back to Agenda

505 City Parkway: Financial Summary

- Purchase Price = $30,200,000 (all cash)
- Price = $149 per RSF
- Tenant Improvement and Capital Expenditure Costs = $10,600,000 (estimate)
- Key Economics:
  - Cumulative Cash Flow Benefit = $1,500,000 over the next 20 years (excludes impact of residual building value)
  - Positive Net Present Value (NPV) of purchase vs. leasing at existing location

505 City Parkway: Financial Considerations

- Right time to buy: office building prices have dropped considerably in past 2-3 years

- Effective use of Tangible Net Equity (TNE) requirement
  - CalOptima needs to hold a minimum of $40,000,000
  - Can put this to better use than keeping in “cash” especially at current low investment returns
  - CalOptima has never spent cash balances down to this level so provider payments should not be impacted

- Building is a “Convertible” Asset
  - This asset can be easily monetized through bank loan if needed

- Asset appreciation over long-term: real estate is a good hedge against inflation

CalOptima
A Public Agency
Better. Together.

Back to Agenda

Next Steps

- Board action today to approve the purchase
- Engage consultants and contractors to prepare budgets for building occupancy and to complete capital improvements
- Bring final building operating budget to Board for approval within next 60 days (e.g., property management expenses, insurance, and utilities)
- Bring final tenant improvement budget to Board within next 90 days (e.g., capital improvements and office build out)

Recommendation

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into a purchase and sale agreement, and to execute all documentation necessary to complete the transaction.

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 3, 2011

A Regular Meeting of the CalOptima Board of Directors was held on February 3, 2011, at CalOptima, 1120 W. La Veta Avenue, Suite 200, Orange, California.

CALL TO ORDER
Chair Michael Stephens called the meeting to order at 3:03 p.m.

ROLL CALL

Members Present: Michael D. Stephens, Chair; Edward Kacic, Vice Chair; Mary Anne Foo, Jim McAleer, Margarita Pereyda, M.D., Supervisor John M. W. Moorlach, David L. Riley

Members Absent: Chung The Bui, M.D.

Others Present: Richard Chambers, Chief Executive Officer; Gregory Buchert, M.D., Chief Operating Officer; Gertrude S. Carter, M.D., Chief Medical Officer; Michael Engelhard, Chief Financial Officer; Gary Crockett, Chief Counsel; Kim Cunningham, Chief Administrative Officer; Suzanne Turf, Clerk of the Board

Presentation to Supervisor John Moorlach
On behalf of the Board of Directors, Chair Stephens honored Supervisor Moorlach for his four years of service on the Board of Directors and for his commitment to the CalOptima program. Supervisor Moorlach will continue to serve on the Board of Directors as an Alternate member.

MINUTES

Approve the Minutes of the January 6, 2011 Special Meeting and the January 6, 2011 Regular Meeting of the CalOptima Board of Directors; Receive and File the Minutes of the September 9, 2010 and November 11, 2010 Regular Meetings of the CalOptima Board of Directors' Provider Advisory Committee, and the September 9, 2010 Minutes of the Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Vice Chair Kacic, seconded and carried, the Board of Directors approved the minutes of the January 6, 2011 Special Meeting and the January 6, 2011 Regular Meeting of the Board of Directors as presented; the minutes of the Provider and Member Advisory Committees were received and filed. (Motion carried 7-0; Director Bui absent)***

Back to Agenda

PUBLIC COMMENT

Paul Yost, M.D. – Oral Re: Recognition of Supervisor Moorlach for his service on the Board of Directors.

Peter Anderson, M.D., Janice Glaab, and Paul Yost, M.D. – Oral Re: VI. B, Approve Refinements to the Methodology for Distribution of Supplemental Provider Payments as Part of the Revised CalOptima Medi-Cal FY 2010-11 Operating Budget.

Reed Royalty and Julie Puentes – Oral Re: VI. C, Revision to CalOptima Board of Directors January 6, 2011 Report Item VI.B., to Clarify the Scope of Research and Business Planning Services CalOptima Seeks to Prepare for the Implementation of the 2010 Patient Protection and Affordable Care Act.

CONSENT CALENDAR

A. Authorize the Chief Executive Officer to Negotiate and Execute an Amendment to the Aging and Disability Resource Center Grant Agreement Administered by the California Health and Human Services Agency

B. Approve the FY 2010-11 Operating Budget for the Real Property Located at 505 City Parkway West, Orange, California

Action: ***On motion of Supervisor Moorlach, seconded and carried, the Consent Calendar was approved as presented. (Motion carried 7-0; Director Bui absent)***

REPORTS

Authorize the Chief Executive Officer to Issue a Request for Proposal for Pharmacy Benefits Manager Services

Chief Medical Officer Gertrude Carter, M.D. presented the recommended action to authorize the Chief Executive Officer to issue a Request for Proposal (RFP) for Pharmacy Benefits Manager (PBM) services.

The current PBM contract for CalOptima's pharmacy program has been in place since January 1, 2007 and will expire on December 31, 2011. Services provided under the current PBM contract include pharmacy claims administration, prior authorization of off-formulary prescriptions, contracting with pharmacies, and management reporting services. The objectives of the PBM RFP process are to ensure member access to medically necessary pharmaceutical care, and to procure PBM services that meet Federal and State contractual and regulatory requirements.

Dr. Carter stated that the RFP will be generated with the assistance of a consultant. The estimated cost of consultant services is $40,000, which is included in the FY 2010-11 Budget. Staff will provide periodic updates to the Board regarding the progress.

Back to Agenda

Action: ***On motion of Director Pereyda, seconded and carried, the Board of Directors authorized the CEO to issue an RFP for PBM services as presented. (Motion carried 7-0; Director Bui absent)***

Approve Refinements to the Methodology for Distribution of Supplemental Provider Payments as Part of the Revised CalOptima Medi-Cal FY 2010-11 Operating Budget

Gregory Buchert, M.D., Chief Operating Officer, presented the following recommended actions: approve modification of January 6, 2010 Board Agenda Item VI.B, to align provider distributions and projected incremental Medi-Cal revenue; and, approve refinements to the distribution methodology for additional funds included in CalOptima's FY2010-11 Medi-Cal rates.

Dr. Buchert stated that the Board approved the revised FY 2010-11 Medi-Cal Operating Budget on January 6, 2011, which included an estimated $20.9 million targeted for provider payment adjustments. Since the January meeting, staff has analyzed additional data that indicates the financial projection is approximately $2 million less favorable than previously forecast. Based on this analysis, $18.9 million has been identified for provider payment adjustments. Input regarding the distribution of new revenue was solicited from the Member and Provider Advisory Committees, the health networks, the Orange County Medical Association and the Hospital Association of Southern California.

Dr. Buchert provided an overview of the proposed distribution of funds as follows: health network capitation increase, $10.1 million; quality, access, and efficiency initiatives, $4.3 million; State MAC pricing implementation reserve, $1.5 million; investments in clinics, $500,000; and, hospital rate freeze reserve, $2.5 million. It was noted that the proposed refinements to the amount and the methodology for distribution of additional Medi-Cal revenue are in line with the reforecasted budget approved by the Board on January 6, 2011.

After discussion of the matter, the Board delayed action on the distribution of $10.1 million for health network capitation increases and $4.3 million in quality, access and efficiency initiatives for 30 days pending additional review by staff and an ad hoc of the Board.

Action: ***On motion of Director McAleer, seconded and carried, the Board of Directors approved the modification of the January 6, 2011Board Agenda Item VI. B., from $20.9 million to $18.9 million to align provider distributions and projected incremental Medi-Cal revenue; and approved the methodology for the distribution of $4.5 million in additional funds included in CalOptima's FY2010-11 Medi-Cal rates as presented: State MAC Pricing Implementation Reserve, $1.5 million; investments in clinics, $500,000; and, hospital rate freeze reserve, $2.5 million. (Motion carried 7-0; Director Bui, absent)***

Back to Agenda

Revision to CalOptima Board of Directors January 6, 2011 Report Item VI.B., to Clarify the Scope of Research and Business Planning Services CalOptima Seeks to Prepare for the Implementation of the 2010 Patient Protection and Affordable Care Act (ACA)

Dr. Buchert presented the following recommended actions: approve the revision to CalOptima Board of Directors January 6, 2011, Report Item VI.B., to clarify the scope of the research and business planning services CalOptima seeks to prepare for the implementation of ACA; and, approve the decision that CalOptima refrain from taking any actions to participate in California's Health Insurance Exchange created pursuant to AB 1602 and authorized in the ACA.

Dr. Buchert reported that the action approved by the Board on January 6, 2011 authorized the Chief Executive Officer to release a Request for Proposal (RFP) to select and contract with one or more consulting firms to study the impact of ACA on CalOptima in two key areas: 2014 Medi-Cal expansion and the Health Insurance Exchange. Dr. Buchert stated that CalOptima anticipates substantial growth in the Medi-Cal program by 2014, and staff will need to focus on developing a strong business plan for this expansion. It was recommended that the RFP be limited to research and analysis pertaining to the 2014 Medi-Cal expansion activities. It was also recommended that CalOptima refrain from examining, researching, or pursuing its participation in California's Health Insurance Exchange.

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

Action: ***On motion of Supervisor Moorlach, seconded and carried, the Board of Directors clarified January 6, 2011 Board Agenda Item VI. B. to limit the Health Care Reform Business and Strategic Planning RFP the scope of work to the ACA Medi-Cal Expansion and not participation in the Health Insurance Exchange; and, CalOptima would refrain from taking any actions to participate in California's Health Insurance Exchange created pursuant to AB 1602 and authorized in the ACA. (Motion carried 5-1, Vice Chair Kacic voting no; Directors Bui and McAleer absent)***

Director Riley reported that the Board of Supervisors recently authorized the Orange County Health Care Agency to apply for a Waiver with the State of California under Section 1115 of the Social Security Act. Mr. Riley commented on the transition of the MSI population as it relates to health care reform in 2014, and proposed that CalOptima and county staff work together to evaluate how this transition can be accomplished on an accelerated timeframe; additional information and a proposal on an early transition to be presented to the CalOptima Board of Directors for consideration.

CEO AND MANAGEMENT REPORTS

Dr. Buchert provided a brief update on the goals and accomplishments of the Managed System of Care (MSC) initiative. MSC is composed of representatives of profit and not-for-profit hospital systems, community clinics, practicing physicians, the Health Funders' Partnership, the Orange County Health Care Agency and CalOptima with the goal of addressing the financing and delivery of care for the uninsured in Orange County in preparation for 2014. Dr. Buchert

Back to Agenda

reported that CalOptima has played a major role in accomplishing MSC goals in the following areas: medical home and coordinated care, specialty care, behavioral health services, urgent care, acute and tertiary hospital care, pharmacy services, and health information technology. As co-chair of the MSC, Vice Chair Kacic congratulated CalOptima staff for the progress that has been made with this effort.

INFORMATION ITEMS

Federal and State Update

Margaret Tatar, Public Affairs Director, presented an overview of the Governor's January Budget Proposal released on January 10, 2011. The proposed budget projects a $25.4 billion deficit over the next 18 months, and proposes closing that deficit with $26.4 billion in spending cuts, taxes, and other budget solutions. The proposed budget includes an overall 3.9% increase to Medi-Cal managed care plans, elimination of the Multipurpose Senior Services Program and Adult Day Health Care, and includes an extension of the hospital fee program through June 30, 2011.

Ms. Tatar reported that the proposed budget includes a restructuring process that shifts funding and responsibility for certain services between the state and local governments over the next five years, including a proposed five-year tax extension measure on the June special election ballot. The Governor assumes that the Legislature will approve the solutions in the proposed budget by March 1, 2011. Staff will continue to keep the Board informed of the progress.

Presentation by Lobbyists

This item was deferred to a future Board meeting.

Update on Behavioral Health Integration

The Behavioral Health Integration Update was continued to the March 3, 2011 Board of Directors Meeting.

CalOptima Care Network Update, Healthy Families Program Update, and CalOptima Regional Extension Center Update

The updates on the CalOptima Care Network, Healthy Families Program, and the CalOptima Regional Extension Center were accepted as presented.

December 2010 Unaudited Financial Statements

Mr. Engelhard presented a brief overview of the unaudited financial statements for the period ended December 31, 2010. The year-to-date change in net assets for all CalOptima lines of business was reported at $(6.3) million, $4.5 million unfavorable to budget. Enrollment for the month of December totaled 421,517, an increase of 5.2% compared to December 2009

PACE Update

Peerapong Tantameng, PACE Manager, presented a brief review of the overall integration program strategy that includes a fully developed multi-site PACE system for Orange County with services that are accessible to all county residents and partners with existing community and long-term care providers. Part 2 of the PACE application will be filed with the DHCS in

Back to Agenda

May, and a community advisory committee will be convened. It is anticipated that the CalOptima PACE center will open in April 2012.

Mr. Engelhard provided an overview of the PACE financial projections. Capital investments of $6.2 million include tenant improvements and equipment; operational breakeven is anticipated in the seventeenth month of operation; and, operational breakeven net income census is 114. Investment returns are favorable over a ten-year period, and a ten-year return on investment is projected at approximately 16.2%, which is consistent with the average financial performance other PACE organizations.

BOARD MEMBER COMMENTS

Vice Chair Kacic commented on the arguments presented and the action taken regarding CalOptima's participation in the California Health Insurance Exchange (agenda item VI. C.), and stated that he voted against the recommended action because a decision of this magnitude should not be made without conducting research and obtaining data to support such a decision.

Supervisor Moorlach extended congratulations to Kerri Ruppert Schiller, Chief Financial Officer (CFO) of Children's Hospital of Orange County for her recognition by the *Orange County Business Journal* as CFO of the Year. Mr. Moorlach also commented in support of the Health Care Agency and CalOptima working together on the transition of the MSI population and offered his support to this effort.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 5:10 p.m. pursuant to: (1) Government Code § 54956.8, Conference with Real Property Negotiator: Property: 13300 Garden Grove Blvd., Garden Grove, CA 92843; Agency Negotiator: Grant Freeman, Ronda Clark, and Joe Bevan, Jones Lang LaSalle; Negotiating Parties: CalOptima and Mr. Young S. Kim and Ms. Soon Y. Kim; and, (2) Government Code § 54957, Public Employee Performance Evaluation [Chief Executive Officer].

The Board reconvened in open session at 5:33 p.m. to address the following Reports.

Consider Approval of the Terms of Agreement Concluding Real Estate Negotiations

Chair Stephens reported that the CalOptima Board of Directors met in closed session with its negotiators regarding the price and terms of payment for the lease of the real property listed on the agenda and located at 13300 Garden Grove Blvd., Garden Grove, CA 92843.

After discussion of the matter, the Board took the following action:

Action: ***On motion of Vice Chair Kacic, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into a lease agreement consistent with the terms of the Letter of Intent, and to execute all documentation necessary to complete the lease transaction. (Motion carried 5-0; Directors Bui, McAleer and Pereyda absent)***

Back to Agenda

Consider Chief Executive Officer Employment Agreement and Incentive Compensation
This item was continued to the March 3, 2011 Board of Directors meeting.

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

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: March 3, 2011

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. F. Consider Authorizing Extension of CalOptima Headquarters Building Site Development Agreement with the City of Orange

Contact
Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into an Amended and Restated Development Agreement with the City of Orange, contingent upon approval by the Orange City Council, extending CalOptima's development rights for up to six years.

Background
In January of 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California. In conjunction with the purchase, CalOptima obtained development rights related to a 2004 Development Agreement with the City of Orange, covering the parcel owned by CalOptima. These development rights include the possible construction of an office tower up to ten-stories and 200,000 square feet of office uses and a maximum five-level, 1528 space parking structure. Per the Development Agreement, both the second office tower and the parking structure are classified under the 605 Building Site. The current ten (10) year Development Agreement is set to expire on October 28, 2014.

Discussion
As part of CalOptima's long-term staffing and space plan, there is a potential need for additional office space beyond what is available within the currently-existing current building. Specifically, the plan includes protecting CalOptima's current development rights on the 505 Building Site, and preserving CalOptima's ability to build additional office space and parking if deemed necessary by the Board.

This item was conceptually approved by your Board of Directors at the September 4, 2014 meeting as part of the Capital Improvement Budget discussion, and the specific direction from the Board to pursue an extension of the Development Agreement and return to the Board for final approval.

Due to the pending expiration of the current Development Agreement, staff worked with CalOptima's consultant and staff at the City of Orange to draft the Amended and Restated Development Agreement (2014 DA), which grants CalOptima up to a six (6) year extension on the current terms.

Along with the extension, the 2014 DA requires that additional Public Benefit Fees be paid by CalOptima to the City of Orange. The total cost of these fees is up to $200,000. However, the fees are broken down into three installments as follows:

1. $50,000 upon the execution of the 2014 DA;
2. $50,000 prior to the second anniversary of the effective date of the 2014 DA;
3. $100,000 prior to the fourth anniversary of the effective date of the 2014 DA.

Back to Agenda

This payment structure allows development flexibility to CalOptima to further determine its office space needs.

This extension was approved by the City of Orange Planning Commission on September 15, 2014, and is scheduled to be considered at the October 14, 2014 meeting of the Orange City Council.

Fiscal Impact
The cost of the extension to the current Development Agreement will not exceed $200,000 over a six-year period, contingent upon the payment schedule. Costs will be funded via existing reserves, and allocated according to the timeline enumerated above.

Rationale for Recommendation
The extension to the current Development Agreement preserves CalOptima's existing development rights and provides flexibility for future growth at the 605 Building Site. Approval of this item will ensure CalOptima has the flexibility to make needed facility improvements under current land use standards and regulations, which allows for greater certainty in terms of project schedules and budget requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
2014 Amended and Restated Development Agreement

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

Back to Agenda

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of _____, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region;

Back to Agenda

(iii) this Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange**." A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

Back to Agenda

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

Back to Agenda

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

Back to Agenda

(c) "**Discretionary Actions**" and "**Discretionary Approvals**" are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) "**Effective Date**" is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) "**Future Approvals**" means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the "**Unused Trips**") may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the “fair share” of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The “fair share” of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the “fair share” contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

Back to Agenda

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting

Back to Agenda

payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with

Back to Agenda

the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5

Back to Agenda

shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

Back to Agenda

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits, certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer

Back to Agenda

is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated

representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this

Back to Agenda

Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

Back to Agenda

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow. Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall

be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval

Back to Agenda

of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee, Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a

Back to Agenda

mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:

City of Orange
300 East Chapman Avenue
Orange, CA 92866
Attention: City Manager
Facsimile: (714) 744-5147

Back to Agenda

With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

Back to Agenda

20. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

21. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

22. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

23. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit “C” – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

24. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

25. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

26. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental

Back to Agenda

hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

27. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

_____
Teresa E. Smith, Mayor

ATTEST:

_____
Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima

_____
its _____

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima

_____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On _____, before me, _____, a Notary Public in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

_____
Notary Public in and for said State

(SEAL)

STATE OF _____)
) ss.
COUNTY OF _____)

On _____, before me, _____, a Notary Public in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

_____
Notary Public in and for said State

(SEAL)

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

Back to Agenda

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions [3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St./Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St./Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

Back to Agenda

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

TABLE OF CONTENTS

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VIII. D. Consider Interim Office Space Leasing Options and Adjustment to Current Limitation on Telework Participation to Reflect Increasing Staffing Levels

Contact

Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of legal counsel, to identify and enter into negotiations for approximately 40,000 square feet of office space for a term not to exceed five years and at a monthly cost per square foot not to exceed $2.75; staff will return to the Board for approval of the proposed transaction; and
2. Authorize the Chief Executive Officer to expand the Telework program from 180 staff to no more than 30% of the total budgeted headcount at any given time (current total employee count is approximately 900).

Background

CalOptima has experienced unprecedented growth over the past two years, and is expected to continue to grow with the expansion of managed care in both Medicaid and Medicare programs, the implementation of the Coordinated Care Initiative, the establishment of a Community Network, and the increased regulatory requirements such as the Model of Care. These programs have resulted in a corresponding increase in CalOptima's staffing levels that have grown from approximately 400 to 900 staff in the past year and a half.

Looking forward, CalOptima management expects headcount to grow to approximately 1,100 staff by the beginning of Fiscal Year (FY) 2015-2016, with continuing modest growth in the months following, leveling out to approximately 1,300 staff by the beginning of FY 2017-2018. In addition, best practice to ensure adequate workspace planning recommends planning for a 10% capacity adjustment to accommodate this required flexibility. By applying this factor to the projected staffing levels, CalOptima will need approximately 1,400 work spaces by the end of FY 2017-2018.

CalOptima's current policy for teleworking was most recently considered by the Board on June 6, 2013, at which time a cap of 180 teleworker slots was approved. At this time, all of these slots are being utilized.

Discussion

Current building capacity, including space currently occupied by our tenants, is approximately 1,000 work spaces. The two (2) tenants in the building occupy half of the second floor, the full third floor and half of the tenth floor, totaling approximately 200 work spaces. This leaves CalOptima with approximately 800 of the 1,000 work spaces available in the building. Management has approached both tenants about their willingness to end their leases early. Only one has shown interest although

Back to Agenda

nothing has been finalized to date. Should the tenant decide to vacate, it will take approximately six months to build out the floor(s) for occupancy by CalOptima.

In the short term, defined as current to three years out, CalOptima will need to secure additional space to accommodate the immediate growth needs in the coming months. To date, management has been creative in handling the growth thus far by leveraging the 180 telework positions under the Board-approved CalOptima Policy GA.8044: Telework Program. In addition, management has repurposed conference rooms, common work spaces and other areas to maximize capacity on each floor.

All of these factors considered, CalOptima will need approximately 40,000 square feet of additional space in the short term to accommodate the growth discussed above. There are several options available to CalOptima in order to secure the additional space:

1. Expand the Telework program to partially accommodate the additional need. This action alone is not a viable short term solution because teleworking is not available to all program areas, including areas in which there will be significant staff growth (e.g., Case Management, Customer Service).

2. Secure a long term lease. This is a viable option, but will require CalOptima to sign a 7 to 10 year commitment, and may require more lead time.

3. Secure a short term or sub-lease. This, along with an incremental increase in the Telework program, is management's recommended option due to the shorter duration of the lease (i.e., 3 to 5 years) and the flexibility for quick occupancy, particularly if the selected site is already furnished.

CalOptima has secured real estate services from Cushman and Wakefield pursuant to the Board-approved CalOptima Policy GA.5002: Purchasing Policy. Cushman and Wakefield has provided eleven (11) different lease alternatives in the surrounding area for CalOptima's consideration. Management will continue to vet the alternatives, and evaluate price and terms within Board approved parameters, and return to the Board for final approval.

Fiscal Impact

Staff estimates that the cost of the leased space will range between $2.20 and $2.75 per square foot, or approximately $1 million to $1.32 million annually. Also, staff anticipates additional expenses associated with preparing and maintaining the newly leased space. These expenses were not included under this fiscal impact.

Rationale for Recommendation

Management believes that by securing a short term lease, CalOptima will obtain the additional space required to address the immediate growth needs to effectively support our programs at a cost that will be reasonable. By securing a space that provides the opportunity for quick occupancy, CalOptima could be ready to occupy the newly leased space within a three to six month timeframe. Selection of

Back to Agenda

a short term lease would also provide additional time for management and the Board to consider longer term options. In addition to adding space, moving the Telework program cap to 30% of budgeted headcount provides management with the flexibility to manage additional growth while minimizing the need for additional space. In addition, expanding teleworking will provide CalOptima with additional leverage in recruiting hard to fill positions such as clinical staff, IT specialists, etc., that may not be located in the immediate area or willing to relocate to Orange County.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *3/27/2015*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. K. Consider Authorizing Execution of Lease Agreement for Office Space, Expenditures on Tenant Improvements and Other Space Planning Options

Contact
Bill Jones, Chief Operating Officer, (714) 246-8796

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute a 66 month lease agreement with 333 City Tower located at 333 W City Blvd., Orange, CA, valued at $6,621,867, and authorize a supplemental budget of $5,464,099 to cover the cost of building out 41,480 square feet of leased space.

Background
At the April 2, 2015, CalOptima Board of Directors meeting, staff presented options for the CalOptima Facilities strategy intended to accommodate the growth in employees that is expected during the next 5 years. There were two options presented:

- Option 1 – Lease longer term for term of 5 years or more; or
- Option 2 – Sub lease space that is already furnished for a shorter term (2-3 years) and purchase or build additional space.

The Board directed staff to evaluate leases for a term of 3 to 5 years, and conduct an evaluation of space needs near the end of the lease term. Staff was to evaluate lease alternatives, and return to the Board with a lease recommendation for 40,000 square feet at a cost of no more than $2.75 per square foot for a length of 5 years.

One related issue is that CalOptima recently received an extension of the development agreement with the City of Orange which allows for the development of a parking structure and an addition office building on the 505 City Parkway site. The agreement extension expires in 2019. Based on the development activity in the area along with considering the City's master plan, it is uncertain whether CalOptima could be successful in obtaining an additional extension once the current development agreement expires. This is a significant consideration in the build/buy option not only for enabling CalOptima to build additional space, but also in consideration of a purchase option that would result in CalOptima selling the current building with the development rights in place.

Discussion
Current usable space at 505 City Parkway West is 144,150 square feet and can accommodate 853 work stations, including cubicles and offices. As of July 2015, CalOptima currently has 966 employees with 180 teleworkers and 51 temporary staff. CalOptima anticipates having 1,284 full-time equivalents (FTEs) by the end of Fiscal Year (FY) 2015-16 with the building capacity growing from 853 to 1,026 work spaces by assuming space currently occupied by two (2) tenants, specifically:

Back to Agenda

- Addition of 23 work spaces from Beacon Health who will vacate their space during July 2015. This space will be ready for occupancy by CalOptima employees in September 2015; and
- Addition of 150 work spaces from tenant AmeriSourceBergen who will vacate their space in November 2015. This space will be ready for occupancy in April 2016.

CalOptima has been experiencing unprecedented growth the past two years. We expect the growth rate to level off in the coming months for Medi-Cal and within the next two years for OneCare. Even with that stabilization, CalOptima expects to grow by approximately 3% annually through 2018.

We are also entering a healthcare environment where the state and federal governments are moving more towards managed care and the regulatory requirements are becoming more intensive as new programs are introduced. We have seen, and will continue to see, continued growth in our Medical Management area due to the administration of the Model of Care, Utilization and Case Management of our CalOptima Direct Network, the execution of our Long Term Care strategy and other drivers. CalOptima's budget and budget assumptions do not include the fiscal impact of the implementation of 1115 waiver programs, the integration of the California Children Services (CCS) program, the implementation of Health Homes and other programs that are possible and will have a significant impact on CalOptima and our staffing.

While the current capacity of the 505 building (including space that will be recovered from departing tenants) of 1,026 will be close to the capacity needed at the end of FY 2015-16, there are several other elements to consider:

- We assume CalOptima will have 30% of total headcount allocation for telework. This may not be realistic depending on the type of work. The work may require staff to be on site;
- The majority of the space recovered from the tenants will not become available until the end of the fiscal year. Most of the headcount required during FY 2015-16 will be hired during the first three to four months of the year; and
- We will continue to grow beyond 2016 in terms of enrollment and headcount. We will not grow at the dramatic rates we have seen during the past two (2) years, but we will continue to grow at about 3-4% per year.

Although the early indication is that we will be under our original projections for OneCare Connect enrollment, we anticipate that under our worst case scenario, we will have 25,000 OneCare Connect members by the end of FY 2015-16. In addition, our staffing was adjusted to manage to a 7.5% administrative cost ratio.

Lastly, an important item to consider is the lease environment. We have seen a price per square foot increase of 13.5% from 2014 to 2015 in Orange County. In addition, space continues to be leased and vacancy rates are declining. In Central Orange County, vacancy rates are now under 10%, and there has been over 600,000 square feet of space taken during the first 6 months of calendar year 2015.

Relative to the build vs. lease analysis, as presented at the April Board meeting, the crossover point in our lease vs. buy analysis was 4 years. This supports the option to sub-lease on a shorter term basis

Back to Agenda

and build or buy the additional capacity necessary for the long term. The following provides an estimate for Option 2 for the Board's consideration:

- Execute a 36 month sub-lease agreement with 1900 S. State College, Anaheim, CA, valued at $3,411,147, and a supplemental budget of $5,464,099 to cover the cost of building out 45,121 square feet of leased space; and
- Execute the CalOptima development agreement to build an adjacent building of approximately 250,000 square feet or purchase an additional building to accommodate space needs.

Staff is aware of concerns related to using funds to purchase real estate. It is recognized that there would be more up-front cost in a purchase or build option vs. a lease. However, when comparing the lease costs against the cost of ownership, , the option to purchase/build is more cost effective in the long term. More specifically, the current 5 year lease option presented will cost approximately $12 million, and will result in significant sunk costs and no equity for the agency at the end of the 5.5 year term in addition to being exposed to the risk that lease prices will be higher at renewal. The preliminary estimate for construction of a building of 250,000 square feet is approximately $26 million.

The proposed lease does not include an opt-out or early termination provision. In fact, none of the four finalists provided that option without significant cost increases in the lease. Should CalOptima decide that an opt-out or early termination option is required, the lease costs outlined above would increase considerably. In order to mitigate the risk of not having an opt-out clause, Staff would pursue, with Board approval, a sub-lease arrangement to offset the cost of any unused space. The proposed lease also does not include any extension options.

Fiscal Impact

The total lease cost for the 66 month duration of the proposed lease is $6,621,867 which equates to $2.42 per square feet. The Fiscal Year (FY) 2015-16 CalOptima Operating Budget approved by the Board on June 4, 2015, included $1,320,000 of the amount. The proposed leased space consists of two floors and the total budgetary impact represents an estimated increase to the FY 2015-16 CalOptima Capital Budget of $5,464,099 to furnish and establish Information Services connectivity. This brings the total cost for the leased space to $12,085,967 over the 66 month period, excluding Common Area Maintenance and Insurance estimated at $0.10 per square foot. These figures also exclude property taxes.

Rationale for Recommendation

Conservative estimates have CalOptima outgrowing our building capacity by the end of FY 2015-16 with no room for growth beyond that. This does not include any of the programs that could significantly impact CalOptima staffing. Examples include the 1115 waiver, the implementation of Health Homes and the integration of CCS. The increasing intensity of government programs along with the growth in our CalOptima Community Network are the main short term drivers along the with implementation and growth of OneCare Connect. Relative to timing, the lease environment is becoming more competitive with a shortage of available space and prices increasing as a result. Specifically, large blocks of space are down to a minimum. If we do not act now, there is a likelihood

Back to Agenda

that needed space will not be available in close proximity to the 505 building and we will have to look in South County to accommodate our growth needs at rates that will be much higher than the current proposal.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Authorize Staff to Negotiate a Lease Agreement for Office Space, Expend Funds on Furnishings and Evaluate and Pursue Other Space Planning Options

Contact
Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer, with the assistance of legal counsel, to negotiate and execute a lease of up to 66 months for up to 20,000 square feet of office space at a price per square foot not to exceed $2.55 per month with City Plaza located at 1 City Boulevard West, Orange, California; and
2. Authorize a supplemental budget of up to $2.8 million for expenditures for associated furnishings.

Background
At the April 2, 2015, CalOptima Board of Directors meeting, staff presented space planning options on the CalOptima Facilities strategy to accommodate the employee growth that is anticipated over the next five years. Along with expansion of the Telework program, the two options for additional office space presented were:

- Option 1 – Lease longer term for term of five years or more; or
- Option 2 – Sublease space that is already furnished for a shorter term of two to three years and purchase or build additional space.

At that meeting, the Board directed staff to evaluate leases for a term of three to five years, and conduct an evaluation of space needs near the end of the lease term. Staff was to evaluate lease alternatives, and return to the Board with a lease recommendation for 40,000 square feet at a cost of no more than $2.75 per square foot for a length of five years.

In addition, CalOptima recently received an extension of the development agreement with the City of Orange that allows for the development of a parking structure and an addition office building on the 505 City Parkway site. The agreement currently expires on October 28, 2019. And while the agreement could potentially be extended further, no such commitment has been requested or received at this time.

Discussion
Current usable space at CalOptima's offices at 505 City Parkway West is 144,150 square feet which accommodates approximately 853 work stations, including cubicles and offices. As of December 2015, CalOptima has 1,007 employees, with 220 teleworkers and 49 temporary staff. CalOptima expects to have 1,209 full time equivalents (FTEs) by June 30, 2016, with the building's capacity growing from 853 to 1,042 work spaces as the build out of the second and third floors (recently vacated by a former tenant) is completed. This space should be ready to be occupied in May 2016.

Back to Agenda

CalOptima has been experiencing unprecedented growth during the past two years. Management projects the employee growth rate to flatten in the coming months for Medi-Cal and within the next two years for Medicare. Even with that stabilization, Management anticipates an annual employee growth rate of approximately 3% through 2018.

In addition, CalOptima is engaged in a healthcare environment where the state and federal governments are moving existing fee-for-service programs into managed care and increasing regulatory requirements as new programs are introduced. CalOptima has seen, and will continue to see, continued growth in our Medical Management area due to the administration of the Model of Care, utilization and case management of our CalOptima Community Network, execution of our Long Term Care strategy and other drivers. CalOptima's budget and budget assumptions do not include the impact of the implementation of the 1115 waiver programs, the integration of California Children Services (CCS) program, the implementation of Health Homes and other programs that will have a significant impact on CalOptima and our staffing.

While the current capacity of the 505 building, including space that will be gained from departing tenants, of 1,042 will be close to the capacity needed at the end of Fiscal Year 2015-16, staff assumes CalOptima will be able to use all of the 30% of total headcount allocation for telework. However, this may not be realistic considering some of the work may not be suited for telework. As such, the work may require staff to be on site.

Lastly, an important item to consider is the lease environment in Orange County. The price per square foot has increased by as much as 13.5% from 2014 to 2015 in certain portions of Orange County. In addition, the demand for space remains relatively strong as space continues to be leased and vacancy rates decline. In Central Orange County, vacancy rates are now under 10% and there has been over 600,000 square feet of space taken during the first six (6) months of calendar year 2015.

Based on these factors, staff has engaged in an RFP process to identify potential additional leased space. Based on this process, management recommends pursuing a lease agreement for one floor at the 1 City Boulevard West building.

The proposed lease does not include an opt-out or early termination provision. In fact, none of the four finalists provided that option without significant cost increases in the lease. In order to mitigate the risk of not having an opt-out clause, in the event that the space was no longer needed by CalOptima, staff would pursue, with Board approval, a sub-lease arrangement to offset the cost of any unused space. The proposed lease structure would include an extension option of two additional terms of sixty (60) months.

Back to Agenda

Fiscal Impact
The total lease cost for recommended action for a 66 month lease agreement with City Plaza at $2.55 per square foot per month is approximately $3,240,700. The recommended action upon approval will be included in the CalOptima FY 2016-17 Operating Budget.

The recommended action to authorize expenditures for furnishing costs to one floor of leased space is an unbudgeted item. Staff estimates the recommended action would increase the CalOptima FY 2015-16 Capital Budget by $2,732,049 in order to furnish and establish Information Services connectivity.

In total, the recommended actions would cost $5,972,749 over a period of 66 months. This estimate excludes increases to reflect property taxes, insurance, and Common Area Maintenance estimated at $0.10 per square foot or approximately $127,215 over 66 months. Cost estimates are based on the un-negotiated proposal received from City Plaza.

Rationale for Recommendation
Conservative estimates have CalOptima outgrowing our building capacity by the end of FY 2015-2016 with no room for growth beyond that. This does not include any of the programs that could significantly impact CalOptima staffing. Examples include the 1115 waiver, the implementation of Health Homes, Behavioral Health, Long Term Care, Whole Person Care and the integration of CCS. The increasing intensity of government programs, growth in our CalOptima Community Network, and implementation and growth of OneCare Connect are the main short term drivers. Relative to timing, the lease environment is becoming more competitive with a shortage of available space and prices increasing as a result. Specifically, large blocks of space are down to a minimum. If we do not act now, there is a likelihood that needed space will not be available in close proximity to the 505 building, and we will have to look in South County to accommodate our growth needs at rates that will be much higher than the current proposal.

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

Attachments
None

/s/ Michael Schrader *02/26/2016*
Authorized Signature **Date**

Back to Agenda

Space Planning

Board of Directors Meeting
March 3, 2016

Chet Uma, Chief Financial Officer
Ken Wong, Director, Budget and Procurement

Background

- 4/2/15 Board meeting: Staff presentation on space planning options
  - Option 1: Lease longer term for 5 years or more
  - Option 2: Sub lease space for 2 to 3 years and purchase or build additional space
  - CalOptima's development agreement with City of Orange expires 10/28/19
- Board action
  - Evaluate leases for term of 3 to 5 years
  - Conduct evaluation of space needs at end of lease term
  - Return with recommendation for 40,000 square feet at a cost of no more than $2.75 per square foot for a term of 5 years

Current Staffing Levels

Staff FTEs (excluding PACE)	Actual (Jan 2016)	Budget (FY 2015-16)
On site		
Filled Seat	692.0	820.6
Temporary Help	49.0	40.0
Subtotal	**741.0**	**860.6**
Off site		
Teleworker	222.0	330.0
Community Worker	19.0	19.0
Shared Space	24.0	--
Total	**1,006.0**	**1,209.6**

Available Space

- 505 City Parkway West: 144,150 square feet (853 work stations)

	Actual (Jan 2016)	Budget (FY 2015-16)
Total Space Available	**853.0**	**853.0**
Total Occupied Space		
Filled Seats and Temporary Help	(741.0)	(860.6)
Additional Space Needs		
Pending Request to Fills	(110.0)	--
Subtotal	**(851.0)**	**(860.6)**
Total Space Surplus (Shortfall)	**2.0**	**(7.6)**
New Construction: 2nd & 3rd Floors	189.0	189.0
New Space: City Plaza	126.0	126.0
Net Space Surplus (Shortfall)	**317.0**	**307.4**
Expected Employee Count for New Programs	(165)	(165)
Net Space Surplus (Shortfall)	**152**	**142.4**

Why Do We Need Additional Space?

- Assumptions
  - 3% annual employee growth rate through 2018
  - Allocation of 30% of total headcount for telework
  - Continued shift from fee-for-service to managed care
  - Increased regulatory requirements
  - Growth in Medical Management (i.e., Model of Care, Community Network)

New Programs	**Date**	**Expected Employee Count**
Long Term Care	Now	20
Behavioral Health Treatment	July 2016	45
California Children's Services (CCS)	July 2017	100
Health Homes	July 2017	TBD
Section 1115 Waiver: Whole Person Care Pilot	May 2016: Applications due	TBD
Total		**165**

Why Do We Need Additional Space? (cont.)

- Orange County Lease Environment
  - As much as 13.5% increase in price per square foot from 2014 to 2016
  - Strong demand for leased space
  - <10% vacancy rates in Central Orange County
  - >600,000 square feet of space leased during January through June 2015
- Staff performed RFP to identify potential additional space
  - Resulted in today's recommendation to pursue lease agreement for one floor at City Plaza
  - If space is no longer needed, Staff will pursue, with Board approval, a sub-lease arrangement to offset the cost of any unused space

Recommended Actions

- 66 month lease agreement with City Plaza
  - Up to 20,000 square feet of leased space to create capacity for additional 126 FTEs
  - Propose extension option of two additional terms of 60 months**
  - Tentative start date: July 2016
    - Date available: April 2016
  - Annual Cost: $612,360

	Total Cost	Monthly Cost
City Plaza: 66 month lease agreement ($2.55 per square foot)	$3,240,700	$49,102
Common area maintenance, insurance, property taxes, utilities	$127,215	$1,928
Total ($2.65 per square foot)	**$3,367,915**	**$51,030**

•Costs are based on the un-negotiated proposal received from City Plaza
•**City Plaza proposal included 1 additional term of 60 months

CalOptima A Public Agency Better. Together.

Recommended Actions (cont.)

- Furnishing costs to leased space:

Category	Total Cost	% of Total
Information Technology	$1,468,372	54%
Furniture	$748,000	27%
Network Cabling	$112,000	4%
Moving Expenses	$55,000	2%
Project Management	$35,000	1%
Security	$30,000	1%
Audio Visual	$22,500	1%
Shelving, Copiers, Signage	$15,750	1%
Incidentals	$31,200	1%
Contingency	$214,227	8%
Total	**$2,732,049**	**100%**

Recap and Conclusion

- Board authorized Management to procure leased space
  - ➢ Up to 40,000 square feet at a cost of no more than $2.75 per square foot
- 2/18/16 meeting: FAC approved recommended actions

	333 City Tower	City Plaza*
Lease cost	$6,621,867	$3,240,700
Furnishing costs	$5,464,099	$2,732,049
Common area maintenance, insurance, property taxes, utilities, parking costs	$432,123	$127,215
Total	**$12,518,089**	**$6,099,964**
Total square feet	41,480	19,275
Lease cost per square foot	$2.58	$2.65
Lease duration	66 months	66 months
Board meeting presentation	8/6/15	3/3/16

* City Plaza's un-negotiated proposal

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Back to Agenda

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

* $ R 0 0 0 7 1 5 5 2 6 5 $ *

2014000535189 9:23 am 12/11/14
93 413 A17 35
0.00 0.00 0.00 0.00 102.00 0.00 0.00 0.00

(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Back to Agenda

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

Back to Agenda

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

Back to Agenda

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

Back to Agenda

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

Back to Agenda

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

Back to Agenda

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

Back to Agenda

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

Back to Agenda

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

Back to Agenda

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

Back to Agenda

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Back to Agenda

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

Back to Agenda

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Back to Agenda

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Back to Agenda

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq.*, all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Back to Agenda

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Back to Agenda

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

Back to Agenda

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Back to Agenda

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

Back to Agenda

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies),~~ and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

Back to Agenda

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

Back to Agenda

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

Back to Agenda

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

Back to Agenda

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Back to Agenda

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

* $ R 0 0 0 7 1 5 5 2 6 5 $ *

2014000535189 9:23 am 12/11/14
93 413 A17 35
0.00 0.00 0.00 0.00 102.00 0.00 0.00 0.00

(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Back to Agenda

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

Back to Agenda

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

Back to Agenda

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

Back to Agenda

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

Back to Agenda

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

Back to Agenda

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

Back to Agenda

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

Back to Agenda

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

Back to Agenda

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

Back to Agenda

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Back to Agenda

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

Back to Agenda

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Back to Agenda

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Back to Agenda

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq.*, all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Back to Agenda

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Back to Agenda

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

Back to Agenda

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Back to Agenda

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

Back to Agenda

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies),~~ and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

Back to Agenda

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

Back to Agenda

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

Back to Agenda

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to issue a Request for Information (RFI) to solicit responses regarding potential interest and options for CalOptima's development rights with results to be presented to the Board at a future date.

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the "605 Building Site." At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized the CEO to enter into an Amended and Restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six additional years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At its August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

At the December 1, 2016 meeting, the Board authorized a contract amendment with real estate consultant, Newport Real Estate Services (NRES), to include site plan development and expenditures from existing reserves of up to $7,000 to fund the contract amendment.

Discussion
At its February 16, 2017 meeting, the Board of Directors' Finance and Audit Committee (FAC) received presentations from CalOptima management and real estate consultant, NRES. The presentation included an update on CalOptima's staffing needs and space alternatives, a review of a site plan developed by NRES, options for exercising the development rights with pros and cons of

Back to Agenda

certain options, and a preliminary timeline. In addition, FAC members discussed the need to gather more information and to gauge potential interest on the following options: Direct Sale, Ground Lease, Joint Venture, and Property Trade.

An additional option is pursuing an extension of the current Development Agreement for an additional 3 years beyond 2020. This option would require approval by the City of Orange, and would likely require CalOptima to make additional public benefit fee payments. In the event the Board elects to pursue this option, and the City of Orange is agreeable to the extension, Staff will return to the Board to present applicable proposals.

Fiscal Impact
The recommended action to issue an RFI for development rights is budget neutral.

Rationale for Recommendation
The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization. Management recommends that the Board authorize the CEO to issue an RFI to fully explore potential interest and options available with the existing development rights.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
2. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
3. NRES PowerPoint Presentation to the Board of Directors' Finance and Audit Committee dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Back to Agenda

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

* $ R 0 0 0 7 1 5 5 2 6 5 $ *

2014000535189 9:23 am 12/11/14
93 413 A17 35
0.00 0.00 0.00 0.00 102.00 0.00 0.00 0.00

(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Back to Agenda

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

Back to Agenda

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

Back to Agenda

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

Back to Agenda

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

Back to Agenda

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

Back to Agenda

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

Back to Agenda

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

Back to Agenda

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

Back to Agenda

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

Back to Agenda

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Back to Agenda

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

Back to Agenda

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Back to Agenda

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Back to Agenda

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq.*, all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Back to Agenda

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Back to Agenda

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

Back to Agenda

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Back to Agenda

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

Back to Agenda

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies),~~ and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

Back to Agenda

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

Back to Agenda

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

Back to Agenda

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

Back to Agenda

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

- FINANCE AND AUDIT COMMITTEE MEETING
- FEBRUARY 16, 2017
- GLEN ALLEN, PRESIDENT
- NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT Real Estate Services, Inc.®

Back to Agenda

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

NEWPORT
Real Estate Services, Inc.®

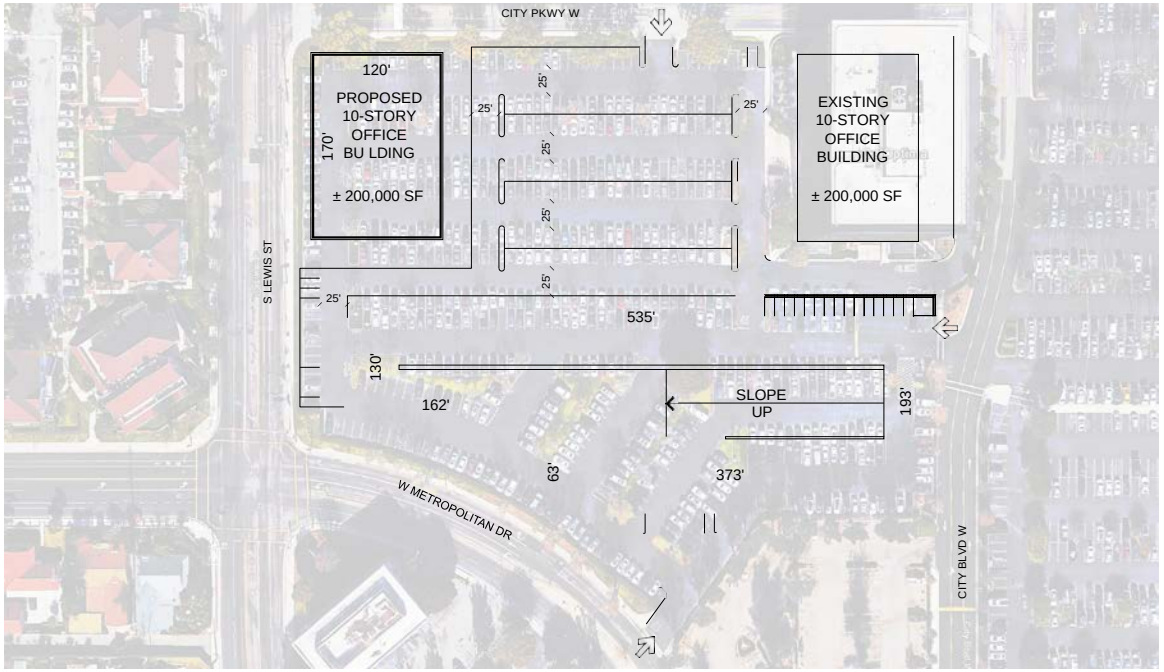
Back to Agenda

Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

NEWPORT
Real Estate Services, Inc.®

Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

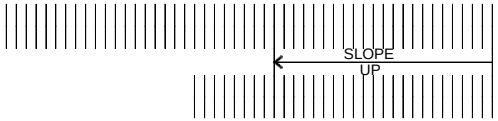
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
SURFACE: 192 STALLS
1ST FLOOR STRUCTURE: 240 STALLS
2-6TH FLOOR STRUCTURE: 1,450 STALLS
(290/STORY, TYP.)
7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Development/Disposition Alternatives

RFI (To be Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

NEWPORT
Real Estate Services, Inc.®

Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	**CalOptima could directly sell the development rights and secure space for CalOptima's use.**	**1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space**	**1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space**
Ground Lease:	**CalOptima could lease the property to a developer.**	**1. Long-term income stream 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space**	**1. Long-term income stream with periodic adjustments 2. Lease payments for additional space**
Direct Development:	**CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.**	**1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space**	**1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement**	**1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants**
Joint Venture:	**CalOptima could develop the property jointly with a developer.**	**1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk**	**1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk**	**1. Variable on-going income from project cash flow 2. No large capital contribution required**
Exchange for Nearby Property:	**CalOptima could exchange the development rights for a developed property**	**1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow**	**1. Market Risk 2. Building operations obligations 3. Value of suitable trade property**	**1. No large capital outlay 2. On-going income stream**

NEWPORT Real Estate Services, Inc.®

Back to Agenda

Conceptual Development Timeline

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Receive and file the Property and Associated Development Rights Request for Information (RFI) results, dated April 21, 2017, that relate to property covered by CalOptima's existing development agreement at the 505 City Parkway West project site;
2. Authorize the Chief Executive Officer (CEO) to: ~~complete a Request for Proposal (RFP) process to select a real estate development consultant to assist CalOptima in:~~
    a. Contact the City of Orange (City) to explore:
        i. Extending CalOptima's existing development agreement for as long as possible (e.g., through 2026);
        ii. Broadening CalOptima's rights under the development agreement from commercial/office to include urban mixed use, including transitional housing; ~~the current Development Agreement with the City of Orange, which covers an office tower of up to 10 stories and a 1,528 space parking structure~~
    b. After confirming that the City is amenable to the proposed changes: ~~Developing a plan for moving forward with a parking structure~~
        i. Initiate a RFI process on development options for the site assuming the use of no Medi-Cal dollars and including a parking structure;
        ii. Seek assistance from the County of Orange Real Estate (Development Services) Department, as appropriate.
    c. ~~Conducting analysis and making recommendations on permissible options for further development of the site (e.g., Mixed Use, etc.), along with potential costs and funding mechanisms that would be associated with the exercise of each option.~~

Rev. 12/7/17

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to 10 stories and 200,000 square feet of office space, and a parking structure of up to five levels and 1,528 spaces. The office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the 505 City Parkway West building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014, meeting, the CalOptima Board of Directors authorized an amended and restated Development Agreement with the City of Orange to extend CalOptima's development rights for six

Back to Agenda

years, until October 28, 2020. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. CalOptima agreed to pay a required $200,000 public benefit fee to the City of Orange in exchange for the extension.

In 2016, at its August 4th and December 1st meetings, the Board authorized contracts with real estate consultant Newport Real Estate Services, Inc. to evaluate options for CalOptima's current development rights and to create a site plan. Newport Real Estate Services completed this analysis and presented the requested information to the Board's Finance and Audit Committee (FAC) in February 2017, and FAC recommended that the Board authorize issuance of a Property and Associated Development Rights Request for Information (RFI). The RFI was designed to gauge potential interest in and options for CalOptima's development rights. The Board approved the issuance of an RFI at its March 2, 2017, meeting.

By the close of the RFI response period on April 21, 2017, only one response had been received, from Trammel Crow Company. The RFI was narrowly focused on office space and parking, as per the current Development Agreement. This limited response to the RFI, as well as other informal discussions with industry representatives during the RFI process, may reflect the real estate community's limited level of interest in commercial office space at this time.

Discussion

In the years since the purchase of 505 City Parkway West, CalOptima's membership has grown significantly with the implementation of the Affordable Care Act. And while membership has been essentially stable in 2017, the operational and oversight demands have continued to grow, as have the number of programs the state has folded into the Medi-Cal managed care plans, in large part due to their member focus and cost effectiveness. While approximately 10% of the available 505 building workstations are currently unoccupied, the building is currently fully occupied as this "flex space" is critical to the Facilities Department's efforts to optimize available workspace to maximum workforce productivity (e.g., placing employees in a particular department in the same area/on the same floor of the building).

While CalOptima's existing office tower and employee workspaces are meeting current needs (with nearly one third of the staff in telework positions), it is anticipated that longer term, additional space may be required to meet the organization's needs. In the immediate term, parking is a pressing issue, with available spaces marginally adequate to meet parking needs during peak hours of operations. While management has explored a number of options to reduce the need to parking (e.g., further expansion of the telework program, carpools, vanpools, flexible start times, supporting alternative transportation, etc.), the need for additional parking is an increasingly pressing issue. One approach under consideration would be to recommend development of the parking structure initially, with a decision on the office tower development rights addressed at a later date.

Regarding the potential development of a second ten story office tower at this time, with the assumption that it would at least initially be partially occupied by third parties, various market factors suggest that growth in demand for professional office space by third party tenants in the North Orange County region appears somewhat limited, though in the immediate area, virtually all available commercial space is currently occupied. According to a Second Quarter 2017 analysis by Colliers

Back to Agenda

International, market activity has slowed compared with the past two years. Staff's understanding is that average lease rates in the North Orange County area remain at approximately $2.23 per square foot, which is below their 2007 peak. Staff also believes that, while there are a number of large developments in the works for central Orange County, the majority of new, large scale professional office projects in the county are proposed within the John Wayne Airport and South Orange County areas as opposed to the North Orange County region. These trends may limit the value of CalOptima's current Development Agreement if the decision is to develop the site as a 10-story commercial building that will, in part, be leased to third parties.

To ensure that a comprehensive review process is completed before a decision is made on the best use of the new tower site, staff is recommending that the Board obtain the expertise of a real estate development consultant to evaluate the potential value of a revised Development Agreement that would allow for other potential uses such as, for example, Urban Mixed-Use zoning, which would include commercial retail and housing uses. While this approach may result in the facility being sold to a third party, it assumes that CalOptima will make other arrangements to meet any increases in need for office space as the current facility is near capacity today. Though it is possible that the commercial vacancy rate in the area may increase in the future, when CalOptima was considering additional space approximately two years ago, very limited space was available within several miles of the 505 building. At this stage, one possible approach the consultant could explore would be to focus on prioritizing the additional parking space now, and either seeking an extension of the remaining rights as further study is completed on the available options, or estimating the cost of seeking a change to the Development Agreement to allow for Mixed Use zoning. Another option would be to sell the rights to a third party who may be interested in exercising the existing development rights, or pursuing a change with the City of Orange.

Fiscal Impact

The FY 2016-17 Board-approved CalOptima Medi-Cal operating budget includes $37,000 for Real Estate Consultant services. In addition to this amount, once the scope of work for the consultant is developed, staff will return to Board with an estimate of additional costs.

California Welfare and Institutions Code section 14087.54, CalOptima's enabling statute, provides that CalOptima was established to "meet the problems of delivery of publicly assisted medical care in the county… and to demonstrate ways of promoting quality care and cost efficiency." The statute also includes provisions limiting the use of "any payment or reserve from the Medi-Cal program" to administration of the Medi-Cal program itself. Consequently, alternative funding (i.e., from a source other than CalOptima) would be an essential element of any recommendation to use the development rights for some purpose not specifically related to CalOptima's administration obligations under the Medi-Cal program.

Rationale for Recommendation

In order to assist the Board in determining next steps with the existing Development Agreement with the City of Orange, staff recommends engaging a real estate consultant.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Board Action dated March 2, 2017, Consider Options for Development Rights at 505 City Parkway West, Orange, California Site
    a. Amended and Restated Development Agreement dated December 10, 2014
2. Notice of Request for Information #17-031, dated March 20, 2017, Amendment No. 1, for Property and Associated Real Estate Development Rights
3. Response to Request for Information: Property and Associated Real Estate Development Rights, TrammellCrowCompany, dated April 21, 2017
4. California Welfare and Institutions Code section 14087.54

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to issue a Request for Information (RFI) to solicit responses regarding potential interest and options for CalOptima's development rights with results to be presented to the Board at a future date.

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the "605 Building Site." At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized the CEO to enter into an Amended and Restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six additional years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At its August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

At the December 1, 2016 meeting, the Board authorized a contract amendment with real estate consultant, Newport Real Estate Services (NRES), to include site plan development and expenditures from existing reserves of up to $7,000 to fund the contract amendment.

Discussion
At its February 16, 2017 meeting, the Board of Directors' Finance and Audit Committee (FAC) received presentations from CalOptima management and real estate consultant, NRES. The presentation included an update on CalOptima's staffing needs and space alternatives, a review of a site plan developed by NRES, options for exercising the development rights with pros and cons of

Back to Agenda

certain options, and a preliminary timeline. In addition, FAC members discussed the need to gather more information and to gauge potential interest on the following options: Direct Sale, Ground Lease, Joint Venture, and Property Trade.

An additional option is pursuing an extension of the current Development Agreement for an additional 3 years beyond 2020. This option would require approval by the City of Orange, and would likely require CalOptima to make additional public benefit fee payments. In the event the Board elects to pursue this option, and the City of Orange is agreeable to the extension, Staff will return to the Board to present applicable proposals.

Fiscal Impact
The recommended action to issue an RFI for development rights is budget neutral.

Rationale for Recommendation
The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization. Management recommends that the Board authorize the CEO to issue an RFI to fully explore potential interest and options available with the existing development rights.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
2. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
3. NRES PowerPoint Presentation to the Board of Directors' Finance and Audit Committee dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Back to Agenda

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

* $ R 0 0 0 7 1 5 5 2 6 5 $ *

2014000535189 9:23 am 12/11/14
93 413 A17 35
0.00 0.00 0.00 0.00 102.00 0.00 0.00 0.00

(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Back to Agenda

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

Back to Agenda

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

Back to Agenda

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

Back to Agenda

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

Back to Agenda

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

Back to Agenda

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

Back to Agenda

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

Back to Agenda

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

Back to Agenda

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

Back to Agenda

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Back to Agenda

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

Back to Agenda

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Back to Agenda

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Back to Agenda

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq.*, all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Back to Agenda

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Back to Agenda

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

Back to Agenda

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Back to Agenda

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

Back to Agenda

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies),~~ and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

Back to Agenda

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

Back to Agenda

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

Back to Agenda

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

Back to Agenda

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

- FINANCE AND AUDIT COMMITTEE MEETING
- FEBRUARY 16, 2017
- GLEN ALLEN, PRESIDENT
- NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT Real Estate Services, Inc.®

Back to Agenda

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

NEWPORT
Real Estate Services, Inc.®

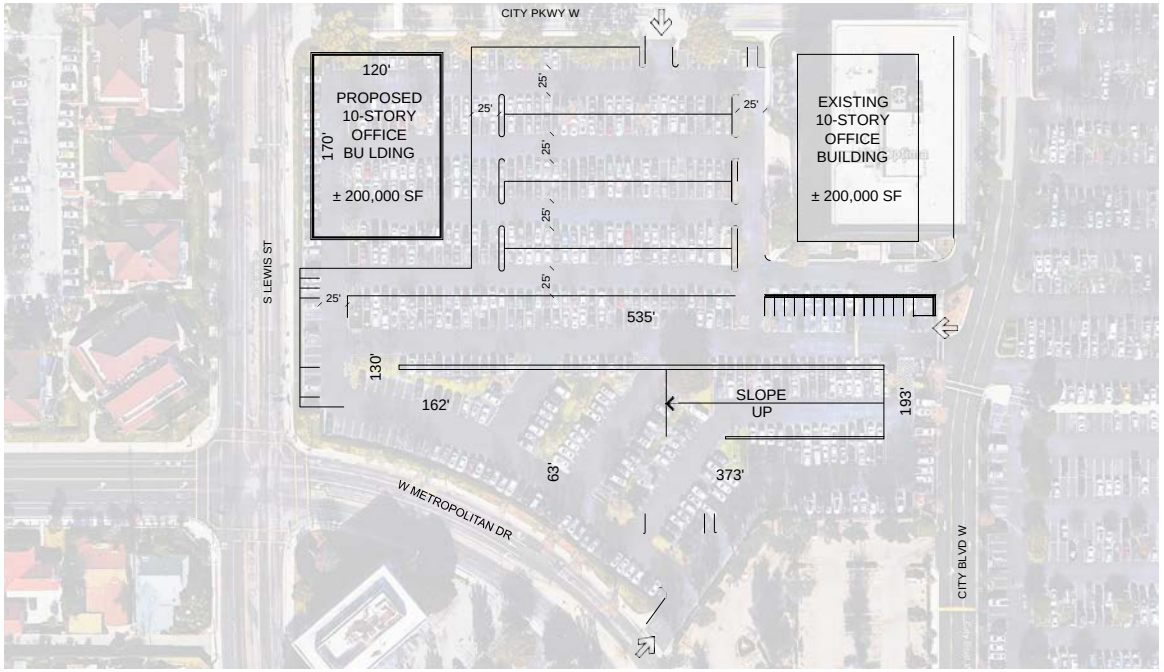
Back to Agenda

Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

NEWPORT
Real Estate Services, Inc.®

Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

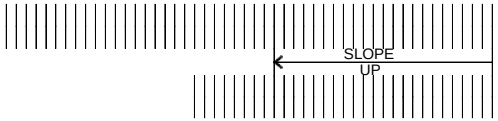
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
SURFACE: 192 STALLS
1ST FLOOR STRUCTURE: 240 STALLS
2-6TH FLOOR STRUCTURE: 1,450 STALLS
(290/STORY, TYP.)
7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

Development/Disposition Alternatives

RFI (To be Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

NEWPORT
Real Estate Services, Inc.®

Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	**CalOptima could directly sell the development rights and secure space for CalOptima's use.**	**1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space**	**1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space**
Ground Lease:	**CalOptima could lease the property to a developer.**	**1. Long-term income stream 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space**	**1. Long-term income stream with periodic adjustments 2. Lease payments for additional space**
Direct Development:	**CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.**	**1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space**	**1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement**	**1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants**
Joint Venture:	**CalOptima could develop the property jointly with a developer.**	**1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk**	**1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk**	**1. Variable on-going income from project cash flow 2. No large capital contribution required**
Exchange for Nearby Property:	**CalOptima could exchange the development rights for a developed property**	**1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow**	**1. Market Risk 2. Building operations obligations 3. Value of suitable trade property**	**1. No large capital outlay 2. On-going income stream**

NEWPORT Real Estate Services, Inc.®

Back to Agenda

Conceptual Development Timeline

NEWPORT
Real Estate Services, Inc.®

Back to Agenda

CalOptima
Better Together

March 20, 2017

Amendment No.1
NOTICE OF REQUEST FOR INFORMATION (RFI)

#17-031

GENERAL CONDITIONS AND INSTRUCTIONS TO RESPONDENTS

For

PROPERTY AND ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

Key RFI Dates

Written Questions Due: March 30, 2017, 12:00 p.m. Pacific Time
Proposal Submittal Date: April 21, 2017, 12:00 p.m. Pacific Time

Back to Agenda

Table of Contents

Back to Agenda

SECTION I: INSTRUCTIONS AND CONDITIONS

1. GENERAL INFORMATION

1.1. The purpose of this Request for Information (RFI) is to seek background information from qualified real estate developers regarding their interest in a potential real estate agreement with regard to CalOptima's Real Estate Development rights located at 605 City Parkway West, Orange, CA 92868.

1.2. THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes to assist CalOptima in finalizing the scope of work and requirements which may be used at a future date in the issuance of a Request for Proposal (RFP). It does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. This request for information does not commit CalOptima to contract for disposition whatsoever. Further, CalOptima is not at this time seeking proposals and will not accept unsolicited proposals. Respondents are advised that CalOptima will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future RFP. If a solicitation is released, it will be released through BidSync. It is the responsibility of the potential Respondent to monitor this site for additional information pertaining to this requirement.

2. POINT OF CONTACT

All communications relating to this RFI must be directed to CalOptima's designated contact below:

Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
Kmarquez2@CalOptima.org

3. QUESTIONS AND CLARIFICATIONS

3.1. If a Respondent desires an explanation or clarification of any kind regarding any provision of this RFI, the Respondent must generate a written request for such explanation or clarification through BidSync by March 30, 2017, 12:00 p.m. Pacific time.

3.2. Inquiries received after March 30, 2017 12:00 p.m. Pacific time will not be responded to. Inquiries received by email to the contact above will not be responded to. All questions should be directed to CalOptima through BidSync.

3.3. CalOptima responses to questions will be communicated via BidSync, and will be sent no later than April 5, 5:00 p.m. Pacific time.

4. RESPONSES

Interested parties are requested to submit their response through BidSync no later than April 21, 2017, 12:00 p.m. Pacific Time. Information submitted outside of Bidsync will not be considered.

5. USE OF RESPONDENT'S RESONSE AND ACCOMPANYING MATERIAL

5.1. All materials submitted become the property of CalOptima and will not be returned. If the Respondent intends to submit confidential or proprietary information as part of its response, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

5.2. CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Respondent response. CalOptima reserves the unrestricted right to copy and disseminate the Respondents response for internal review and for review by external advisors, at CalOptima's sole discretion.

Back to Agenda

6. INDUSTRY DISCUSSIONS

CalOptima representatives may or may not choose to meet with Respondents. Such discussions would only be intended to get further clarification of potential capability to meet the requirements.

7. SUMMARY

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY to identify available opportunities in the market as well as resources that can provide information regarding the CalOptima Real Estate Development rights. The information provided in the RFI is subject to change and is not binding on CalOptima. CalOptima has not made a commitment to contract for any of the items discussed, and release of this RFI should not be construed as such a commitment. All submissions become CalOptima property and will not be returned.

Back to Agenda

SECTION II: CALOPTIMA BACKGROUND AND OVERVIEW

1. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

2. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

Back to Agenda

SECTION III: GENERAL REQUIREMENTS

1. BUSINESS OBJECTIVES/TIMING

CalOptima is considering monetizing the additional available land and entitlement rights located adjacent to its headquarters building located at 505 City Parkway West, Orange, California. CalOptima has the following key objectives:

1.1. Monetizing this asset while the development rights are still available;

1.2. Providing for potential additional expansion space to meet CalOptima's chartered goals and objectives.

While CalOptima has the ability and resources to develop the parcel internally, there may be significant advantages to having this development be completed through a sale (with leaseback opportunities), joint venture or other financial structure with a third-party.

The primary objective of this RFI is to begin to collect information on third parties that may be potentially interested in acquiring, joint venturing, trading or otherwise assist CalOptima in monetizing this asset.

While no particular timeframe has been established, the initial goal would be to enter into an agreement with a third-party that would allow for the development and construction of the building before expiration of the development rights in October, 2020.

As one of CalOptima's stated goals is to provide for the potential expansion of its workforce in furtherance of its core mission, and development rights for an additional office building are currently in place, CalOptima will only consider expressions of interest, and ultimately development of a class A office building of a type that is similar in quality and configuration to its existing 505 Building. Parties interested in land-use conversion (i.e. apartments or high density residential) should not respond to this RFI, as any such proposed uses will be dismissed without comment.

2. PROJECT OVERVIEW/BACKGROUND

CalOptima acquired the real estate development rights in 2014. The original development of the property site contemplated future construction of an additional 10 story 200,000 SF building to be known as 605 City Parkway West, Orange, CA, as well as an adjacent parking structure, which would accommodate both 505 and 605 buildings.

The objective of this RFI is to collect information from potential interested parties that might help CalOptima achieve these goals.

CalOptima is willing to consider a variety of potential real estate transaction structures. Responders are encouraged to address each of the alternatives outlined below. CalOptima does not, at this time, have a preferred structure. CalOptima will evaluate each of the responses in the interest of obtaining the greatest economic and intrinsic benefit to CalOptima. Respondents are also encouraged to propose alternative ideas that may be of interest to CalOptima.

CalOptima predicts that it may need additional space beyond its corporate headquarters, over time. As such, a continuing right, but not the obligation, to occupy space in the future building to be constructed by Offeror on the Excess Land may be of significant interest to CalOptima.

3. Considerations

3.1. Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of

Back to Agenda

proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.

3.2. Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.

3.3. Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.

3.4. Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.

4. Highlights of CalOptima's Development Rights Agreement

4.1. Development Agreement

a. Rights for development of the "605 Building" and related parking structure. Development rights for the referenced City Plaza Two Site were subsequently assigned to another developer (see Estoppel Certificate).

b. Section 1(j)(2)(B) - CUP for 605 Building site (approved by City Council 10/9/01) – 10 story, 200,000 SF building and a 5-level, 1,528 space parking structure.

c. Section 1(j)(3)-(6) – Cost sharing with other projects for area traffic improvements and widening of Orangewood Avenue bridge over the Santa Ana River (should be no exposure to such costs if development does not occur at the 605 Building site).

d. Section 7(e) – Good Faith Efforts Regarding Block of Orange Expansion – Mentions CC&R's of "The City" (to be further researched).

e. Section 12 – Term expires 10/28/19.

f. Section 14(a) – Covers assignment for a portion of the project sold; requires 30 day notification by Seller and Purchaser is to agree in writing to be subject to terms of the Agreement.

g. Section 14(b) – Reference is made to responsibility for reporting and annual review requirements (to clarify).

h. Public Benefit Fees. Fees would have needed to be paid in order to keep the Agreement active, including library and park related fees.

a. Prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations.

Back to Agenda

4.2. First Amendment to Development Agreement – Executed 1/20/06:

a. Public Benefit Fees Payable - $15,000 of a $100,000 Park Fee to be paid within two business days of receiving a building permit for the 605 Building.

4.3. Second Amendment to Development Agreement

a. Amended Exhibit D is provided for, with remaining applicable fees being as follows

1. $15,000 Library Fee (15% of $100,000) and $15,000 Park Fee (15% of $100,000) within two business days of receiving a building permit for the 605 Building.

2. If the Agreement has not been terminated and an agreement has not been reached with the Block owner regarding certain elements of the proposed Block expansion, prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations; and

3. Commencing on the Second Resolution Effective Date (5/30/07) and each anniversary thereof, continuing through the initial term (10/28/14), a $30,000 fee is required.

4.4. Operating Memorandum – Executed 1/22/07:

a. Block expansion plans were modified and CC&R's were amended by Block ownership and the City Parkway ownership at the time.

b. City Parkway owner relieved of any or all of the Public Benefit Fees.

4.5. Estoppel Certificate – Provided by City of Orange to the Current Ownership, 5/13/09:

a. Indicates Maguire assigned its rights to the City Plaza Two Site in August 2008 to HFOP City Plaza, LLC.

b. Acknowledges there were no Public Benefit Fees or other development, traffic mitigation or processing fees due from Maguire (seller) at that time.

c. Certificate shall inure to the benefit of Purchaser, Lender and their respective successors and assigns.

4.6. Conditional Use Permit – Resolution No. PC 19-01 (as referenced in Section 1(j)(2)(B) of the Development Agreement):

a. Approval for a 10-story, 200,000 SF office building and 5-level, 1,528 space parking structure, subject to several conditions and mitigation measures outlined in the CUP.

5. SUGGESTED CONTENT OF RESPONSE

CalOptima is asking interested Respondents to submit a response containing, at a minimum, the following information.

5.1. General Respondents Information

a. Explain the reason for your firm's interest in possibility providing the services listed within this RFI.

b. Name and contact information of person we can contact if we have questions.

c. Brief history of your firm.

d. Brief description of past experience providing similar services.

5.2. Additional Questions

a. Provide any comments, observations or suggestions which may assist CalOptima in drafting a procurement solicitation.

b. Please provide a brief summary of how you might envision the transaction structures that your firm would propose.

Back to Agenda

c. If possible, please provide preliminary economic results of how you might see a transaction being structured.

d. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

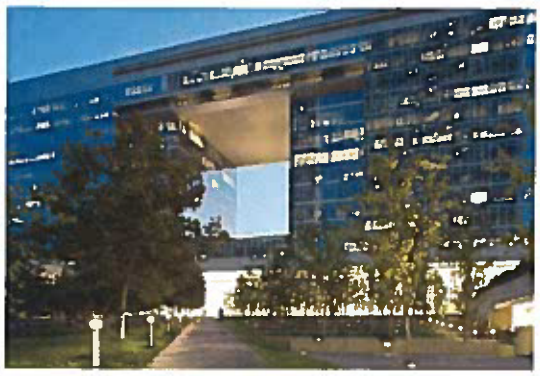
e. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

Back to Agenda

RESPONSE TO REQUEST FOR INFORMATION:

PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

605 CITY PARKWAY WEST, ORANGE, CA



PRESENTED TO:

CalOptima
A Public Agency
Better. Together.

PRESENTED BY:

Trammell Crow Company

APRIL 21, 2017

Back to Agenda

Back to Agenda

Tom Bak
Senior Managing Director
Trammell Crow Company
Development and Investment

Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, California 92660

Work: 949.477.4702
Fax: 949.477.9107

tbak@trammellcrow.com
www.trammellcrow.com

April 21, 2017

Ms. Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

RE: Response to RFI for Property & Associated Real Estate Development Rights at 605 City Parkway West

Dear Ms. Marquez:

We are pleased to formally provide this Response to Request for Information for the Property and Associated Real Estate Development Rights located at 605 City Parkway West in the City of Orange.

The Trammell Crow Company is widely recognized as the Nation's largest developer by total product under construction, and has been ranked #1 for the past three consecutive years in Commercial Property Executive Magazine's 2014, 2015, & 2016 list of national developers. The proposed team highlighted in this proposal offers local Class A Office Development experience backed by a nationally renowned organization.

In the pages that follow, you will find a detailed response that seeks to emphasize the following key elements that we believe position our team to provide CalOptima with the highest level of service and certainty of performance:

Local Presence & Experience: Trammell Crow Company has had a strong presence in Southern California since 1972. Our SoCal team is currently comprised of 28 real estate professionals who cover Orange County, Los Angeles, San Diego, and the Inland Empire. Over the last few years, while many of our competitors have disappeared, our balanced business model combining development with acquisitions has allowed us to thrive and gain substantial market share. Our Southern California team has experience building and entitling well over 100 projects across class "A" office, healthcare, industrial, retail, mixed use, and residential product types.

Office Development Expertise: Trammell Crow Company's Southern California Development & Investment team has an established reputation in Class-A office development, with individuals who dedicate their entire practice to the successful execution of office projects, specifically development and leasing. In just the past ten years, we have developed a diverse array of office product, including speculative, build-to-suit, ground-up and redevelopment, totaling 1.9M SF and valued at over $1.3 billion.

Public Agency & Government Collaboration: Our Team has a proven track record of successfully working with local governments on the acquisition, ground-leasing, development, planning, construction, leasing, and property management of office buildings leased to public agencies and governmental tenants. We are also experts in developing strategies for designing, financing and constructing projects that serve as sources of economic development for the surrounding community. These buildings are compelling places to work as well as sources of community identity and renewal.

Our team offers extensive Southern California development experience, a strong history of partnerships with governmental clients, design-build expertise, ability to independently finance the project, and, most importantly, a culture of honesty and dedication with a commitment to exceeding client expectations. We greatly appreciate your consideration and the opportunity to work with CalOptima on this exciting piece of property. We look forward to meeting with you to discuss our proposal. If you have any questions regarding the attached proposal, please do not hesitate to contact me.

Warm regards,

Tom Bak
Senior Managing Director

Back to Agenda

Back to Agenda

TABLE OF CONTENTS

RESPONSE TO REQUEST FOR INFORMATION:
PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS
605 CITY PARKWAY WEST, ORANGE, CA

Trammell Crow Company

Back to Agenda

Back to Agenda

SECTION 1. GENERAL RESPONDENTS INFORMATION

A. EXPLAIN THE REASON FOR YOUR FIRM'S INTEREST IN POSSIBILITY PROVIDING THE SERVICES LISTED WITHIN THIS RFI.

Since 1948, Trammell Crow Company (TCC) has consistently been viewed as a leader and innovator within the real estate development industry. The organization has built it's reputation by focusing on building the best product in the best location. Our Southern California Business Unit has been continually developing successful Class A office product on both a build-to-suit and speculative basis, throughout each of the past ten years, totaling the successful delivery and leasing of over 1.35M SF of office space since 2007, with another 550K SF on track to be completed later this year.

TCC has a long, successful reputation of development within Orange County, and is extremely bullish on this market. We are currently under construction on the largest speculative ground up office development in Southern California. As such, we are in contact with every tenant in the market that is looking for new, high quality work space. We view this as a tremendous opportunity to deliver Class-A office product to the Central County marketplace due to the asset's:

Premier Location: The subject property's premier location in the heart of the City of Orange, adjacent to existing Class A office product, and a surplus of amenities within walking distance makes this an ideal opportunity to provide the newest product to Central Orange County. TCC previously developed the Arena Corporate Center, a 385,000 SF nearby Class A office park, with significant success and has actively been searching for another opportunity in the sub-market.

In-Place Entitlements: The existing entitlements for the project offer a tremendous opportunity to deliver high quality space in a market that has seen minimal development in the past several years. Speed to market is essential in satisfying the needs of tenants in search of space.

We are confident that not only does this particular property offer tremendous potential to satisfy the needs of Orange County's tenant base, but TCC is the ideal group to strategically position, design, develop, and lease this excellent asset with a reputation of:

Successful Collaboration & Partnership with Public Agencies: TCC has worked with numerous governmental and public agencies to entitle, finance, design, and develop numerous Class-A projects throughout Southern California. As detailed in the following case studies, in the past 10 years alone, the TCC Southern California team has successfully completed five built-to-suit office projects, totaling approximately 600,000 SF, and is nearing start of construction on a 200,000 SF, highly customized Medical Office Building for the County of Riverside.

Consistent On-time & On-budget Deliveries: Whether CalOptima determines a need for additional space, or the entire building is ultimately marketed to the outside community, every tenant depends upon a reliable budget and schedule. TCC has a proven track record for delivering projects on-time and on-budget, resulting in consistent repeat business with our clients.

B. Name and contact information of person we can contact if we have questions.

Profiles for the primary members of the development team that would be dedicated to this project are included on the following pages. David Nazaryk , Managing Director, will serve as Primary Point of Contact.

DEVELOPMENT TEAM

TOM BAK
SENIOR MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4702
tbak@trammellcrow.com

Tom Bak is Senior Managing Director of Trammell Crow Company where he serves as a member of the firm's Operating Committee and as a subject matter expert for the National Investment Committee. In his capacity as Senior Managing Director, Tom is responsible for raising capital, setting investment strategy, creating deal flow, negotiating and structuring transactions, advising on financing, asset management and property-related issues, and overseeing the day to day activities of Trammell Crow's Southern California Development & Investment professionals.

EXPERIENCE

Under Tom's leadership, the Southern California Development & Investment Group has completed, or is in the process of completing, the acquisition and development of office, industrial and brownfield projects totaling over 20 million square feet and representing investments of over $1.5 billion from public and corporate pension funds, insurance companies, REITs, Taft Hartley funds, endowments and high net worth partners.

Tom began his career with Trammell Crow Company as a leasing agent. He has received numerous regional and national awards recognizing his achievements as a top leasing and development producer. In 1989, he became one of the youngest partners in the firm. In 1996, Tom became leader of the Southern California Development & Investment Group.

EDUCATION & CREDENTIALS

University of California Los Angeles, MBA
Amherst College, B.A.

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Past President, National Association of Industrial and Office Properties (NAIOP) - Los Angeles Chapter
NAIOP I.CON Conference Speaker, Industrial Trends
University of California - Irvine, Center for Real Estate Advisory Board
Urban Land Institute Conference Speaker, Office Building Design Trends
Pension Real Estate Association (PREA), Developer Affinity Group
St. Joseph Hospital, Planning and Community Benefits Committees

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Knox Logistics Center
1-215 Logistics Center
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II

Trammell Crow Company

Back to Agenda

DEVELOPMENT TEAM (PRIMARY POINT OF CONTACT)

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Innovation Village Research Park
Knox Logistics Center
I-215 Logistics Center

DAVID NAZARYK
MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4732
DNAZARYK@TRAMMELLCROW.COM

David has developed much of TCC's portfolio in Southern California since joining the company in 1996. He also manages the operations of the group. He is responsible for sourcing, underwriting, financing and developing office and industrial projects throughout the Southern California region.

Through his relationships with the brokerage network, governmental officials and capital partners, David has seamlessly and successfully completed some of the largest and most complicated projects within the TCC national portfolio. He has structured and documented numerous development projects with TCC's existing investment relationships and has forged new ones for the company. He is also highly regarded in the company for his unique ability to craft and execute complicated built-to-suit projects. His reputation is one of over-delivering on his promise and providing maximum returns on a variety of real estate development projects. His efforts have been recognized locally and nationally by colleagues through NAIOP Best Project, San Gabriel Valley Best Developer and numerous other awards.

EXPERIENCE

Trammell Crow Company – Southern California– 1996 to Present
Managing Director

- Successfully master planned 10,600,000 SF and developed 6,000,000 SF of office and industrial projects throughout Southern California.
- Established land use designs and/or development plans through selecting, supervising and directing required consultants.
- Negotiates with cities and other governmental agencies to obtain appropriate development mix, entitlements, and land use design standards.
- Effectively markets specific projects such as land, speculative development or build-to-suit, for lease or sale.
- Coordinates all stages of off-site and on-site construction, including tentative and final parcel maps, infrastructure and utility drawings, street and utility construction, preliminary building site plans or office floor plans, working drawings, permit process, construction bidding, on-site shell and tenant improvement construction, Certificate of Occupancy and punch-list completion.
- Provides value engineering through construction experience and local consultant expertise.

Catellus Development Corporation – 1983 to 1996
Project Director

EDUCATION & CREDENTIALS

Evangel College, Springfield, MO, B.A., 1983

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Board of Directors, American Red Cross
Member, National Association of Industrial and Office Properties
Member, Urban Land Institute

Trammell Crow Company

Back to Agenda

DEVELOPMENT TEAM

MATT CRAMER
SENIOR VICE PRESIDENT
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4735
mcramer@trammellcrow.com

Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

Matt brings more than 25 years of development and construction expertise to Trammell Crow Company. During his career, he has managed development and/or construction of over 9,000,000 square feet of office buildings, parking structures, mixed-use projects, industrial buildings, high tech facilities and public facilities, ranging from $5 million to over $300 million from conception to project completion. Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
Phase 3, 4, & 5
Washington Mutual Irvine
Office Expansion
Opus Center Irvine Phase I & II
Fairway Center II
Summit Phase I
Westec Orange County
Communications
Galaxy Latin America
Cabot, Cabot & Forbes
Corporate Center
South Coast Metro Center
I-215 Amazon BTS
Amazon Fulfillment Center
Redlands Business Park
Magnolia Point

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2005 to Present
Senior Vice President, Development Management

Howard S. Wright Construction Company – 2003 to 2005
Project Executive/Business Unit Manager

Opus West Construction Corporation – 1998 to 2003
Senior Project Manager

L.E. Wentz Company – 1997 to 1998
Senior Project Manager

ARB, Inc. – 1995 to 1997
Project Manager

Turner Construction Company – 1987 to 1995
Project Superintendent

EDUCATION & CREDENTIALS

California State University, Long Beach, B.S., Construction Management

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Member, NAIOP, SoCal and Inland Empire chapters
Advisory Council Member, California State University Long Beach School of Engineering
Member, Trammell Crow Company National LEED® "Green Task Force"
State of CA Registered Disaster Service Worker, OES Certified Safety Assessment Volunteer
Step Up On Second Charitable Organization, Past Chairman, Board of Directors

Trammell Crow Company

Back to Agenda

DEVELOPMENT TEAM

PROJECT DEVELOPMENTS

The Boardwalk

County Law Building

Gateway at Alhambra

Ontario Innovation Center I & II

Knox Logistics Center

1-215 Logistics Center

Magnolia Point

Innovation Village 5

CHRIS TIPRE
SENIOR VICE PRESIDENT
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4717
ctipre@trammellcrow.com

Chris serves as Senior Vice President for Trammell Crow Company's Southern California Business Unit in Newport Beach, California. He is responsible for land and deal sourcing, financial analysis, due diligence, entitlements, capital relationships, development coordination, and project marketing and leasing.

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2011 to Present
Senior Vice President

- Responsible for management of finance, marketing, leasing, development and operations of 545K SF Class A speculative office development.
- Performs detailed and customized underwriting as primary analyst for all office and industrial acquisitions
- Prepares comprehensive investment summaries with asset and market level analyses for presentation to internal investment committee and institutional investment partners
- Works alongside capital partners, brokers, tenant representatives and prospective investors to analyze new opportunities

LBA Realty – Irvine, CA – 2011
Asset Management Intern

- Assisted in the valuation and management of a $4B portfolio of office and industrial assets

Terranomics Retail Services – Burlingame, CA – 2007 to 2008
Retail Commercial Real Estate Specialist

- Represented Fortune 500 and regional tenants to establish expansion plans, select locations, and negotiate leases in prime retail space
- Managed the leasing of over 2M SF of Power Centers and Grocery anchored shopping center space

Sotheby's International Realty – Santa Barbara, CA – 2006 to 2007
Residential Real Estate Agent

EDUCATION & CREDENTIALS

UC Irvine Merage School of Business, MBA, Real Estate & Finance
UC Santa Barbara, BA, Business & Economics with Emphasis in Accounting

PROFESSIONAL AFFILIATIONS & COMMUNITY INVOLVEMENT

NAIOP – SoCal Chapter
NAIOP – SoCal YPG Alumni
LEED® AP BD+C

Trammell Crow Company

Back to Agenda

C. Brief History of your firm.

National Experience

Trammell Crow Company (TCC), founded in 1948 in Dallas, Texas, is one of the nation's leading developers and investors in real estate. The company has developed or acquired 2,600 buildings valued at $60 billion and over 565 million square feet. TCC's teams are dedicated to building value for its clients with professionals in 16 major cities throughout the United States. The company serves users of, and investors in office, industrial, retail, healthcare, multi-family residential, mixed use projects, higher education, and airport facilities. For those who occupy real estate, TCC can execute the development or acquisition of facilities tailored to meet its clients' needs. For investor clients, the company specializes in joint venture speculative development, acquisition/re-development ventures, build-to-suit development or providing incentive-based fee development services.

TCC is an independently operated subsidiary of CBRE Group, Inc. (NYSE:CBG), a publicly traded, Fortune 500 and S&P 500 company headquartered in Los Angeles, California. CBRE is the world's largest commercial real estate services and investment firm (in terms of 2016 revenue). For more information visit www.TrammellCrow.com.

Local Expertise

Since TCC's Southern California Development and Investment Group (SoCal D&I) opened in 1972, our team has developed over 100 office, industrial, retail, healthcare, and mixed use projects totaling more than 35 million square feet throughout Los Angeles, Orange, San Bernardino, Riverside, San Joaquin and San Diego Counties. Our Southern California team of 28 professionals is consistently ranked as a "Top Tier" developer and is known for consistently creating the right product in the right market.

Over the past fifteen years, SoCal D&I has built, or is in the process of building, 45 projects comprised of 115 buildings, totaling more than 18 million square feet of office, retail, and industrial product on nearly 1,000 acres of land with costs eclipsing $2.0 Billion. Our team includes in-house environmental expertise through EASI, a division dedicated to managing and mitigating environmental impacts and risks on all new developments. We have worked with numerous cities and municipalities throughout California including, but not limited to Alhambra, Anaheim, Century City, Corona, County of Riverside, Diamond Bar, Fontana, Indio, Irvine, Irwindale, Lake Forest, Los Angeles, Moreno Valley, Pasadena, Redlands, Riverside, and Tracy. Our Team has a proven track record of land acquisitions, ground-leasing, development, planning, construction, leasing, and property management of office buildings. Our experience in each of these areas is demonstrated by the projects outlined herein.

ONE OF THE NATION'S LEADING DEVELOPERS AND INVESTORS IN COMMERCIAL REAL ESTATE

TCC DEVELOPMENT

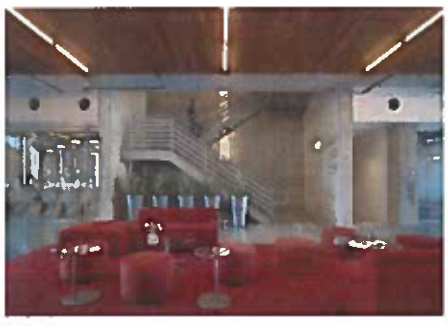
As of 4Q 2016	
Development in Process	$6.5B
Pipeline	$4.1B
Operating	$0.2B
TOTAL	$10.8B

MERITS

#1 Top Development Firm Commercial Property Executive National 2014, 2015 & 2016

#1 Development Company 2014 & 2015
Modern Healthcare Magazine's Design and Construction Survey

$2.6B in construction starts in 2016



D. Brief description of past experience providing similar services.

The following case studies highlight the TCC SoCal Business Unit's range of experience and expertise across a range of office development product, including speculative, build-to-suit, ground up, and redevelopment.

COUNTY LAW BUILDING - INDIO, CA

PROJECT:	**COUNTY LAW BUILDING**
LOCATION:	Indio, CA
COMPLETION DATE:	December 2014, On Time and Under Budget
REFERENCE:	Stephen Gilbert, Development Manager, Riverside County EDA, (951) 955-4824
PROJECT TYPE:	Class A Office, Governmental Agency Build-to-Suit
SQUARE FOOTAGE:	90,000 SF
PROJECT SUMMARY:	In November 2012, Trammell Crow Company's Southern California Business Unit was selected by the County of Riverside Economic Development Agency as Developer to design, entitle, and construct a state of the art County Law Building in the City of Indio, CA. The new building consolidated multiple County legal departments into a single facility adjacent to the Larsen Courthouse. Located at the prominent corner of Highway 111 and Jackson Street, the Class-A, three story structure creates a focal point at the justice center complex in the midst of its revitalization. The 90,000 SF steel frame building takes advantage of a uniquely shaped site, addressing security and offering multiple access points to separate the public from employee and security oriented vehicle traffic. The building program resulted in the Family Justice Center and the Victim Witness functions occupying 55,000 SF, the Public Defender occupying 24,500 SF, the County Counsel 1,400 SF and the County Law Library 9,450 SF. A future freestanding 5,000 SF retail building will serve the law building and the adjacent community. The project is designed to provide a variety of passive people places both inside and out, including a generous entry plaza complete with an attractive water feature and public art sculpture, shaded outdoor seating and generously landscaped spaces. Through strategic planning, the design team was able to introduce multiple sustainable features including extensive sun shading devices, drought tolerant landscaping, on-site storm drain water retention while recharging the local ground water system, electric vehicle charging stations, photovoltaic parking shade structures, recycled content, low-emitting building materials and many other solutions that have resulted in the project receiving a LEED® Platinum Certification. The project was delivered ahead of schedule and $4M under budget.

GATEWAY AT ALHAMBRA - ALHAMBRA, CA

PROJECT:	**GATEWAY AT ALHAMBRA**
LOCATION:	Alhambra, CA
COMPLETION DATE:	September 2012, On Time and Under Budget
REFERENCE:	Jeffrey Siebens, Assistant Director Construction Management, Community Development Commission, County of Los Angeles (626) 586-1792
PROJECT TYPE:	Class A Office, Redevelopment, Governmental Agency Build-to-Suit
SQUARE FOOTAGE:	118,265 SF

PROJECT SUMMARY:

In August 2010, the Trammell Crow Company's Southern California Business Unit was selected by the National Development Council and the Community Development Commission of the County of Los Angeles (LACDC) as the Developer to design, entitle and construct a state of the art office building for the LACDC. The Gateway at Alhambra was developed in an urban area, where the supply of land is severely constrained. The project development required the demolition of an existing theatre and renovation of an existing parking structure. By selecting a site that could utilize an existing structure, the project was guaranteed sufficient parking, and benefitted from decreased construction time and costs.

The Build-to-Suit office building consolidated two County entities, The Community Development Commission and the Housing Authority, previously located in three separate facilities into a single location. A requirement of the project was to integrate three different and distinct user groups into one building environment. As a redevelopment with an existing parking structure, the building ended up occupying nearly the entirety of the remaining site and the resulting space planning was integrated into a non-typical building site plan.

As a result of extremely efficient design and a collaborative space planning effort by all project constituents, TCC and the project architect were able to reduce the County's original space requirement from 155K SF down to 118K SF, a reduction of nearly 20%, resulting in a significant overall savings in project costs. As part of the project requirements the Community Development Commission required a LEED Silver certification level from the USGBC with the goal of developing a highly sustainable project that would conserve energy, water and non-renewable natural resources while creating a healthier and more comfortable work environment for the Commission and Housing Authority employees. Through strategic planning, the project far exceeded the Community Development Commissions goals as the project ultimately achieved LEED Gold certification.

Back to Agenda

USC HEALTH SCIENCES BUILDING - LOS ANGELES, CA

PROJECT:	**USC HEALTH SCIENCES BUILDING**
LOCATION:	Los Angeles, CA
COMPLETION DATE:	August 2011, On Time and Under Budget
REFERENCE:	Kristina Raspe, Director, Real Estate and Facilities - Apple, (408) 862-7099
PROJECT TYPE:	Class A Office, Institutional Build-to-Suit
SQUARE FOOTAGE:	120,000 SF
PROJECT SUMMARY:	Trammell Crow Company was selected by the University of Southern California, from a pool of 17 development teams, to ground lease a 5.3 acre property adjacent to the University's Health Science Campus in downtown Los Angeles, create a financing structure to execute the project, and then develop a 120,000 SF administrative office building, which USC would lease back on a concurrent 20 year lease term. To provide USC with a turnkey building, Trammell Crow Company stepped in to manage the programming, design and layout, construction and FF&E delivery of the administrative office, classroom, fitness center and café space. This entailed consolidating 13 different users from all over the USC Los Angeles portfolio into a singular building, while maintaining the specific academic needs of each user group. The project was a resounding success, opening its doors on August 2011 to an onslaught of incoming students ready for their first day of the school year. The project was 4.5 months ahead of USC's required schedule and $2M under budget..

Back to Agenda

INNOVATION VILLAGE RESEARCH PARK - POMONA, CA

PROJECT:	**INNOVATION VILLAGE RESEARCH PARK AT CAL POLY POMONA**
LOCATION:	Pomona, CA
COMPLETION DATE:	2007, June 2011, December 2015, On Time and Under Budget
REFERENCE:	Sandra Vaughan-Acton, Director of RE Development, Cal Poly Pomona Foundation, Inc. (909) 869-3154
PROJECT TYPE:	Master Planned Class A Office Park, Speculative & Build-to-Suit
SQUARE FOOTAGE:	369,000 SF
PROJECT SUMMARY:	Trammell Crow Company and Cal Poly Pomona University entered into a public/private venture to create a Research Park on its campus. The mission of the partnership was to create an environment in which the business community and the University could interact and collaborate with one another by offering internships to students, job opportunities for graduating students, support of campus programs, etc. TCC and Cal Poly worked together to refine a Master Plan for the remaining 65 acre master planned development with the goal of utilizing additional development opportunities for Build-to-Suits, on-campus academic and student housing facilities. Early in the process it was determined that modern 3-story tilt-up concrete buildings would be the most cost effective construction solution for the product type that was identified to meet the demand in the marketplace. Efficient 40,000 SF floor plates containing a core for each floor with two elevators and adequate restrooms offered flexibility for a wide variety of users, including corporate headquarters, back office, and multi-tenant spaces. The work environment was enhanced by the inclusion of lush landscaping, large people places for relaxation, lunches and outdoor work space, as well as extensive sustainable design features for energy savings, renewable energy, recycled materials, drought tolerant landscaping and water retention resulting in recharging the local groundwater system. Innovation Village Phase 3 commenced as a speculative development by TCC, however Southern California Edison (SCE) was soon identified as a tenant for the entire building. During Phase 3, TCC developed a close partnership with SCE, leading to additional Build-to-Suit opportunities at Innovation Village. In 2009 and again in 2014, TCC was selected as the Developer to design, entitle, and construct Phase 4 and Phase 5 as additional state-of-the-art office buildings to house SCE's Transmission Business Unit.

Back to Agenda

ARENA CORPORATE CENTER - ANAHEIM, CA

PROJECT: **ARENA CORPORATE CENTER**

LOCATION: Anaheim, CA

COMPLETION DATE: 2003, On Time and Under Budget

PROJECT TYPE: Speculative Class A Office Park

SQUARE FOOTAGE: 385,000 SF

PROJECT SUMMARY: Arena Corporate Center is a prime example of how TCC's capabilities benefit our clients. Trammell Crow Company purchased 23 acres of land directly adjacent to the Arrowhead Pond in August 2001. The project, comprised of 3 two-story buildings totaling 385,000 square feet, was considered risky by industry experts due to rising vacancy rates, falling rental rates and the languishing recession.

The TCC team recognized that the submarket lacked quality back office space and determined the local tenant base would prefer a campus type environment, a product that was lacking in Central Orange County. Based on these findings, our team scrapped the existing entitled plans and designed 3 two-story buildings with the largest floor plates in the market. The project includes a one-acre palm tree courtyard with electrical and data hookups, outdoor jogging tracks, basketball court and on site showers. Tenants benefit from features such as 1,000 feet of visibility from the 57 freeway, traffic of almost 300,000 cars per day and 5:1 parking.

The project was an immediate success with Tenant Healthcare signing the first lease for 150,000 square feet prior to groundbreaking in March 2002. Construction was completed in June of 2003 and the project was 100% leased at above pro forma rents just 4 months later. Tenants include: Washington Mutual (56,210 SF), Advantage Sales (46,432 SF), Ameriquest (127,750 SF).

THE BOARDWALK - IRVINE, CA

PROJECT:	**THE BOARDWALK**
LOCATION:	Irvine, CA
COMPLETION DATE:	Projected Completion Summer 2017, Currently On Time & On Budget
PROJECT TYPE:	Class A Speculative Office Campus
SQUARE FOOTAGE:	545,385 SF
PROJECT SUMMARY:	Located on Orange County's most traveled thoroughfare, this 7.5 acre project will be comprised of two, nine-story towers totaling approximately 545,000 square feet of best-in-class office space, two acres of landscaped outdoor space, and abundant on-site amenities. Designed by world renowned architect Gensler, The Boardwalk is poised to revolutionize the Orange County workplace through a perfect blend of form and function, delivering not only iconic architecture and a picturesque landscape, but a design that promotes productivity, efficiency, wellness, and a coastal lifestyle. The buildings offer large floor plates, connected on alternating floors with indoor bridges and outdoor terraces. By bridging the two buildings, The Boardwalk provides the opportunity for up to 65,000 square feet of contiguous space on a single floor, offering unmatched connectivity and efficiency, and office and amenity space unlike anything else in the market. This cutting edge design will enhance productivity by promoting collaboration and demonstrate a creative culture. The Boardwalk offers a comprehensive amenity package including indoor and outdoor workspace, on-site fitness and wellness center, and on-site dining options to provide a well-rounded lifestyle for its occupants. The project is currently under construction, with completion scheduled for Summer of 2017. Leasing is underway, with multiple leases and LOI's currently being negotiated with potential to account for over 400,000 SF of space.

Back to Agenda

RIVERSIDE UNIVERSITY HEALTH SYSTEM MOB - MORENO VALLEY, CA

PROJECT: **RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL OFFICE BUILDING**

LOCATION: Moreno Valley, CA

COMPLETION DATE: Projected Completion 4Q 2019

PROJECT TYPE: Master Planned Development, Phase 1: Class A Build-to Suit Medical Office Building

SQUARE FOOTAGE: 200,000 SF

PROJECT SUMMARY: In April 2015, Trammell Crow Company's Southern California Business Unit was selected as the Master Developer and Owner to plan, design, entitle and construct a state of the art medical office building for the County of Riverside Economic Development Agency and the Riverside University Health System Medical Center. The new building would be located within the existing parking field of the Medical Center and would provide ambulatory care services and ancillary functions for the hospital.

TCC was requested to provide a 200,000 SF MOB located directly in front of the main entrance to the hospital from Cactus Avenue. The building was sited in a manner that allows for connectivity to the existing Education Building & parking fields, as well as future integration into the hospital campus and a proposed parking structure to the east. The location of the building required the re-location of the main entry drive further from the current southern location to the west and creating a new 8,000 SF Lobby/Café building with a connected canopy structure to bring visitors and patients in from the west side of the hospital. Services provided include multi-specialty clinics, outpatient surgery, and physical therapy programs.

After evaluating various financing structures, it was determined that the MOB would be constructed with funds secured through a Credit Tenant Lease (CTL). CTL loans are credit-based debt instruments that provide fully amortizing loans that are coterminous with a tenant's lease. This unique and extremely complex financing vehicle provides tenants with investment grade credit, the ability to finance the entire cost of a new facility through a "rent-to-own" structure. CTL financing offers options for both monetizing existing assets and capitalizing build to suits.

In April 2017, TCC successfully completed entitlements, finalized negotiations on the ground lease and facilities lease, and secured the CTL loan for the County of Riverside. Construction of the 200,000 SF MOB facility is slated to commence later this year, with completion projected for 4Q 2019.

Back to Agenda

SECTION 2. ADDITIONAL QUESTIONS

A. PROVIDE ANY COMMENTS, OBSERVATIONS OR SUGGESTIONS WHICH MAY ASSIST CALOPTIMA IN DRAFTING A PROCUREMENT SOLICITATION.

TCC has vast experience working with numerous public agencies throughout the RFP and ultimately the development process. As a result, some of the fundamental elements that we have identified and recommend which will allow for the smoothest and most efficient procurement process include:

1. Provide a central point of contact for the decision making team. A clear line of communication will simplify and expedite the procurement and negotiation process.

2. Be prepared with a streamlined decision making process. As outlined below, the entire development process will take two or more years to complete. In order to capitalize on the in-place entitlements and current market demand, CalOptima and the new buyer will need to ready to move quickly and efficiently.

3. If possible, be prepared to further define CalOptima's future space requirements prior to issuance of the RFP. Quantifying the square footage required reduces risk by providing greater certainty for the developer and could expedite the overall development process.

4. Evaluate the overall quality of the developer as part of the offer. In addition to the basic terms of the proposal, CalOptima's consideration should include not only track record, experience, and capitalization, but also the reputation and culture. At a minimum, CalOptima will be neighboring the new building, and could potentially occupy space in the new project. As such, a collaborative buyer and potential partner will be a critical element in the next phase of the project.

B. PLEASE PROVIDE A BRIEF SUMMARY OF HOW YOU MIGHT ENVISION THE TRANSACTION STRUCTURES THAT YOUR FIRM WOULD PROPOSE.

As outlined in the above case studies, TCC has the capability to finance and develop premier office space under various deal structures and can offer a range of financing structures. Our team is equally well suited for traditional joint venture relationships with institutional capital partners, as well as collaborative partnerships with governmental and public agencies. We have substantial experience with and are open to various deal structures. While each arrangement is ultimately market driven, we focus on how we can assist and deliver results to our clients.

1. **Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.**

   While TCC anticipates fair market value for the land and associated entitlements, additional aspects of the project would need to be further understood before pricing could be determined. TCC is highly interested and prepared to pursue this asset, but will require additional information relating to status of entitlements, CC&R's, off-sites, subdivision process, reciprocal parking agreements, exactions, and plan check and permit fees. Additionally, CalOptima's future requirements for space or options on space could have an impact on what would be determined to be fair market value.

2. **Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.**

   While Trammell Crow Company's Newport Beach Business Unit has extensive experience with ground leases, it is not our preferred deal structure. However, we have a thorough understanding of the process, including the unique nuances of underwriting and structuring of ground lease documents. In the eyes of the ownership and investment community, the ground lease is generally considered to be an inferior structure to fee simple ownership. As such, the terms of the ground lease would need to reflect this discount in valuation.

Under a ground lease scenario, the rent or rate of return to CalOptima as the ground lessor will be largely dependent upon the requirement as a tenant. In order to appropriately propose pricing, TCC will need to further understand whether the existing building would be included, and if so, the physical condition and CalOptima's intended occupancy duration of the existing building, as well as any potential future space and timing needs within the new building.

3. **Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.**

   TCC has completed Joint Ventures in various forms with public and governmental agencies, as well as traditional partnerships with institutional investors. In order to best structure an agreement with any partner, in depth conversations must take place in order to communicate, understand, and agree upon an overall investment strategy. In order to propose the most appropriate deal structure, TCC would request the opportunity to discuss CalOptima's appetite for risk, return expectations, equity and debt contributions, investment duration, and potential occupancy needs within the to-be-built building.

   By determining CalOptima's future needs, TCC can establish a clear and strategic go forward strategy that will maximize the value of the property, as well as provide or arrange for a variety of financing vehicles which will provide ultimate flexibility for both parties.

4. **Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.**

   TCC is open to exploring trade opportunities following further discussion and understanding of CalOptima's needs and requirements.

C. If possible, please provide preliminary economic results of how you might see a transaction being structured.

As previously discussed, TCC is open to and will entertain various types of structures. However, returns will be predicated upon market forces, as well as a number of economic factors which will need to be further discussed as a partnership or buyer/seller relationship progresses. As a potential occupant of the to-be-built building, the needs of CalOptima will be a primary driver in how best to structure a deal and potential profitability. TCC brings substantial experience and expertise in the development process, as well as deal structure creativity and capital relationships which provide for ultimate flexibility in delivering a variety of finance vehicles, including traditional equity and debt joint ventures, tax exempt bond financing, Credit Tenant Leases (CTL), or synthetic leases, among others. TCC will be better suited to address profitability for both parties after assessing CalOptima's needs as both a tenant and investor.

D. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

Following the April 21st receipt of the RFI responses CalOptima will need to read, evaluate, and interview the respondents. By allowing 30 to 45 days for that process, TCC would estimate a June 2017 commencement and the following approximate timelines if an RFP was deemed necessary.

a) RFP – 60 to 90 days
b) PSA / JV document – 30 days
c) Escrow – 60 to 90 days
d) Design – 10 to 12 months
e) Construction – 14 to 18 months
f) Lease Up of non-CalOptima space – TBD subject to determining CalOptima expansion requirement – 0 to 24 months

E. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

As a potential partner or purchaser of the property, TCC would request from CalOptima, the following obligation and information:

- Exclusive right to negotiate
- Further understanding of CalOptima's timing expectations for identifying future expansion needs
- Further understanding of CalOptima's preferred deal structure
- Further understanding of CalOptima's experience and history as both a Joint Venture Partner or Ground Lessor

TESTIMONIALS

Trammell Crow Company

amazon

"Trammell Crow Company's teamwork atmosphere and leadership in the development process has led to a highly successful project for all parties concerned."

"Trammell Crow Company is a great partner, and we look forward to continuing our relationship."

"Their expertise in development management and their knowledge of the university's and the state's approval process greatly aided the project team in successfully completing these two projects in a timely manner; allowing SCE to move personnel into the facilities ahead of all expectations. Their guidance and counsel to the project team was invaluable. All personnel associated with the project were both helpful and professional in all aspects."

SOUTHERN CALIFORNIA EDISON

An EDISON INTERNATIONAL Company

City of Alhambra

"Trammell Crow Company team leadership capabilities and knowledge of development has created an effective relationship with City Staff and a proactive approach to the development which has yielded an outstanding project that will enhance the City Central Business District for years to come. Trammell Crow Company continues to be a reliable partner, one that meets their obligations and commitments to the community."

"The Cal Poly Pomona Foundation highly recommends the Trammell Crow Company as a developer. We are very pleased to be partnering with them now, and we look forward to future partnerships."

Cal Poly Pomona Foundation

COUNTY OF LOS ANGELES CALIFORNIA

"The Community Development Commission of the County of Los Angeles wishes to express its appreciation to the Trammell Crow Company... "

"Trammell Crow Company's excellence as a developer is second to none. The firm meets its commitments."

Back to Agenda

Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, CA 92660
(949) 477-4700

www.trammellcrow.com

Back to Agenda

State of California

WELFARE AND INSTITUTIONS CODE

Section 14087.54

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) (1) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(2) A commission operating pursuant to this section may also enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs. The commission shall not use any payments or reserves from the Medi-Cal program for this purpose.

(3) In addition to the authority specified in paragraph (1), the board of supervisors may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(A) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395).

(C) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The commission shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(4) Nothing in this section shall prohibit a commission established pursuant to this section from providing services pursuant to subparagraph (C) of paragraph (3) in counties other than the commission's county if the commission is approved by the Department of Managed Health Care to provide services in those counties. The

Back to Agenda

commission shall not use any payment or reserve from the Medi-Cal program for purposes of this paragraph.

(5) For purposes of providing services to persons described in subparagraph (A) or (B) of paragraph (3), if the commission seeks a contract with the federal Centers for Medicare and Medicaid Services to provide Medicare services as a Medicare Advantage program, the commission shall first obtain a license under the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(6) With respect to the provision of services for persons described in subparagraph (A) or (B) of paragraph (3), the commission shall conform to applicable state licensing and freedom of choice requirements as directed by the federal Centers for Medicare and Medicaid Services.

(7) Any material, provided to a person described in subparagraph (A) or (B) of paragraph (3) who is dually eligible to receive medical benefits under both the Medi-Cal program and the Medicare Program, regarding the enrollment or availability of enrollment in Medicare services established by the commission shall include notice of all of the following information in the following format:

(A) Medi-Cal eligibility will not be lost or otherwise affected if the person does not enroll in the plan for Medicare benefits.

(B) The person is not required to enroll in the Medicare plan to be eligible for Medicare benefits.

(C) The person may have other choices for Medicare coverage and for further assistance may contact the federal Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or www.Medicare.gov.

(D) The notice shall be in plain language, prominently displayed, and translated into any language other than English that the commission is required to use in communicating with Medi-Cal beneficiaries.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section

Back to Agenda

6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at the time that the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Care Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

(j) Nothing in this section shall be construed to supersede Section 14093.06 or 14094.3.

(Amended by Stats. 2007, Ch. 483, Sec. 51. Effective January 1, 2008.)

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating and Capital Budgets for Various Information Services Items

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Actions

Authorize unbudgeted:

1) Capital expenditures in an amount not to exceed $390,000 from existing reserves for the following:
   a) An increase of up to $200,000 for Infrastructure-Security-Professional Fees, and an increase of up to $120,000 for Infrastructure-Security-Hardware to fund the Data Masking project; and
   b) An increase of up to $70,000 for Infrastructure-Network-Hardware to fund the RightFax tool upgrade.
2) Operating expenditures within the Medi-Cal program administrative expenses category in an amount not to exceed $393,000 from existing reserves for the following:
   a) An increase of up to $75,000 for Other Operating Expenses-Software Maintenance to fund an upgrade to the Contract Manager system from Change Healthcare;
   b) An increase of up to $300,000 for Professional Fees for Medical Affairs/Information Services consulting; and
   c) An increase of $18,000 for Other Operating Expenses-Software Maintenance to support an upgrade to CalOptima's help desk tool, uGovernIT.

Background/Discussion

The recommended budget adjustments for various items included within the Information Services Fiscal Year (FY) 2019-20 Operating and Capital budgets as summarized below.

1. Capital Expenditures

   a. Data Masking. Data Masking is a critical addition to CalOptima's security infrastructure. Data Masking will begin with static data masking (i.e., the ability to consistently mask Protected Health Information (PHI) within databases). When any copy of production data is made for testing purposes, the PHI within that database will be masked. For example, a last name may be modified to appear as "J*****n" rather than "Johnson," or scrambled (e.g., "Nsohjon," etc.). This will further protect member data and minimize the possibility of unauthorized internal and external exposure.

      This Capital project was planned two years ago and an estimate of the software cost at $320,000 was included in and approved with the FY2017-18 Capital budget. A Request For Proposal process was completed and a tool was selected (Informatica) in early 2019. The cost of the software was less than anticipated and covered by the original Capital budget. However, hardware and professional fees were needed in addition to the software.

Back to Agenda

Professional fees are needed to enlist the support of the vendor during implementation and initial usage. An amount of up to $200,000 is requested for Capital Professional Fees as well as $120,000 for Capital Hardware for this project.

b. RightFax Tool. RightFax is the tool used to electronically send and receive faxes to business partners. This software tool is undergoing an upgrade during the current fiscal year. Although the upgrade was planned, and had no cost beyond labor, it was unforeseen that the upgrade to the software would also require an upgrade to the hardware. This request is to allocate a Capital Hardware budget increase in the amount of $70,000.

2. Operating Expenditures

a. Contract Manager. Contract Manager is CalOptima's software solution for the management of provider contracts. As part of an upcoming upgrade, CalOptima would like to add the module known as Courier to enable electronic routing, collaboration, editing, and electronic signature of provider contracts. This requested addition to budget is to cover the cost of the additional module and the licensing for the secure electronic signatures in the amount of $75,000.

b. Consulting. Consulting services are needed to support various initiatives involving Medical Affairs and the use of the various underlying information systems. The consultant will provide support for CalOptima's Care Management solution and the provider data involved with the authorization and referral process, supporting the goal of improving our members' experience and minimizing grievances. The cost of this consultant is not budgeted and is requested for support up to $300,000.

c. uGovernIT. uGovernIT is CalOptima's service desk, or help desk, tool. An upgrade to this tool was unexpected and requires an update to the hardware architecture to improve both performance and user experience. The request is for $18,000 to cover this additional funding that was not budgeted.

Fiscal Impact

The recommended actions to authorize operating expenditures within the Medi-Cal program administrative expense category in an amount not to exceed $393,000 is unbudgeted. As proposed, an allocation of up to $393,000 from existing reserves will fund this action.

The recommended actions to authorize capital expenditures in an amount not to exceed $390,000 for infrastructure capital projects is unbudgeted. A proposed allocation of up to $390,000 from existing reserves will fund this action.

Back to Agenda

Rationale for Recommendation
To ensure that the referenced elements of CalOptima IT infrastructure remain fully functional, management recommends the proposed unbudgeted operating and capital expenditures.

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

Attachment
None

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Authorizing Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2020

Contact

Brigette Gibb, Executive Director, Human Resources (714) 246-8400

Recommended Actions

Recommend that the Board of Directors:

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision for CalOptima employees and retirees (and their dependents), and basic life, accidental death and dismemberment, short-term disability (STD) and long-term disability (LTD) insurance, an employee assistance program, and flexible spending accounts for CY 2020 in an amount not to exceed $21.5 million which includes:
   a. An increase to employer contributions (based on the percentage of premium the employer pays for each plan), to absorb a portion of the gross 8% increase to premium rates, increasing costs to CalOptima for CY 2020 of an amount of $1,605,723;
   b. Eliminating the Cigna PPO medical plan for active employees and early retirees living in California and restricting enrollment of the Cigna PPO medical plan to eligible early retirees and active employees who reside outside of California;
   c. A decrease in employer contributions at each tier level for the Kaiser HMO medical plan to cover less of the premium costs;
   d. A change in Retiree health benefits for Medicare eligible Retirees and Dependents with AmWins, which will include an increase to employer contributions (based on the percentage of premium the employer pays for the Cigna PPO plan) to absorb a portion of the increase to premium rates in an estimated amount of $24,393;
   e. A continuation of employer contributions for CY 2020 in an estimated amount of $168,750 to fully fund the Health Savings Accounts on January 1, 2020 for employees or retirees currently enrolled in the Cigna High Deductible Health Plan (HDHP) to help ease the transition related to the elimination of the Cigna PPO plan for active employees and retirees living in California (item 1.b. above);
   f. An increase to employer contributions for Cigna dental premiums of 2.5% or $36,986. The addition of adult orthodontia coverage to the Cigna PPO dental plan at no additional cost to CalOptima; and
   g. An increase in Short Term Disability (STD) coverage at a cost of $100,107 to align this benefit with the California State Disability Insurance (SDI) benefit, which provides disability benefits of up to a maximum of 70% of income.

2. Authorize the receipt and expenditures for CalOptima staff wellness programs from $20,000 funding received from Cigna HealthCare (Cigna) Wellness/Health Improvement Fund for CY 2020.

Back to Agenda

3. Authorize the continuation of a Spousal Surcharge of $50 per pay period (for 24 pay periods), to continue from year to year, unless amended by the Board of Directors, for those employees/retirees whose spouses or Registered Domestic Partners: (a) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan; or (b) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan.

4. Authorize a semi-monthly $100 stipend, to continue from year to year, unless amended by the Board of Directors, in lieu of medical benefits as an incentive and cost saving measure for employees who have medical coverage outside of CalOptima

Background

California Government Code section 53201 provides that local public agencies, including CalOptima, have the option of providing health and welfare benefits for the benefit of their officers, employees, and retired employees, who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues, or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. While CalOptima previously contracted with the California Public Employees Retirement System (CalPERS) to provide these benefits, on August 5, 2003, the Board approved the cancellation of CalOptima's contract with CalPERS for employee health insurance coverage effective January 1, 2004 and opted to contract directly with Aetna and Kaiser for plan year 2004. CalOptima has offered such benefits from commercial insurers since that time. CalOptima has been purchasing group health insurance through Relation Insurance Services (formally Ascension), an insurance broker, since 2014 on a year-to-year basis. CalOptima currently contracts with both Kaiser and Cigna to provide group health insurance coverage for all benefited employees. CalOptima more recently began contracting with AmWins to provide Medicare supplemental coverage for qualifying Medicare eligible retirees and their dependents.

By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima currently pays a portion of the premiums for health and welfare benefits for officers, employees, and eligible retired employees, as well as their eligible dependents. In plan year 2015, there was no increase to the employee contributions because CalOptima received a rate decrease, which in effect decreased CalOptima's contributions towards the premiums. In plan year 2016, there was an increase in premium rates, wherein CalOptima shared in the costs of premium rate increases, paying a small portion and passing along the remaining increase to employees, averaging roughly 3% to 4% to employee contributions for Kaiser HMO, Cigna HMO, Cigna HDHP, Cigna PPO and Cigna Dental PPO. In plan year 2017, there was an increase in premium rates, wherein CalOptima absorbed the 2.3% or $321,608 costs of premium rate increases. In plan year 2018, there was an increase in premium rates averaging roughly 10%, wherein employees shared in the costs of premium rate increases. In plan year 2019, there was in increase in premium rates, wherein CalOptima absorbed the 0.8% increase or $145,047 costs of premium rate increases.

Discussion

On behalf of CalOptima, Relation Insurance Services negotiated for the renewal of CalOptima's health and welfare benefits which resulted in a gross increase of 8% or $1,605,723 for CY 2020. Based on the recommendations below, CalOptima's share of the total group health and welfare benefits package will

result in an annual net increase of 7.2% or $1,301,756 for CY 2020, with CalOptima's share of the premiums totaling approximately $19,423,620. The proposed premium increase falls below the regional average increase range of 9% to 12%. The recommended changes are summarized below:

Benefit	**CY 2019**	**CY 2020**	**Difference**
Medical	$17,380,027	$18,905,325	$1,525,298
Wellness Activities	$20,000	$20,000	$0
Dental Insurance	$1,477,536	$1,514,523	$36,986
Vision Insurance	$196,790	$191,060	($5,730)
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	$70,577	$47,868	($22,709)
STD Insurance	$459,080	$559,187	$100,107
LTD Insurance	$242,776	$218,498	($24,278)
Employee Assistance	$38,562	$34,611	($3,951)
Flexible Spending	$34,305	$34,305	$0
Medical Stipend	$292,800	$292,800	$0
Total	**$20,212,453**	**$21,818,177**	**$1,605,723**
CalOptima's Share	$18,121,864	$19,423,620	$1,301,756
Employees' Share	$1,846,189	$2,150,156	$303,967
Spousal Surcharge	$224,400	$224,400	$0
Cigna Wellness Funding	$20,000	$20,000	$0

Please find below additional details by benefit plan for CY 2020 in Attachment A.

Medical

Cigna: Relation negotiated the initial increase down from roughly 15% to a proposed 7.0% increase for active employees/eligible retirees. As was noted last year, HR is now requesting the elimination of the more expensive PPO plan in CY 2020 for active employees and retirees residing in California. Due to limitations associated with out-of-state coverage, Staff is requesting authorization to restrict enrollment in the Cigna PPO plan for active employees and retirees (who are not yet eligible for Medicare) living outside of California.

Kaiser: Relation negotiated the initial increase down from 15% to a proposed increase of 13% for active employees/retirees. Staff recommends sharing the rate increase with employees/retirees by increasing the employee/retiree contributions from the current average of 8% to a total flat contribution rate of 10%, thereby increasing employee contributions in the total amount of $304,721. With the Kaiser HMO plan having lower co-pays and some additional benefits not available with the Cigna HMO plan, the increase in premium for Kaiser will help align the employee and retiree contributions with the benefits.

AmWins PPO**:** AmWins provides PPO Supplemental coverage to Medicare-eligible retirees and dependents. In the past few years, CalOptima elected a Medicare supplemental coverage option that may have been confusing for some retirees, with a $300 deductible, and then thereafter, the retiree was responsible for a 4% coinsurance amount on Medicare Part B expenses, up to a maximum of $1,500. To simplify the benefit for retirees, Staff recommends changing the Medicare supplemental coverage for

Part B to a different benefit option that would include a calendar year deductible of $185, where this would be the only out-of-pocket expense. The approximate cost increase to change the coverage benefit is $24,393.

Wellness Funding: Cigna provides a Wellness/Health Improvement Fund to assist in improving the health and productivity of CalOptima's employees, focusing on behavior change and health status improvement, and creating a health and wellness program strategy leading toward a culture of well-being. Each year, Cigna informs CalOptima of the amount of funds offered for the upcoming calendar year, and for CY 2020, the provided amount is $20,000. Cigna has specific guidelines regarding the types of events the Wellness/Health Improvement Fund can be used towards. The funds may be used to reimburse CalOptima for employee health and wellness program expenses, including but not limited to gym discount sponsorships, educational workshops, and employee wellness activities. Cigna also has specific guidelines by which proposed activities are approved and submitted for reimbursement.

For CY 2020, the proposed wellness activities recommended include:

2020 Wellness Program/Event/Activity	**Estimated Cost**
Wellness Programs (Walk Across America, Pick Your Challenge)	$5,000.00
Wellness Month (Wellness fair and activities)	$9,000.00
Customer Service Week (massage therapy)	$3,000.00
Health Education/Wellness Incentives	$3,000.00
Total	**$20,000.00**

Dental
Cigna Dental: Relation negotiated an overall 2.5% or $36,986 increase to premiums for both CalOptima and employees/eligible retirees. Cigna has also proposed adding adult orthodontia benefit of up to $1,500 per lifetime for the PPO plan to mirror the HMO plan coverage at no added cost. Staff recommends that CalOptima absorb the overall increase in premiums for dental coverage as well as add the adult orthodontia benefit for the PPO plan at no additional cost.

Vision
VSP**:** The renewal came in at a decrease of 2.9% or $5,730 in savings for active employees/eligible retirees. Staff recommends maintaining the current rate contribution for employees/retirees, with CalOptima absorbing the savings.

Other Ancillary Plans
Cigna Life & Disability:

Basic Life/AD&D – Renewal came in at a decrease of 32.2% or $22,709 in savings with a 3-year rate guarantee. The Basic/Life/AD&D benefit is one times full-time employees' annual salary up to a maximum of $325,000. Staff recommends increasing the maximum amount from $325,000 to $400,000 at no additional cost.

Back to Agenda

Voluntary Life/AD&D: Renewal came at no rate change.

Cigna Short Term Disability (STD): The renewal came in at a decrease of 3.2% or $14,809 in savings with a 2-year rate guarantee. For an additional $100,107, Staff recommends increasing the benefit from a maximum of 60% of employees' income to a maximum of 70% of employees' income to align with the amount of the disability benefit provided by State Disability Insurance (SDI).

Cigna Long Term Disability (LTD): The renewal came in at a decrease of 10% or $24,278 in savings with a 3-year rate guarantee.

Employee Assistance Program: The renewal came in at a decrease of 10.2% or $3,951 in savings. There is a 3-year rate guarantee.

Health Savings Account

CalOptima offers a Health Savings Account for employees enrolled in the HDHP medical plan. CalOptima first started offering this medical plan in 2014 and funded the Health Savings Account 100% that same year as an incentive for employees to transition to the Cigna HDHP. The Cigna HDHP is more cost effective and offers the same or comparable benefits as the PPO plan CalOptima currently offers. As part of the benefits renewal last year, staff suggested eliminating the more expensive PPO plan in the future. CalOptima currently has less than 35 employees enrolled in the PPO plan. To provide cost savings to CalOptima and encourage employees to select the Cigna Choice Fund medical plans, staff is recommending eliminating the PPO medical plan option for employees and retirees living in the state of California. Due to the limits associated with medical coverage outside of California, staff is recommending keeping the PPO medical plan for out of state employees and/or retirees and restricting enrollment in the PPO plan to out of state (CA) employees and retirees. Currently, there are 2 employees/retirees who are living outside of California. To assist further with a transition period away from the PPO medical plan to the Cigna HDHP medical plan, staff is recommending that CalOptima fund the Health Savings Accounts 100% for CY 2020 on January 1, 2020 for employees who elect the Cigna HDHP medical plan. This will help alleviate the move from the PPO plan to the Cigna HDHP. Even with CalOptima's funding of the Health Savings Accounts, the anticipated net annual savings for CalOptima is $147,806 for CY 2020, assuming all employees enrolled in the PPO plan transition to the Cigna HDHP, if eligible.

Spousal Surcharge

For CY 2019, the Board authorized a Spousal Surcharge of $50 per pay period (for 24 pay periods) for employees whose spouses or Registered Domestic Partners (1) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan, or (2) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan. This Spousal Surcharge also applied to retirees. The approximate cost savings is $224,400. Staff recommends that CalOptima continue to deduct the Spousal Surcharge on an on-going basis, to continue from year to year, unless amended by the Board of Directors, and require that employees submit an attestation substantiating the enrollment of their spouse/Registered Domestic Partner.

Back to Agenda

Medical Stipend

CalOptima offers a medical stipend of $100 per pay period (for 24 pay periods) as a cost saving measure to CalOptima and an incentive for employees who have medical coverage outside of CalOptima. Employees must submit proof of outside coverage in order to be eligible for this benefit. Approximately 187 employees are receiving this benefit for an annual cost of approximately $292,800. Staff recommends that CalOptima continue to offer this benefit from year to year, unless amended by the Board of Directors.

Employer and Employee Contribution Comparison

CalOptima's and individual employee's share of the premiums differ depending on the employee's elections. As set forth in the attached presentation, employer premium contributions for full time employees range from 78.3% to 94.7% and the premium contributions rates for employees and retirees range from 5.3% to 21.7%. The methodology used to calculate the employer and employee contributions is intended to aid management in attracting and retaining talented employees. CalOptima's group health benefits insurance are comparable to the County of Orange with an average of 89.6% employer contribution rate for CalOptima's employee only coverage, in comparison to the County's 90% employer contribution rate. However, CalOptima's employer contribution for employees with dependents is higher than the County of Orange at an average of 85.5% employer contribution rate compared to the County's 75% employer contribution rate.

Staff Recommendations

Staff recommends increasing CalOptima's contributions to absorb only a portion of the gross 8% increase to premium rates, which will increase costs to CalOptima for CY 2020 in an amount estimated at $1,301,756. At the same time, the dollar amount employees contribute toward the total premium costs will also increase, but the same percentage of the premium paid by the employee will remain the same from CY 2019, with the exception of employee/retiree contribution for Kaiser. The employee and retirees (eligible for Medicare) contribution rate for Kaiser will increase to a flat 10% (currently average 8%). This recommendation, along with the other recommended actions, are made based on a thorough review by CalOptima's Human Resources Department to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent.

Fiscal Impact

The fiscal impact for group health insurance policies for CalOptima employees and retirees in CY 2020 is estimated at a total cost not to exceed $21.5 million. The employer cost to absorb the increased premiums totals $1,301,756.

The recommended action to provide group health insurance policies for CalOptima employees and retirees for the period of January 1, 2020, through June 30, 2020, and associated anticipated expenditures are budgeted items in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. Management will include funding for group health insurance policies for the period July 1, 2020 through December 31, 2020, in the CalOptima FY 2020-21 Operating Budget.

Back to Agenda

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

Attachment
A. CalOptima Presentation – January 2020 Renewal Meeting

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

CalOptima
A Public Agency
Better. Together.

January 2020 Renewal Executive Summary

Relation™

Back to Agenda

Recommendation

Renewal Summary

Based on current enrollment, CalOptima's **2020** NET insurance costs will increase by 7.2% or $1,301,756, which is the cumulative increase for both employer and employee. Below is each medical plan's renewal action:

- Cigna Medical – Relation negotiated a final no-bid offer that reduced the renewal down to 7.0%; Cigna stated the renewal warranted a mid-teen increase; wellness fund will remain at $20,000 for 2020
  - CalOptima to eliminate the PPO plan for California employees due to low enrollment; renewal cost assumes all employees enrolled in the PPO will move to the HDHP PPO plan; PPO plan will still be made available to out of state employees (currently 1 early retiree and 1 active employee)
  - Currently 32% participation and carriers require 50% or more alongside Kaiser (last year was 35%)
- CalOptima to fund 100% of the Health Savings Accounts on 1/1/2020 for anyone enrolled in the Cigna HDHP medical plan; with the PPO being eliminated in California, these employees will move to the HDHP and benefit from 100% funding
- Kaiser Medical - initial renewal increase was 14.9% (cap); Relation negotiated renewal increase is 13.0%; includes an increase to employee contributions to a flat 10% of premium
- Cigna Dental – renewal increase is 2.5% for the PPO and DHMO plans. The PPO plan will include orthodontia coverage for adults as of 1/1/2020 at no additional cost
- VSP Vision – renewal decrease of -2.9%
- Cigna Basic Life/AD&D – initial renewal was a rate pass; Relation negotiated a renewal decrease of -32.2% and a 3 year rate guarantee; includes maximum benefit increase to $400,000
- Cigna LTD – initial renewal was a rate pass; Relation negotiated a renewal decrease of -10.0% and a 3 year rate guarantee
- Cigna STD – benefit percentage will increase from 60% to 70% with a 2 year rate guarantee; renewal increase for this benefit change is 21.8%
- ACI EAP – renewal decrease of -10.2%
- WageWorks FSA – renewal pending
- AmWINS PPO (Medicare Retirees) – final rates pending; estimated renewal increase of 5%; includes a plan change to Plan G to enhance benefits by reducing the annual deductible to $185 and eliminating the coinsurance where the deductible will be the only out of pocket expense
- Keep the Benefit Income amount for waivers the same at $200/month; keep the Spousal Surcharge amount the same at $100/month

Back to Agenda

Recommended Total Package Cost

		2019 Current	2020 Cigna HMO/HDHP in CA Cigna PPO Outside CA Only Kaiser Status Quo AmWins Medicare Plan G (estimated) Cigna Dental PPO with $1,500 Adult Ortho VSP Vision Status Quo Increase Cigna Basic Life/AD&D max for full-time employees to $400,000 Increase Cigna STD to 70% Cigna LTD Status Quo ACI EAP Status Quo	$ Change	% Change
All Medical		**$17,380,027**	**$18,905,325**	**$1,525,298**	**8.78%**
Kaiser HMO Actives	691	$8,466,941	$9,563,612	$1,096,671	12.95%
Kaiser HMO Early Retirees (Pre-65)	6	$106,264	$120,044	$13,780	12.97%
Kaiser HMO Medicare Retirees (Post-65)	20	$102,451	$107,418	$4,967	4.85%
Cigna HMO Actives & Early Retirees (Pre-65)	397	$6,696,649	$7,165,659	$469,011	7.00%
Cigna PPO Actives & Early Retirees (Pre-65)	36	$781,377	$40,197	($741,179)	-94.86%
Cigna HDHP Actives Only	55	$895,869	$1,489,242	$593,373	66.23%
AmWins PPO Medicare Retirees (Post-65)	30	$221,258	$245,651	$24,393	11.02%
HSA Administration	55	$2,970	$4,752	$1,782	60.00%
HSA Funding ($1,250 single / $2,500 with deps)	55	$106,250	$168,750	$62,500	58.82%
Wellness Funding spent by CalOptima		$20,000	$20,000	$0	0.00%
Wellness Funding reimbursement from Cigna		($20,000)	($20,000)	$0	0.00%
All Ancillary		**$2,519,626**	**$2,600,051**	**$80,425**	**3.19%**
Cigna Dental PPO Actives & Retirees	1,003	$1,362,962	$1,397,064	$34,102	2.50%
Cigna Dental HMO Actives & Retirees	310	$114,574	$117,459	$2,884	2.52%
VSP Vision Actives & Retirees	1,316	$196,790	$191,060	($5,730)	-2.91%
Cigna Basic Employee Life & AD&D	1,295	$70,577	$47,868	($22,709)	-32.18%
Cigna Short Term Disability	1,295	$459,080	$559,187	$100,107	21.81%
Cigna Long Term Disability	1,295	$242,776	$218,498	($24,278)	-10.00%
ACI Employee Assistance Program	1,317	$38,562	$34,611	($3,951)	-10.25%
WageWorks Flexible Spending Accounts	535	$34,305	$34,305	$0	0.00%

Relation

Recommended Total Package Cost

CalOptima shares the increase with employees; employee contributions would change as follows:

- Kaiser contributions would increase to 10% due to on a higher level of benefits the Kaiser plan should cost a little more than the Cigna HMO
- Cigna contributions would remain the same percentage as current
- No change to dental or vision contributions

Benefit Income (waivers) - $200/month	122	$292,800	$292,800
Spousal Surcharge - $100/month	187	($224,400)	($224,400)
Monthly - Estimated		**$1,664,004**	**$1,797,815**
Annual - Estimated		**$19,968,053**	**$21,573,776**
GROSS Differences			
Versus Current - $			**$1,605,723**
Versus Current - %			**8.0%**
Annual Employee Contributions		**$1,846,189**	**$2,150,156**
NET Annual -Estimated (Employer - EE Contribs)		**$18,121,864**	**$19,423,620**
NET Differences (Employer - EE Contribs)			
Versus Current - $			**$1,301,756**
Versus Current - %			**7.2%**

Relation

Recommended Employee Contributions

CalOptima shares the increase with employees; employee contributions would change as follows:

- Kaiser contributions would increase to 10% due to on a higher level of benefits the Kaiser plan should cost a little more than the Cigna HMO
- Cigna contributions would remain the same percentage as current

Medical for Full-Time Actives and Early Retirees

2019 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		**Cigna HMO**				
Employee	120	$659.47	$34 98	5.3%	$624.49	94.7%
Employee + One	46	$1,443.08	$88 29	6.1%	$1,354.79	93.9%
Employee + Child(ren)	84	$1,303.43	$79.75	6.1%	$1,223.68	93.9%
Employee + Family	147	$2 061.55	$127.81	6.2%	$1 933.74	93.8%
MONTHLY TOTAL	397	$558,054	$33,746		$524,308	
Actives & Early Retirees		**Cigna PPO**				
Employee	18	$1,057.81	$187.02	17.7%	$870.79	82.3%
Employee + One	7	$2,291.60	$445.30	19.4%	$1,846.30	80.6%
Employee + Child(ren)	5	$2,072.70	$402.76	19.4%	$1,669.94	80.6%
Employee + Family	6	$3 278.24	$667.98	20.4%	$2 610.26	79.6%
MONTHLY TOTAL	36	$65,115	$12,505		$52,610	
Actives		**Cigna HDHP**				
Employee	25	$801.37	$102.13	12.7%	$699.24	87.3%
Employee + One	11	$1,609.35	$275.52	17.1%	$1,333.83	82.9%
Employee + Child(ren)	8	$1,453.61	$248.86	17.1%	$1,204.75	82.9%
Employee + Family	11	$2 299.07	$498.18	21.7%	$1 800.89	78.3%
MONTHLY TOTAL	55	$74,656	$13,055		$61,601	
Actives		**Kaiser HMO**				
Employee	259	$518.54	$34 98	6.7%	$483.56	93.3%
Employee + One	75	$1,037.08	$88 29	8.5%	$948.79	91.5%
Employee + Child(ren)	144	$985.23	$79.75	8.1%	$905.48	91.9%
Employee + Family	211	$1 659.33	$127.81	7.7%	$1 531.52	92.3%
MONTHLY TOTAL	689	$704,075	$54,133		$649,941	
Early Retirees		**Kaiser HMO**				
Employee	3	$776.78	$34 98	4.5%	$741.80	95.5%
Employee + One	1	$1,553.56	$88 29	5.7%	$1,465.27	94.3%
Employee + Child(ren)	0	$1,475.89	$79.75	5.4%	$1,396.14	94.6%
Employee + Family	2	$2 485.70	$127.81	5.1%	$2 357.89	94.9%
MONTHLY TOTAL	6	$8,855	$449		$8,406	

2020 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Actives & Early Retirees		**Cigna HMO**					
Employee	120	$705 66	$37.43	5 3%	$668.23	94.7%	$2.45
Employee + Spouse	46	$1,544.15	$94.47	6.1%	$1,449.68	93 9%	$6.18
Employee + Child(ren)	84	$1,394.72	$85.34	6.1%	$1,309.38	93 9%	$5.59
Employee + Family	147	$2 205.93	$136.76	6 2%	$2 069.17	93 8%	$8.95
MONTHLY TOTAL	397	$597,138	$36,109		$561,029		
Early Retirees (Outside CA)		**Cigna PPO**					
Employee	1	$1,131.90	$200.12	17.7%	$931.78	82 3%	$13.10
Employee + Spouse	0	$2,452.10	$476.49	19.4%	$1,975.61	80 6%	$31.19
Employee + Child(ren)	1	$2,217.87	$430.97	19.4%	$1,786.90	80 6%	$28 21
Employee + Family	0	$3 507.84	$714.76	20.4%	$2 793.08	79 6%	$46.78
MONTHLY TOTAL	2	$3,350	$631		$2,719		
Actives		**Cigna HDHP**					
Employee	41	$813 26	$103.65	12.7%	$709.61	87 3%	$1.52
Employee + Spouse	18	$1,707.85	$292.38	17.1%	$1,415.47	82 9%	$16 86
Employee + Child(ren)	12	$1,545.19	$264.54	17.1%	$1,280.65	82 9%	$15 68
Employee + Family	17	$2 439.78	$528.67	21.7%	$1 911.11	78 3%	$30.49
MONTHLY TOTAL	88	$124,104	$21,674		$102,429		
Actives		**Kaiser HMO**					
Employee	259	$585.70	$58.57	10.0%	$527.13	90 0%	$23 59
Employee + Spouse	75	$1,171.40	$117.14	10.0%	$1,054.26	90 0%	$28 85
Employee + Child(ren)	144	$1,112.84	$111.28	10.0%	$1,001.56	90 0%	$31 53
Employee + Family	211	$1 874.26	$187.43	10.0%	$1 686.83	90 0%	$59 62
MONTHLY TOTAL	689	$795,269	$79,527		$715,742		
Early Retirees		**Kaiser HMO**					
Employee	3	$877 51	$58.57	6.7%	$818.94	93 3%	$23 59
Employee + Spouse	1	$1,755.02	$117.14	6.7%	$1,637.88	93 3%	$28 85
Employee + Child(ren)	0	$1,667.27	$111.28	6.7%	$1,555.99	93 3%	$31 53
Employee + Family	2	$2 808.04	$187.43	6.7%	$2 620.61	93 3%	$59 62
MONTHLY TOTAL	6	$10,004	$668		$9,336		

Back to Agenda

Relation™

Recommended Employee Contributions

CalOptima shares the increase with employees; employee contributions would change as follows:

- Kaiser contributions would increase to 10% due to on a higher level of benefits the Kaiser plan should cost a little more than the Cigna HMO
- Cigna contributions would remain the same percentage as current

Medical for Part-Time Actives and Medicare Retirees

2019 Employer vs. Employee Contributions

PART TIME ACTIVES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna HMO						
Employee	0	$659.47	$69.97	10.6%	$589.50	89.4%
Employee + One	0	$1,443 08	$176 57	12.2%	$1,266 51	87 8%
Employee + Child(ren)	0	$1,303.43	$159 50	12.2%	$1,143 93	87 8%
Employee + Family	0	$2 061 55	$255 63	12.4%	$1 805 92	87 6%
MONTHLY TOTAL	0	$0	$0		$0	
Cigna PPO						
Employee	0	$1,057 81	$374 04	35.4%	$683.77	64 6%
Employee + One	0	$2,291 60	$890 62	38.9%	$1,400 98	61.1%
Employee + Child(ren)	0	$2,072.70	$805 52	38.9%	$1,267.18	61.1%
Employee + Family	0	$3 278 24	$1 335 93	40.8%	$1 942 31	59 2%
MONTHLY TOTAL	0	$0	$0		$0	
Cigna HDHP						
Employee	0	$801.37	$204 25	25.5%	$597.12	74 5%
Employee + One	0	$1,609 35	$551 03	34.2%	$1,058 32	65 8%
Employee + Child(ren)	0	$1,453 61	$497.72	34.2%	$955.89	65 8%
Employee + Family	0	$2 299 07	$996 37	43.3%	$1 302.70	56.7%
MONTHLY TOTAL	0	$0	$0		$0	
Kaiser HMO						
Employee	1	$518.54	$69.97	13.5%	$448.57	86 5%
Employee + One	0	$1,037 08	$176 57	17.0%	$860.51	83 0%
Employee + Child(ren)	1	$985.23	$159 50	16.2%	$825.73	83 8%
Employee + Family	0	$1 659 33	$255 63	15.4%	$1 403.70	84 6%
MONTHLY TOTAL	2	$1,504	$229		$1,274	
MEDICARE RETIREES	**Enrollment**	**2019 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
Amwins PPO						
Retiree (Medicare)	14	$400.83	$70.98	17.7%	$329.85	82 3%
Retiree + 1 (2 Medicare)	16	$801.66	$160 95	20.1%	$640.71	79 9%
MONTHLY TOTAL	30	$18,438	$3,569		$14,869	
Kaiser HMO						
Subscriber with Medicare	8	$216.72	$12.85	5 9%	$203.87	94.1%
Subscriber with Medicare + Spouse with Medicare	9	$433.44	$32.42	7 5%	$401.02	92 5%
Subscriber with Medicare + Spouse without Medicare	2	$993.50	$82.35	8 3%	$911.15	91.7%
Subscriber with Medicare and Children	1	$915.83	$135 88	14.8%	$779.95	85 2%
MONTHLY TOTAL	20	$8,538	$695		$7,842	

2020 Employer vs. Employee Contributions

PART TIME ACTIVES	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Cigna HMO							
Employee	0	$705.66	$74 87	10 6%	$630.79	89.4%	$4.90
Employee + Spouse	0	$1,544.15	$188.94	12 2%	$1,355 21	87.8%	$12.37
Employee + Child(ren)	0	$1,394.72	$170.67	12 2%	$1,224 05	87.8%	$11.17
Employee + Family	0	$2 205.93	$273.53	12.4%	$1 932.40	87.6%	$17.90
MONTHLY TOTAL	0	$0	$0		$0		
Cigna PPO							
Employee	0	$1,131.90	$400.24	35.4%	$731.66	64.6%	$26.20
Employee + Spouse	0	$2,452.10	$953.00	38 9%	$1,499.10	61.1%	$62.38
Employee + Child(ren)	0	$2,217.87	$861.94	38 9%	$1,355 93	61.1%	$56.42
Employee + Family	0	$3 507.84	$1 429.50	40 8%	$2 078 34	59.2%	$93.57
MONTHLY TOTAL	0	$0	$0		$0		
Cigna HDHP							
Employee	0	$813.26	$207.28	25 5%	$605.98	74.5%	$3.03
Employee + Spouse	0	$1,707.85	$584.76	34 2%	$1,123 09	65.8%	$33.73
Employee + Child(ren)	0	$1,545.19	$529.08	34 2%	$1,016.11	65.8%	$31.36
Employee + Family	0	$2 439.78	$1 057.35	43 3%	$1 382.43	56.7%	$60.98
MONTHLY TOTAL	0	$0	$0		$0		
Kaiser HMO							
Employee	1	$585.70	$74 87	12 8%	$510.83	87.2%	$4.90
Employee + Spouse	0	$1,171.40	$188.94	16.1%	$982.46	83.9%	$12.37
Employee + Child(ren)	1	$1,112.84	$170.67	15 3%	$942.17	84.7%	$11.17
Employee + Family	0	$1 874.26	$273.53	14 6%	$1 600.73	85.4%	$17.90
MONTHLY TOTAL	2	$1,699	$246		$1,453		$16.07
MEDICARE RETIREES	**Enrollment**	**2020 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**	**EE Contributions Monthly Increase from Current**
Amwins PPO							
Retiree (Medicare)	14	$445.02	$78 81	17.7%	$366.21	82.3%	$7.83
Retiree + 1 (2 Medicare)	16	$890.04	$178.69	20.1%	$711.35	79.9%	$17.74
MONTHLY TOTAL	30	$20,471	$3,962		$16,509		
Kaiser HMO							
Subscriber with Medicare	8	$220.92	$22 09	10 0%	$198.83	90.0%	$9.24
Subscriber with Medicare + Spouse with Medicare	9	$441.84	$44.18	10 0%	$397.66	90.0%	$11.76
Subscriber with Medicare + Spouse without Medicare	2	$1,098.43	$109.84	10 0%	$988.59	90.0%	$27.49
Subscriber with Medicare and Children	1	$1 010.68	$101.07	10 0%	$909.61	90.0%	
MONTHLY TOTAL	20	$8,951	$895		$8,056		

Back to Agenda

Relation

Recommended Employee Contributions

No change to dental or vision contributions

Dental and Vision for All

2019 Employer vs. Employee Contributions

FULL TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees		**Dental PPO**				
Employee	348	$48.26	$5 20	10.8%	$43.06	89.2%
Employee + One	168	$95.88	$15.72	16.4%	$80.16	83.6%
Employee + Child(ren)	158	$123.18	$20.20	16.4%	$102.98	83.6%
Employee + Family	328	$186.34	$31.54	16.9%	$154.80	83.1%
MONTHLY TOTAL	1,002	$113,484	$17,987		$95,497	
Actives & Retirees		**Dental HMO**				
Employee	108	$12.76	$0 00	0.0%	$12.76	100.0%
Employee + One	36	$25.34	$0 00	0.0%	$25.34	100.0%
Employee + Child(ren)	55	$32.56	$0 00	0.0%	$32.56	100.0%
Employee + Family	110	$49.25	$0 00	0.0%	$49.25	100.0%
MONTHLY TOTAL	309	$9,499	$0		$9,499	
Actives & Retirees		**VSP Vision**				
Employee	498	$7 37	$0 00	0.0%	$7.37	100.0%
Employee + One	189	$11.45	$1 00	8.7%	$10.45	91.3%
Employee + Child(ren)	197	$11.93	$1 50	12.6%	$10.43	87.4%
Employee + Family	429	$19.06	$2 00	10.5%	$17.06	89.5%
MONTHLY TOTAL	1 313	$16 361	$1 343		$15 019	
PART TIME DENTAL & VISION	**Enrollment**	**2019 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
Actives		**Dental PPO**				
Employee	0	$48.26	$10.40	21.5%	$37.86	78.5%
Employee + One	1	$95.88	$31.44	32.8%	$64.44	67.2%
Employee + Child(ren)	0	$123.18	$40.40	32.8%	$82.78	67.2%
Employee + Family	0	$186.34	$63.08	33.9%	$123.26	66.1%
MONTHLY TOTAL	1	$96	$31		$64	
Actives		**Dental HMO**				
Employee	0	$12.76	$0 00	0.0%	$12.76	100.0%
Employee + One	0	$25.34	$0 00	0.0%	$25.34	100.0%
Employee + Child(ren)	0	$32.56	$0 00	0.0%	$32.56	100.0%
Employee + Family	1	$49 25	$0 00	0.0%	$49 25	100.0%
MONTHLY TOTAL	1	$49	$0		$49	
Actives		**VSP Vision**				
Employee	1	$7 37	$0 00	0.0%	$7.37	100.0%
Employee + One	1	$11.45	$2 00	17.5%	$9.45	82.5%
Employee + Child(ren)	0	$11.93	$3 00	25.1%	$8.93	74.9%
Employee + Family	1	$19.06	$4 00	21.0%	$15.06	79.0%
MONTHLY TOTAL	3	$38	$6		$32	

2020 Employer vs. Employee Contributions

FULL TIME DENTAL & VISION	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Actives & Retirees		**Dental PPO**					
Employee	348	$49.47	$5 20	10.5%	$44.27	89 5%	$0.00
Employee + Spouse	168	$98.28	$15.72	16.0%	$82.56	84 0%	$0.00
Employee + Child(ren)	158	$126.26	$20.20	16.0%	$106.06	84 0%	$0.00
Employee + Family	328	$191.00	$31.54	16.5%	$159.46	83 5%	$0.00
MONTHLY TOTAL	1002	$116,324	$17,987		$98,336		
Actives & Retirees		**Dental HMO**					
Employee	108	$13.08	$0 00	0.0%	$13.08	100.0%	$0.00
Employee + Spouse	36	$25.98	$0 00	0.0%	$25.98	100.0%	$0.00
Employee + Child(ren)	55	$33.38	$0 00	0.0%	$33.38	100.0%	$0.00
Employee + Family	110	$50.49	$0 00	0.0%	$50.49	100.0%	$0.00
MONTHLY TOTAL	309	$9,738	$0		$9,738		
Actives & Retirees		**VSP Vision**					
Employee	498	$8.14	$0 00	0.0%	$8.14	100.0%	$0.00
Employee + Spouse	189	$12.65	$1 00	8.7%	$11.65	92.1%	$0.00
Employee + Child(ren)	197	$13.17	$1 50	12.6%	$11.67	88 6%	$0.00
Employee + Family	429	$21.08	$2 00	10.5%	$19.08	90 5%	$0.00
MONTHLY TOTAL	1 313	$18 082	$1 343		$16 740		$0.00
PART TIME DENTAL & VISION	**Enrollment**	**2020 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**	**EE Contributions Monthly Increase from Current**
Actives		**Dental PPO**					
Employee	0	$49.47	$10.40	21.0%	$39.07	79 0%	$0.00
Employee + Spouse	1	$98.28	$31.44	32.0%	$66.84	68 0%	$0.00
Employee + Child(ren)	0	$126.26	$40.40	32.0%	$85.86	68 0%	$0.00
Employee + Family	0	$191.00	$63.08	33.0%	$127.92	67 0%	$0.00
MONTHLY TOTAL	1	$98	$31		$67		$0.00
Actives		**Dental HMO**					
Employee	0	$13.08	$0 00	0.0%	$13.08	100.0%	
Employee + Spouse	0	$25.98	$0 00	0.0%	$25.98	100.0%	$0.00
Employee + Child(ren)	0	$33.38	$0 00	0.0%	$33.38	100.0%	$0.00
Employee + Family	1	$50 49	$0 00	0.0%	$50 49	100.0%	$0.00
MONTHLY TOTAL	1	$50	$0		$50		
Actives		**VSP Vision**					
Employee	1	$8.14	$0 00	0.0%	$8.14	100.0%	$0.00
Employee + Spouse	1	$12.65	$2 00	17.5%	$10.65	84 2%	$0.00
Employee + Child(ren)	0	$13.17	$3 00	25.1%	$10.17	77 2%	$0.00
Employee + Family	1	$21.08	$4 00	21.0%	$17.08	81 0%	$0.00
MONTHLY TOTAL	3	$42	$6		$36		

Back to Agenda

Relation™

Option

Relation™

Total Package Cost

No difference from recommended

		2019 Current	2020 Cigna HMO/HDHP in CA Cigna PPO Outside CA Only Kaiser Status Quo AmWins Medicare Plan G (estimated) Cigna Dental PPO with $1,500 Adult Ortho VSP Vision Status Quo Increase Cigna Basic Life/AD&D max for full-time employees to $400,000 Increase Cigna STD to 70% Cigna LTD Status Quo ACI EAP Status Quo	$ Change	% Change
All Medical		**$17,380,027**	**$18,905,325**	**$1,525,298**	**8.78%**
Kaiser HMO Actives	691	$8,466,941	$9,563,612	$1,096,671	12.95%
Kaiser HMO Early Retirees (Pre-65)	6	$106,264	$120,044	$13,780	12.97%
Kaiser HMO Medicare Retirees (Post-65)	20	$102,451	$107,418	$4,967	4.85%
Cigna HMO Actives & Early Retirees (Pre-65)	397	$6,696,649	$7,165,659	$469,011	7.00%
Cigna PPO Actives & Early Retirees (Pre-65)	36	$781,377	$40,197	($741,179)	-94.86%
Cigna HDHP Actives Only	55	$895,869	$1,489,242	$593,373	66.23%
AmWins PPO Medicare Retirees (Post-65)	30	$221,258	$245,651	$24,393	11.02%
HSA Administration	55	$2,970	$4,752	$1,782	60.00%
HSA Funding ($1,250 single / $2,500 with deps)	55	$106,250	$168,750	$62,500	58.82%
Wellness Funding spent by CalOptima		$20,000	$20,000	$0	0.00%
Wellness Funding reimbursement from Cigna		($20,000)	($20,000)	$0	0.00%
All Ancillary		**$2,519,626**	**$2,600,051**	**$80,425**	**3.19%**
Cigna Dental PPO Actives & Retirees	1,003	$1,362,962	$1,397,064	$34,102	2.50%
Cigna Dental HMO Actives & Retirees	310	$114,574	$117,459	$2,884	2.52%
VSP Vision Actives & Retirees	1,316	$196,790	$191,060	($5,730)	-2.91%
Cigna Basic Employee Life & AD&D	1,295	$70,577	$47,868	($22,709)	-32.18%
Cigna Short Term Disability	1,295	$459,080	$559,187	$100,107	21.81%
Cigna Long Term Disability	1,295	$242,776	$218,498	($24,278)	-10.00%
ACI Employee Assistance Program	1,317	$38,562	$34,611	($3,951)	-10.25%
WageWorks Flexible Spending Accounts	535	$34,305	$34,305	$0	0.00%

Relation

Total Package Cost – Employee Contribution Option

CalOptima shares the increase with employees; employee contributions are same percentage as current (except for Kaiser, which is the same dollar amount as Cigna HMO) for medical plans only. This is the current employee contribution strategy.

Based on current enrollment, CalOptima's 2020 NET insurance costs for this employee contribution option will increase by 8.6% or $1,565,625, which is the cumulative increase for both employer and employee; no change to dental and vision contributions

Benefit Income (waivers) - $200/month	122	$292,800	$292,800	
Spousal Surcharge - $100/month	187	($224,400)	($224,400)	
Monthly - Estimated		**$1,664,004**	**$1,797,815**	
Annual - Estimated		**$19,968,053**	**$21,573,776**	
GROSS Differences				
Versus Current - $			**$1,605,723**	
Versus Current - %			**8.0%**	
Annual Employee Contributions		**$1,846,189**	**$1,886,287**	Change from recommended
NET Annual -Estimated (Employer - EE Contribs)		**$18,121,864**	**$19,687,489**	Change from recommended
NET Differences (Employer - EE Contribs)				
Versus Current - $			**$1,565,625**	Change from recommended
Versus Current - %			**8.6%**	

Back to Agenda

Relation

Employee Contribution Option

CalOptima shares the increase with employees; employee contributions are same percentage as current (except for Kaiser, which is the same dollar amount as Cigna HMO) for medical plans only. This is the current employee contribution strategy.

Medical for Full-Time Actives and Early Retirees

2019 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		**Cigna HMO**				
Employee	120	$659.47	$34.98	5 3%	$624.49	94.7%
Employee + One	46	$1,443.08	$88.29	6.1%	$1,354.79	93 9%
Employee + Child(ren)	84	$1,303.43	$79.75	6.1%	$1,223.68	93 9%
Employee + Family	147	$2 061.55	$127.81	6 2%	$1 933.74	93 8%
MONTHLY TOTAL	397	$558,054	$33,746		$524,308	
Actives & Early Retirees		**Cigna PPO**				
Employee	18	$1,057.81	$187.02	17.7%	$870.79	82 3%
Employee + One	7	$2,291.60	$445.30	19.4%	$1,846.30	80 6%
Employee + Child(ren)	5	$2,072.70	$402.76	19.4%	$1,669.94	80 6%
Employee + Family	6	$3 278 24	$667 98	20.4%	$2 610 26	79 6%
MONTHLY TOTAL	36	$65,115	$12,505		$52,610	
Actives		**Cigna HDHP**				
Employee	25	$801.37	$102.13	12.7%	$699 24	87 3%
Employee + One	11	$1,609.35	$275.52	17.1%	$1,333.83	82 9%
Employee + Child(ren)	8	$1,453.61	$248.86	17.1%	$1,204.75	82 9%
Employee + Family	11	$2 299.07	$498.18	21.7%	$1 800.89	78 3%
MONTHLY TOTAL	55	$74,656	$13,055		$61,601	
Actives		**Kaiser HMO**				
Employee	259	$518.54	$34.98	6.7%	$483 56	93 3%
Employee + One	75	$1,037.08	$88.29	8 5%	$948.79	91 5%
Employee + Child(ren)	144	$985.23	$79.75	8.1%	$905.48	91 9%
Employee + Family	211	$1 659.33	$127.81	7.7%	$1 531.52	92 3%
MONTHLY TOTAL	689	$704,075	$54,133		$649,941	
Early Retirees		**Kaiser HMO**				
Employee	3	$776.78	$34.98	4 5%	$741 80	95 5%
Employee + One	1	$1,553.56	$88.29	5.7%	$1,465.27	94 3%
Employee + Child(ren)	0	$1,475.89	$79.75	5.4%	$1,396.14	94 6%
Employee + Family	2	$2 485.70	$127.81	5.1%	$2 357.89	94 9%
MONTHLY TOTAL	6	$8,855	$449		$8,406	

2020 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Actives & Early Retirees		**Cigna HMO**					
Employee	120	$705.66	$37.43	5 3%	$668.23	94.7%	$2.45
Employee + Spouse	46	$1,544.15	$94.47	6.1%	$1,449.68	93.9%	$6.18
Employee + Child(ren)	84	$1,394.72	$85.34	6.1%	$1,309.38	93.9%	$5 59
Employee + Family	147	$2 205.93	$136.76	6 2%	$2 069.17	93.8%	$8 95
MONTHLY TOTAL	397	$597,138	$36,109		$561,029		
Early Retirees (Outside CA)		**Cigna PPO**					
Employee	1	$1,131.90	$200.12	17.7%	$931.78	82.3%	$13.10
Employee + Spouse	0	$2,452.10	$476.49	19.4%	$1,975.61	80.6%	$31.19
Employee + Child(ren)	1	$2,217.87	$430.97	19.4%	$1,786.90	80.6%	$28.21
Employee + Family	0	$3 507 84	$714 76	20.4%	$2 793 08	79.6%	$46.78
MONTHLY TOTAL	2	$3,350	$631		$2,719		
Actives		**Cigna HDHP**					
Employee	41	$813.26	$103.65	12.7%	$709.61	87.3%	$1 52
Employee + Spouse	18	$1,707.85	$292.38	17.1%	$1,415.47	82.9%	$16.86
Employee + Child(ren)	12	$1,545.19	$264.54	17.1%	$1,280.65	82.9%	$15.68
Employee + Family	17	$2 439.78	$528.67	21.7%	$1 911.11	78.3%	$30.49
MONTHLY TOTAL	88	$124,104	$21,674		$102,429		
Actives		**Kaiser HMO**					
Employee	259	$576.45	$37.43	6 5%	$539.02	93.5%	$2.45
Employee + Spouse	75	$1,152.90	$94.47	8 2%	$1,058.43	91.8%	$6.18
Employee + Child(ren)	144	$1,095.26	$85.34	8 2%	$1,009.92	92.2%	$5 59
Employee + Family	211	$1 844.65	$136.76	7.4%	$1 707.89	92.6%	$8 95
MONTHLY TOTAL	689	$782,707	$57,925		$724,782		
Early Retirees		**Kaiser HMO**					
Employee	3	$863.27	$37.43	4 3%	$825.84	95.7%	$2.45
Employee + Spouse	1	$1,726.54	$94.47	5 5%	$1,632.07	94.5%	$6.18
Employee + Child(ren)	0	$1,640.22	$85.34	5 2%	$1,554.88	94.8%	$5 59
Employee + Family	2	$2 762.48	$136.76	5 0%	$2 625.72	95.0%	$8 95
MONTHLY TOTAL	6	$9,841	$480		$9,361		

Employee Contribution Option

CalOptima shares the increase with employees; employee contributions are same percentage as current (except for Kaiser, which is the same dollar amount as Cigna HMO) for medical plans only. This is the current employee contribution strategy.

Medical for Part-Time Actives and Medicare Retirees

PART TIME ACTIVES	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna HMO						
Employee	0	$659.47	$69.97	10.6%	$589.50	89.4%
Employee + One	0	$1,443 08	$176 57	12.2%	$1,266 51	87 8%
Employee + Child(ren)	0	$1,303.43	$159 50	12.2%	$1,143 93	87 8%
Employee + Family	0	$2 061 55	$255 63	12.4%	$1 805 92	87 6%
MONTHLY TOTAL	0	$0	$0		$0	
Cigna PPO						
Employee	0	$1,057 81	$374 04	35.4%	$683.77	64 6%
Employee + One	0	$2,291 60	$890 62	38.9%	$1,400 98	61.1%
Employee + Child(ren)	0	$2,072.70	$805 52	38.9%	$1,267.18	61.1%
Employee + Family	0	$3 278 24	$1 335 93	40.8%	$1 942 31	59 2%
MONTHLY TOTAL	0	$0	$0		$0	
Cigna HDHP						
Employee	0	$801.37	$204 25	25.5%	$597.12	74 5%
Employee + One	0	$1,609 35	$551 03	34.2%	$1,058 32	65 8%
Employee + Child(ren)	0	$1,453 61	$497.72	34.2%	$955.89	65 8%
Employee + Family	0	$2 299 07	$996 37	43.3%	$1 302.70	56.7%
MONTHLY TOTAL	0	$0	$0		$0	
Kaiser HMO						
Employee	1	$518.54	$69.97	13.5%	$448.57	86 5%
Employee + One	0	$1,037 08	$176 57	17.0%	$860.51	83 0%
Employee + Child(ren)	1	$985.23	$159 50	16.2%	$825.73	83 8%
Employee + Family	0	$1 659 33	$255 63	15.4%	$1 403.70	84 6%
MONTHLY TOTAL	2	$1,504	$229		$1,274	
MEDICARE RETIREES	**Enrollment**	**2019 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
Amwins PPO						
Retiree (Medicare)	14	$400.83	$70.98	17.7%	$329.85	82 3%
Retiree + 1 (2 Medicare)	16	$801.66	$160 95	20.1%	$640.71	79 9%
MONTHLY TOTAL	30	$18,438	$3,569		$14,869	
Kaiser HMO						
Subscriber with Medicare	8	$216.72	$12.85	5 9%	$203.87	94.1%
Subscriber with Medicare + Spouse with Medicare	9	$433.44	$32.42	7 5%	$401.02	92 5%
Subscriber with Medicare + Spouse without Medicare	2	$993.50	$82.35	8 3%	$911.15	91.7%
Subscriber with Medicare and Children	1	$915.83	$135 88	14.8%	$779.95	85 2%
MONTHLY TOTAL	20	$8 538	$695		$7 842	

PART TIME ACTIVES	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Cigna HMO							
Employee	0	$705.66	$74 87	10 6%	$630.79	89.4%	$4.90
Employee + Spouse	0	$1,544.15	$188.94	12 2%	$1,355 21	87.8%	$12.37
Employee + Child(ren)	0	$1,394.72	$170.67	12 2%	$1,224 05	87.8%	$11.17
Employee + Family	0	$2 205 93	$273.53	12.4%	$1 932.40	87.6%	$17.90
MONTHLY TOTAL	0	$0	$0		$0		
Cigna PPO							
Employee	0	$1,131 90	$400.24	35.4%	$731.66	64.6%	$26.20
Employee + Spouse	0	$2,452.10	$953.00	38 9%	$1,499.10	61.1%	$62.38
Employee + Child(ren)	0	$2,217 87	$861.94	38 9%	$1,355 93	61.1%	$56.42
Employee + Family	0	$3 507 84	$1 429.50	40 8%	$2 078 34	59.2%	$93.57
MONTHLY TOTAL	0	$0	$0		$0		
Cigna HDHP							
Employee	0	$813.26	$207.28	25 5%	$605.98	74.5%	$3.03
Employee + Spouse	0	$1,707 85	$584.76	34 2%	$1,123 09	65.8%	$33.73
Employee + Child(ren)	0	$1,545.19	$529.08	34 2%	$1,016.11	65.8%	$31.36
Employee + Family	0	$2 439.78	$1 057.35	43 3%	$1 382.43	56.7%	$60.98
MONTHLY TOTAL	0	$0	$0		$0		
Kaiser HMO							
Employee	1	$576.45	$74 87	13 0%	$501.58	87.0%	$4.90
Employee + Spouse	0	$1,152 90	$188.94	16.4%	$963.96	83.6%	$12.37
Employee + Child(ren)	1	$1,095 26	$170.67	15 6%	$924.59	84.4%	$11.17
Employee + Family	0	$1 844 65	$273.53	14 8%	$1 571.12	85.2%	$17.90
MONTHLY TOTAL	2	$1,672	$246		$1,426		$16.07
MEDICARE RETIREES	**Enrollment**	**2020 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**	**EE Contributions Monthly Increase from Current**
Amwins PPO							
Retiree (Medicare)	14	$445.02	$78 81	17.7%	$366.21	82.3%	$7.83
Retiree + 1 (2 Medicare)	16	$890.04	$178.69	20.1%	$711.35	79.9%	$17.74
MONTHLY TOTAL	30	$20,471	$3,962		$16,509		
Kaiser HMO							
Subscriber with Medicare	8	$220.92	$14 34	6.5%	$206.58	93.5%	$1.49
Subscriber with Medicare + Spouse with Medicare	9	$441.84	$36 21	8.2%	$405.63	91.8%	$3.79
Subscriber with Medicare + Spouse without Medicare	2	$1,098.43	$90 01	8.2%	$1,008.42	91.8%	$7.66
Subscriber with Medicare and Children	1	$1 010 68	$74 93	7.4%	$935.75	92.6%	
MONTHLY TOTAL	20	$8 951	$696		$8 256		

Back to Agenda

Relation™

Employee Contribution Option

No change to dental or vision contributions

Dental and Vision for All

2019 Employer vs. Employee Contributions

FULL TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees		**Dental PPO**				
Employee	348	$48.26	$5 20	10.8%	$43.06	89.2%
Employee + One	168	$95.88	$15.72	16.4%	$80.16	83.6%
Employee + Child(ren)	158	$123.18	$20.20	16.4%	$102.98	83.6%
Employee + Family	328	$186.34	$31.54	16.9%	$154.80	83.1%
MONTHLY TOTAL	1,002	$113,484	$17,987		$95,497	
Actives & Retirees		**Dental HMO**				
Employee	108	$12.76	$0 00	0.0%	$12.76	100.0%
Employee + One	36	$25.34	$0 00	0.0%	$25.34	100.0%
Employee + Child(ren)	55	$32.56	$0 00	0.0%	$32.56	100.0%
Employee + Family	110	$49.25	$0 00	0.0%	$49.25	100.0%
MONTHLY TOTAL	309	$9,499	$0		$9,499	
Actives & Retirees		**VSP Vision**				
Employee	498	$7 37	$0 00	0.0%	$7.37	100.0%
Employee + One	189	$11.45	$1 00	8.7%	$10.45	91.3%
Employee + Child(ren)	197	$11.93	$1 50	12.6%	$10.43	87.4%
Employee + Family	429	$19.06	$2 00	10.5%	$17.06	89.5%
MONTHLY TOTAL	1 313	$16 361	$1 343		$15 019	

PART TIME DENTAL & VISION	Enrollment	2019 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives		**Dental PPO**				
Employee	0	$48.26	$10.40	21.5%	$37.86	78.5%
Employee + One	1	$95.88	$31.44	32.8%	$64.44	67.2%
Employee + Child(ren)	0	$123.18	$40.40	32.8%	$82.78	67.2%
Employee + Family	0	$186.34	$63.08	33.9%	$123.26	66.1%
MONTHLY TOTAL	1	$96	$31		$64	
Actives		**Dental HMO**				
Employee	0	$12.76	$0 00	0.0%	$12.76	100.0%
Employee + One	0	$25.34	$0 00	0.0%	$25.34	100.0%
Employee + Child(ren)	0	$32.56	$0 00	0.0%	$32.56	100.0%
Employee + Family	1	$49 25	$0 00	0.0%	$49 25	100.0%
MONTHLY TOTAL	1	$49	$0		$49	
Actives		**VSP Vision**				
Employee	1	$7 37	$0 00	0.0%	$7.37	100.0%
Employee + One	1	$11.45	$2 00	17.5%	$9.45	82.5%
Employee + Child(ren)	0	$11.93	$3 00	25.1%	$8.93	74.9%
Employee + Family	1	$19.06	$4 00	21.0%	$15.06	79.0%
MONTHLY TOTAL	3	$38	$6		$32	

2020 Employer vs. Employee Contributions

FULL TIME DENTAL & VISION	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Actives & Retirees		**Dental PPO**					
Employee	348	$49.47	$5 20	10.5%	$44.27	89 5%	$0.00
Employee + Spouse	168	$98.28	$15.72	16.0%	$82.56	84 0%	$0.00
Employee + Child(ren)	158	$126.26	$20.20	16.0%	$106.06	84 0%	$0.00
Employee + Family	328	$191.00	$31.54	16.5%	$159.46	83 5%	$0.00
MONTHLY TOTAL	1002	$116,324	$17,987		$98,336		
Actives & Retirees		**Dental HMO**					
Employee	108	$13.08	$0 00	0.0%	$13.08	100.0%	$0.00
Employee + Spouse	36	$25.98	$0 00	0.0%	$25.98	100.0%	$0.00
Employee + Child(ren)	55	$33.38	$0 00	0.0%	$33.38	100.0%	$0.00
Employee + Family	110	$50.49	$0 00	0.0%	$50.49	100.0%	$0.00
MONTHLY TOTAL	309	$9,738	$0		$9,738		
Actives & Retirees		**VSP Vision**					
Employee	498	$8.14	$0 00	0.0%	$8.14	100.0%	$0.00
Employee + Spouse	189	$12.65	$1 00	8.7%	$11.65	92.1%	$0.00
Employee + Child(ren)	197	$13.17	$1 50	12.6%	$11.67	88 6%	$0.00
Employee + Family	429	$21.08	$2 00	10.5%	$19.08	90 5%	$0.00
MONTHLY TOTAL	1 313	$18 082	$1 343		$16 740		$0.00

PART TIME DENTAL & VISION	Enrollment	2020 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium	EE Contributions Monthly Increase from Current
Actives		**Dental PPO**					
Employee	0	$49.47	$10.40	21.0%	$39.07	79 0%	$0.00
Employee + Spouse	1	$98.28	$31.44	32.0%	$66.84	68 0%	$0.00
Employee + Child(ren)	0	$126.26	$40.40	32.0%	$85.86	68 0%	$0.00
Employee + Family	0	$191.00	$63.08	33.0%	$127.92	67 0%	$0.00
MONTHLY TOTAL	1	$98	$31		$67		$0.00
Actives		**Dental HMO**					
Employee	0	$13.08	$0 00	0.0%	$13.08	100.0%	
Employee + Spouse	0	$25.98	$0 00	0.0%	$25.98	100.0%	$0.00
Employee + Child(ren)	0	$33.38	$0 00	0.0%	$33.38	100.0%	$0.00
Employee + Family	1	$50 49	$0 00	0.0%	$50 49	100.0%	$0.00
MONTHLY TOTAL	1	$50	$0		$50		
Actives		**VSP Vision**					
Employee	1	$8.14	$0 00	0.0%	$8.14	100.0%	$0.00
Employee + Spouse	1	$12.65	$2 00	17.5%	$10.65	84 2%	$0.00
Employee + Child(ren)	0	$13.17	$3 00	25.1%	$10.17	77 2%	$0.00
Employee + Family	1	$21.08	$4 00	21.0%	$17.08	81 0%	$0.00
MONTHLY TOTAL	3	$42	$6		$36		

Relation

Renewal & Open Enrollment Timeline

- October
  - October 4th – All decisions for 2020 must be made in order to provide rates, contributions & benefits to Dayforce for system update for Open Enrollment
  - October 4th – October 25th
    - Communications developed & distributed
    - Dayforce system updated, tested, and ready for Open Enrollment
    - Required notices/documentation prepared & distributed
    - Carriers notified of 2020 decisions
  - October 28th – November 8th – Open Enrollment

- November/December
  - Carriers update systems with new elections, produce & distribute new ID cards as necessary

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Approval of Reappointments to the Board of Directors' Investment Advisory Committee

Contact

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

Recommended Action

Reappoint the following individuals to the CalOptima Board of Directors' Investment Advisory Committee (IAC) for two-year terms beginning November 1, 2019:

1. Caroline Harkins; and
2. Peggy Eckroth.

Background

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

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

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

Discussion

The candidates recommended for reappointment, Caroline Harkins and Peggy Eckroth, have consistently provided leadership and service to CalOptima's investment strategies through their participation as IAC members.

Caroline Harkins

Caroline Harkins has served as a member of the IAC since June 1998. Ms. Harkins has over 30 years of commercial banking experience in Orange County. She is currently Regional President at Bridge Bank, a division of Western Alliance Bank, where she is responsible for the business lending activities of the technology, capital finance and corporate banking groups. Prior to joining Bridge Bank, Caroline held leadership roles at Irwin Union Bank, Comerica Bank, Imperial Bank and Bank of the West.

Back to Agenda

Ms. Harkins also serves on the Board of Directors of a non-public REIT. In the local community, she is a member of the Board of Directors for the Orange County Association for Corporate Growth, and volunteers to teach financial literacy in classrooms. She is also on the executive Board of Directors for Junior Achievement - Orange County. Her current term on the IAC expires on October 31, 2019.

Peggy Eckroth

Peggy Eckroth has served as a member of the IAC since November 1999. Ms. Eckroth retired in 2008 from Autumn Capital Investment Services, a California corporation and Women-Owned Business Enterprise (WBE), as the Executive Vice President and partner. Autumn Capital, an investment consulting firm specialized in the structure and placement of municipal bond proceeds. She has over twenty-five (25) years of financial services experience in marketing, investment services, banking services, real estate and commercial lending, finance and equipment leasing through employment with financial institutions, including First Interstate Bank, Wells Fargo Bank, Litton Industries and AVCO Financial Services.

During her career, she was appointed by the State Treasurer to serve on the State of California Local Agency Investment Advisory Board, served as an Advisory Board Member of the California Association of County Treasurers & Tax Collectors, and was a Founding Member of the Women's Network for National Government Finance Officers Association. Her current term expires on October 31, 2019.

Fiscal Impact

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

Rationale for Recommendation

The individuals recommended for CalOptima's IAC have extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidates have already provided outstanding service as members of the IAC.

Concurrence

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

Attachment

None

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
9. Consider Revising the Membership of the CalOptima Board of Directors' Quality Assurance Committee

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

Recommended Actions
Reduce the size of the CalOptima Board of Directors' Quality Assurance Committee from four to three seats.

Background/Discussion
On March 12, 1996, the Board of Directors established the Quality Assurance Committee consisting of three Board members appointed by the CalOptima Board Chair.

The Board of Directors' Quality Assurance Committee (QAC) membership is charged with oversight responsibilities related to the overall quality of CalOptima's healthcare programs. Since the QAC's establishment, its size has ranged from three to five members depending on the composition and size of the Board, and on the availability of Board members to serve on this important advisory committee. While the QAC currently has four seats, it is recommended that this number be reduced to three to better ensure that minimum quorum requirements are met at scheduled meetings.

Fiscal Impact
None

Rationale for Recommendation
The recommended action should help to ensure that the Quality Assurance Committee is able to meet on a regular basis and make recommendations to the full CalOptima Board of Directors on quality-related issues.

Concurrence
Gary Crockett, Chief Counsel

Attachments
August 4, 2016 Consider Revising Membership of the CalOptima Board of Directors' Finance and Audit Committee and the Board of Directors' Quality Assurance Committee

/s/ Michael Schrader — *9/25/2019*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee and the Board of Directors' Quality Assurance Committee

Contact

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

Recommended Actions

Reduce the size of the CalOptima Board of Directors':

1. Finance and Audit Committee from four to three seats; and
2. Quality Assurance Committee from five to four seats.

Background/Discussion

On March 12, 1996, the Board of Directors established the Finance and Quality Assurance Committees consisting of three Board members appointed by the CalOptima Board Chair. The Finance Committee was charged with oversight responsibilities for all financial matters affecting CalOptima. In November 2009, the Board changed the Finance Committee title to the Board of Directors' Finance and Audit Committee (FAC) and expanded the scope of responsibilities to include audit oversight. In April 2010, the Board expanded the size of the FAC to four Board members.

The Board of Directors' Quality Assurance Committee (QAC) membership is charged with oversight responsibilities related to the overall quality of CalOptima's healthcare programs. In June 2012, the Board expanded the membership of the Committee to four (4) members due to increasing regulatory quality requirements that require review by this Committee. In light of CalOptima's growth and business requirements, the Board approved the expansion of this Committee to five (5) members.

These changes were implemented as a result of changes to the composition/size of the CalOptima Board of Directors. Based on the reduction in the size of the CalOptima Board from 11 to nine voting members effective August 4, 2016, it is recommended that the size of the FAC be reduced to three seats, and the QAC to four seats, with each committee comprised of members of the Board of Directors.

Fiscal Impact

None

Rationale for Recommendation

The recommended action will bring the Finance and Audit Committee and Quality Assurance Committee into alignment with the current Board membership.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader *07/29/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Accepting and Receiving and Filing the Fiscal Year 2019 CalOptima Audited Financial Statements

Contact

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

Recommended Action

Recommend accepting and receiving and filing the Fiscal Year (FY) 2019 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP

Background

CalOptima has contracted with financial auditors Moss-Adams, LLP since May 21, 2015, to complete CalOptima's annual financial audit. At the May 16, 2019, meeting of the CalOptima Finance and Audit Committee, Moss-Adams presented the 2019 Audit Plan. The plan includes performing the mandatory annual consolidated financial statement audit and drafting the consolidated financial statements for the year ending June 30, 2019.

Discussion

Moss-Adams conducted the interim audit from May 20, 2019, through May 24, 2019, and the year-end on-site audit from July 22, 2019, through August 9, 2019. The significant audit areas that Moss-Adams reviewed included:

- Capitation revenue and receivables;
- Medical claims liability and claims expense;
- Obligations payable to State of California or the California Department of Health Care Services; and
- Pension and other post-employment benefits (OPEB) liabilities.

Results from CalOptima's FY 2019 Audit were positive. The auditor made no changes in CalOptima's approach to applying critical accounting policies, nor did they report having encountered any significant difficulties during the audit. Additionally, there were no material misstatements identified by the auditor. As such, Management recommends that the Board accept the CalOptima FY 2019 audited financial statements, as presented.

Fiscal Impact

There is no fiscal impact related to this recommended action.

Concurrence

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

Back to Agenda

Attachments
FY 2019 CalOptima Audited Financial Statements
Presentation by Moss-Adams, LLP

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

REPORT OF INDEPENDENT AUDITORS AND
CONSOLIDATED FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA

June 30, 2019 and 2018

DRAFT

Back to Agenda

Table of Contents

DRAFT

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Management's Discussion and Analysis

The intent of management's discussion and analysis of CalOptima's consolidated financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2019, 2018, and 2017. Readers should review this summation in conjunction with CalOptima's consolidated financial statements and accompanying notes to the consolidated financial statements to enhance their understanding of CalOptima's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima for the fiscal years ended June 30, 2019, 2018, and 2017:

Key Operating Indicators	2019	2018	2017 (as restated)
Members (at end of fiscal period):			
Medi-Cal program	743,936	763,824	772,228
OneCare	1,537	1,418	1,121
OneCare Connect	14,123	14,768	15,505
PACE	327	267	212
Average member months			
Medi-Cal program	751,409	772,511	777,057
OneCare	1,448	1,372	1,237
OneCare Connect	14,398	15,079	16,834
PACE	303	239	190
Operating revenues (in millions)	$ 3,475	$ 3,446	$ 3,549
Operating expenses (in millions)			
Medical expenses	3,217	3,292	3,400
Administrative expenses	131	132	111
Operating income (in millions)	$ 127	$ 22	$ 38
Operating revenues PMPM (per member per month)	$ 377	$ 364	$ 372
Operating expenses PMPM			
Medical expenses PMPM	349	348	356
Administative expenses PMPM	14	14	12
Operating income PMPM	$ 14	$ 2	$ 4
Medical loss ratio	93%	96%	96%
Administrative expenses ratio	4%	4%	3%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 137	$ 143	$ 138
Administrative expenses (in millions)	137	143	138

DRAFT

Overview of the Consolidated Financial Statements

This annual report consists of consolidated financial statements and notes to those statements, which reflect CalOptima's financial position as of June 30, 2019, 2018, and 2017, and results of its operations for the fiscal years ended June 30, 2019, 2018, and 2017. The consolidated financial statements of CalOptima, including the consolidated statements of net position, statements of revenues, expenses and changes in net position, and statements of cash flows, represent the consolidated accounts and transactions of the five (5) programs – Medi-Cal, OneCare, OneCare Connect, Program of All-inclusive Care for the Elderly (PACE), and CalOptima Foundation.

- The consolidated statements of net position include all of CalOptima's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of Board of Directors' policy.

- The consolidated statements of revenues, expenses, and changes in net position present the results of operating activities during the fiscal year and the resulting increase or decrease in net position.

- The consolidated statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing and capital and related financing activities.

The following discussion and analysis addresses CalOptima's overall program activities. CalOptima's Medi-Cal program accounted for 90.2 percent, 89.8 percent, and 88.6 percent of its annual revenues during fiscal years 2019, 2018, and 2017, respectively. CalOptima's OneCare program accounted for 0.6 percent, 0.5 percent, and 0.5 percent of its annual revenues during fiscal years 2019, 2018, and 2017, respectively. CalOptima's OneCare Connect program accounted for 8.4 percent, 9.1 percent, and 10.5 percent of its annual revenues during fiscal years 2019, 2018, and 2017, respectively. All other programs consolidated accounted for 0.8 percent, 0.6 percent, and 0.4 percent of CalOptima's annual revenues during fiscal years 2019, 2018, and 2017, respectively.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 dedicated to the betterment of public health care services in Orange County. The Foundation Board of Directors approved the dissolution of the Foundation in May 2019, and all assets of the Foundation were transferred back to CalOptima. CalOptima had sole control over the activities of the Foundation and as such, the activities of the Foundation are included in the consolidated financial statements of CalOptima.

DRAFT

2019 and 2018 Financial Highlights

As of June 30, 2019 and 2018, total assets and deferred outflows of resources were approximately $1,957.2 and $1,879.1 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $935.5 and $764.5 million, respectively.

Net position increased by approximately $171.1 million, or 22.4 percent, during fiscal year 2019 including the transfer of Foundation assets of approximately $2.9 million, and increased by approximately $45.8 million, or 6.4 percent, during fiscal year 2018.

Table 1a: Condensed Consolidated Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2019	2018	Change From 2018 Amount	Change From 2018 Percentage
ASSETS				
Current assets	$ 1,279,064	$ 1,278,680	$ 384	0.0%
Board-designated assets and restricted cash	620,445	538,548	81,897	15.2%
Capital assets, net	46,625	50,758	(4,133)	-8.1%
Total assets	1,946,134	1,867,986	78,148	4.2%
DEFERRED OUTFLOWS OF RESOURCES	11,090	11,133	(43)	-0.4%
Total assets and deferred outflows of resources	$ 1,957,224	$ 1,879,119	$ 78,105	4.2%
LIABILITIES				
Current liabilities	$ 965,968	$ 1,061,545	$ (95,577)	-9.0%
Other liabilities	48,307	49,766	(1,459)	-2.9%
Total liabilities	1,014,275	1,111,311	(97,036)	-8.7%
DEFERRED INFLOWS OF RESOURCES	7,407	3,329	4,078	122.5%
NET POSITION				
Net investment in capital assets	46,580	50,637	(4,057)	-8.0%
Restricted by legislative authority	84,930	89,037	(4,107)	-4.6%
Unrestricted	804,032	624,805	179,227	28.7%
Total net position	935,542	764,479	171,063	22.4%
Total liabilities, deferred inflows of resources and net position	$ 1,957,224	$ 1,879,119	$ 78,105	4.2%

Current assets increased $0.4 million from $1,278.7 million in 2018 to $1,279.1 million in 2019. Current liabilities decreased $95.6 million from $1,061.5 million in 2018 to $966.0 million in 2019. The decrease is mostly due to a remittance back to the California Department of Health Care Services (DHCS) for the Medi-Cal expansion Medical Loss Ratio (MLR) reconciliation for fiscal year 2014 through 2016 and recognition of previously unearned revenue.

DRAFT

2019 and 2018 Financial Highlights (continued)

Board-designated assets and restricted cash increased by $81.9 million and $3.1 million in fiscal years 2019 and 2018, respectively. In fiscal year 2019, in addition to the existing Board-designated reserve, the Board of Directors designated a $60 million funding initiative for homeless health.

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2019, is at 1.98 times of monthly average premium revenue.

CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2018 and 2017 Financial Highlights

As of June 30, 2018 and 2017, total assets and deferred outflows of resources were approximately $1,879.1 million and $2,743.0 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $764.5 million and $718.6 million, respectively.

Net position increased by approximately $45.8 million, or 6.4 percent, during fiscal year 2018 and increased by approximately $56.2 million, or 8.5 percent, during fiscal year 2017.

DRAFT

2018 and 2017 Financial Highlights (continued)

Table 1b: Condensed Consolidated Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2018	2017 (as restated)	Change From 2017 Amount	Change From 2017 Percentage
ASSETS				
Current assets	$ 1,278,680	$ 2,141,667	$ (862,987)	-40.3%
Board-designated assets and restricted cash	538,548	535,438	3,110	0.6%
Capital assets, net	50,758	54,301	(3,543)	-6.5%
Total assets	1,867,986	2,731,406	(863,420)	-31.6%
DEFERRED OUTFLOWS OF RESOURCES	11,133	11,577	(444)	-3.8%
Total assets and deferred outflows of resources	$ 1,879,119	$ 2,742,983	$ (863,864)	-31.5%
LIABILITIES				
Current liabilities	$ 1,061,545	$ 1,981,195	$ (919,650)	-46.4%
Other liabilities	49,766	41,809	7,957	19.0%
Total liabilities	1,111,311	2,023,004	(911,693)	-45.1%
DEFERRED INFLOWS OF RESOURCES	3,329	1,340	1,989	148.4%
NET POSITION				
Net investment in capital assets	50,637	54,104	(3,467)	-6.4%
Restricted by legislative authority	89,037	98,445	(9,408)	-9.6%
Unrestricted	624,805	566,090	58,715	10.4%
Total net position	764,479	718,639	45,840	6.4%
Total liabilities, deferred inflows of resources and net position	$ 1,879,119	$ 2,742,983	$ (863,864)	-31.5%

Current assets decreased $863.0 million from $2,141.7 million in 2017 to $1,278.7 million in 2018, primarily in cash, short-term investments and premium receivables categories. Current liabilities decreased $919.7 million from $1,981.2 million in 2017 to $1,061.5 million in 2018. The decrease is mainly related to recoupment from DHCS on Medi-Cal expansion rate changes and shared risk pool payouts to the health networks.

Board-designated assets and restricted cash increased by $3.1 million and $59.3 million in fiscal years 2018 and 2017, respectively. The Board of Directors' policy is to augment Board-designated assets to provide a desired level of funds between 1.4 months and 2 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2018, is at 1.9 times of monthly average premium revenue. CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

DRAFT

2019 and 2018 Results of Operations

CalOptima's fiscal year 2019 operations and nonoperating revenues resulted in a $171.1 million increase in net position, $125.2 million more compared to a $45.8 million decrease in fiscal year 2018. The following table reflects the changes in revenues and expenses for 2019 compared to 2018:

Table 2a: Consolidated Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2019	2018	Change From 2018 Amount	Change From 2018 Percentage
PREMIUM REVENUES	$ 3,474,634	$ 3,445,699	$ 28,935	0.8%
Total operating revenues	3,474,634	3,445,699	28,935	0.8%
MEDICAL EXPENSES	3,216,673	3,291,712	(75,039)	-2.3%
ADMINISTRATIVE EXPENSES	130,574	131,847	(1,273)	-1.0%
Total operating expenses	3,347,247	3,423,559	(76,312)	-2.2%
OPERATING INCOME	127,387	22,140	105,247	475.4%
NONOPERATING REVENUES AND EXPENSES	43,676	23,700	19,976	84.3%
Increase in net position	171,063	45,840	125,223	273.2%
NET POSITION, beginning of year	764,480	718,640	45,840	6.4%
NET POSITION, end of year	$ 935,543	$ 764,480	$ 171,063	22.4%

2019 and 2018 Operating Revenues

The increase in consolidated operating revenues of $28.9 million in fiscal year 2019 is attributable to an overall capitation rate increase, Intergovernmental Transfers (IGT), expansion of Proposition 56, recognition of net increase to Coordinated Care Initiative (CCI) revenue after an update made to enrollment logic (offset by decreased blended paid rate from DHCS). Overall lower enrollment in fiscal year 2019 compared to fiscal 2018 offsets part of the revenue increase.

2019 and 2018 Medical Expenses

Overall medical expenses decreased by $75.0 million or 2.3 percent in fiscal year 2019, totaling $3,216.7 million, compared to $3,291.7 million in fiscal year 2018. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, decreased 2.9 percent from 95.5 to 92.6 percent in fiscal year 2018 to 2019.

DRAFT

2019 and 2018 Medical Expenses (continued)

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 2.4 percent from fiscal year 2018 to fiscal year 2019. Capitated member enrollment accounted for approximately 76.3 percent of CalOptima's enrollment, averaging 573,455 members during fiscal year 2019, and 76.4 percent of CalOptima's enrollment, averaging 590,204 members during fiscal year 2018. Included in the capitated environment are 192,011 or 33.5 percent and 198,508 or 33.6 percent members in a shared risk network for fiscal years 2019 and 2018, respectively. Shared Risk Networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal provider capitation expenses totaled $1,094.3 million in fiscal year 2019, compared to $1,068.4 million in fiscal year 2018. The increase reflects additional capitation expenses relating to Proposition 56 (the Research and Prevention Tobacco Tax Act of 2016), which authorizes additional supplemental payments to impacted physician services compared to 2018.

Medi-Cal claims expense to providers and facilities, including Long-term care (LTC) services decreased by 8.3 percent from fiscal year 2018 to fiscal year 2019. This decrease is attributable to lower enrollment and the discontinuation of In-Home Supportive Services (IHSS) services beginning January 2018.

Prescription drugs costs increased by 0.8 percent in fiscal year 2019, compared to fiscal year 2018. Results from fiscal year 2019 reflects an increase in prescription drug prices.

In addition to items mentioned above, total Quality Assurance Fee (QAF) payments received and passed through to hospitals decreased from $307.8 million to $297.4 million from fiscal year 2018 to fiscal year 2019. These receipts and payments are not included in the consolidated statements of revenues, expenses, and changes in net position.

2019 and 2018 Administrative Expenses

Total administrative expenses were $130.6 million in 2019 compared to $131.8 million in 2018. Overall administrative expenses decreased by 1.0 percent or $1.3 million, corresponding to lower salaries and benefits due to the effect of a non-recurring CalPERS discount rate reduction from 7.7 percent to 7.2 percent, with offsetting inflation increases in other expense categories. During fiscal years 2019 and 2018, respectively, CalOptima's administrative expenses remained at 3.8 percent of total operating revenues.

DRAFT

2018 and 2017 Results of Operations

CalOptima's fiscal year 2018 operations and nonoperating revenues resulted in a $45.8 million increase in net position, $10.3 million less compared to a $56.2 million increase in fiscal year 2017. The following table reflects the changes in revenues and expenses for 2018 compared to 2017:

Table 2b: Consolidated Revenues, Expenses and Changes in Net Position for Fiscal Years Ended June 30, (Dollars in Thousands)

Results of Operations	2018	2017 (as restated)	Change From 2017 Amount	Change From 2017 Percentage
CAPITATION REVENUES	$ 3,445,699	$ 3,549,462	$ (103,763)	-2.9%
OTHER INCOME	-	27	(27)	-100.0%
Total operating revenues	3,445,699	3,549,489	(103,790)	-2.9%
MEDICAL EXPENSES	3,291,712	3,399,612	(107,900)	-3.2%
ADMINISTRATIVE EXPENSES	131,847	111,428	20,419	18.3%
Total operating expenses	3,423,559	3,511,040	(87,481)	-2.5%
OPERATING INCOME	22,140	38,449	(16,309)	-42.4%
NONOPERATING REVENUES AND EXPENSES	23,700	17,724	5,976	33.7%
Increase in net position	45,840	56,173	(10,333)	-18.4%
NET POSITION, beginning of year	718,640	662,467	56,173	8.5%
NET POSITION, end of year	$ 764,480	$ 718,640	$ 45,840	6.4%

2018 and 2017 Operating Revenues

The decrease in consolidated operating revenues of $103.8 million in fiscal year 2018 is attributable to lower enrollment in fiscal year 2018 compared to fiscal year 2017, overall rate decreases in the Medi-Cal line of business for both Medi-Cal classic and Medi-Cal expansion members, and the discontinuation of In-Home Supportive Services (IHSS) beginning January 2018. Part of the revenue decrease is offset by the recognition of prior year unearned revenue from the Coordinated Care Initiative (CCI) program after reconciling the blended rates with DHCS.

2018 and 2017 Medical Expenses

Overall medical expenses decreased by $107.9 million or 3.2 percent in fiscal year 2018, totaling $3,292.7 million, compared to $3,399.6 million in fiscal year 2017. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 95.5 percent in fiscal year 2018 similar to the result in fiscal year 2017, which was 95.8 percent.

DRAFT

2018 and 2017 Medical Expenses (continued)

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 8.5 percent from fiscal year 2017 to fiscal year 2018 due to the transition of a shared risk group network to a health maintenance organization (HMO) model during the year. Capitated member enrollment accounted for approximately 76.4 percent of CalOptima's enrollment, averaging 590,204 members during fiscal year 2018 and 78.6 percent of CalOptima's enrollment, averaging 610,893 members during fiscal year 2017. Included in the capitated environment are 198,508 or 33.6 percent and 298,552 or 48.9 percent members in a shared risk network for fiscal years 2018 and 2017, respectively. Shared Risk Networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal provider capitation expenses totaled $1,068.4 million in fiscal year 2018, compared to $984.4 million in fiscal year 2017. The increase reflects the transition of one group to HMO, and additional capitation expenses relating to Proposition 56, which authorizes supplemental payments to impacted physician services.

Medi-Cal claims expense to providers and facilities, including Long-term care (LTC) services decreased by 10.1 percent from fiscal year 2017 to fiscal year 2018. This decrease is attributable to lower enrollment, the transition of one shared risk network to HMO as mentioned above, and the discontinuation of In-Home Supportive Services (IHSS) services beginning January 2018. The decrease is offset by additional IHSS expenses recorded based on an updated IHSS report from DHCS for service dates between fiscal year 2016 to fiscal year 2018.

Prescription drugs costs increased by 4.8 percent in fiscal year 2018, compared to fiscal year 2017. Results from fiscal year 2018 reflects an increase in prescription drug prices.

In addition to items mentioned above, total QAF payments received and passed through to hospitals increased from $307.8 million to $402.3 million from fiscal year 2017 to fiscal year 2018. These receipts and payments are not included in the consolidated statements of revenues, expenses, and changes in net position.

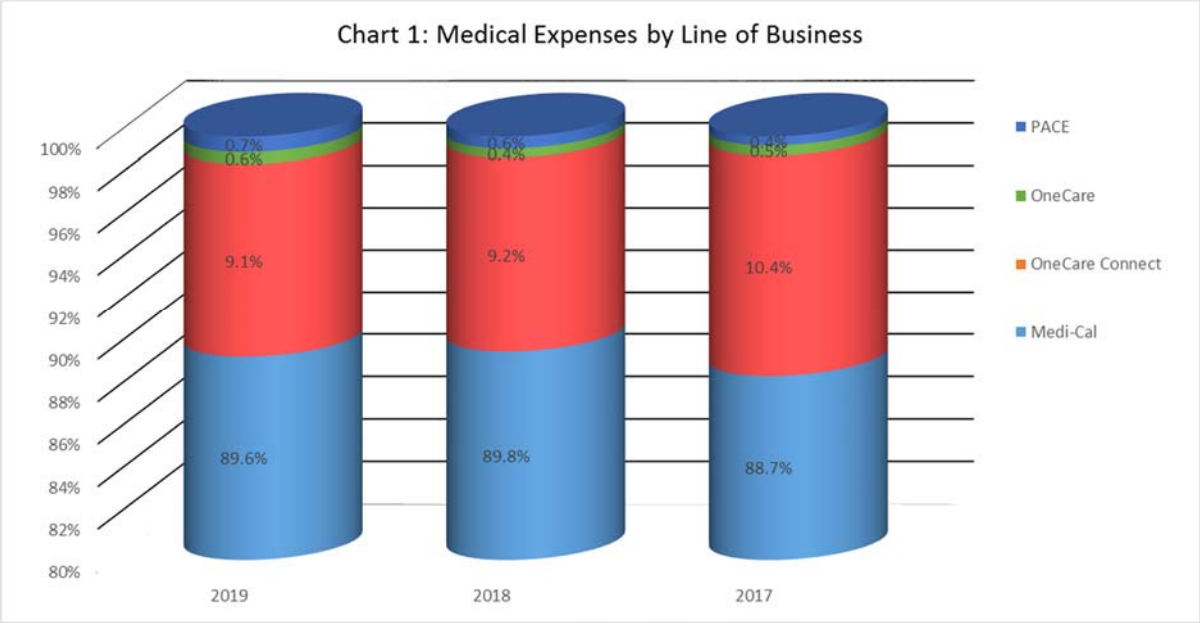
2018 and 2017 Administrative Expenses

Total administrative expenses were $131.8 million in 2018 compared to $111.4 million in 2017. Overall administrative expenses increased by 18.3 percent or $20.4 million, due to increases in salaries and benefits for behavioral health services brought in house, along with a CalPERS actuarial valuation increase of $10 million related to a discount rate reduction from 7.65% to 7.15%. The administrative expenses for both 2018 and 2017 reflected the implementation of Government Accounting Standards Board (GASB) Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other than Pensions* for CalOptima's other post-employment benefits for decreases of $2.1 million and $2.3 million, respectively. During fiscal years 2018 and 2017, respectively, CalOptima's administrative expenses were 3.8 percent and 3.1 percent of total operating revenues.

DRAFT

2019, 2018, and 2017 Medical Expenses by Line of Business

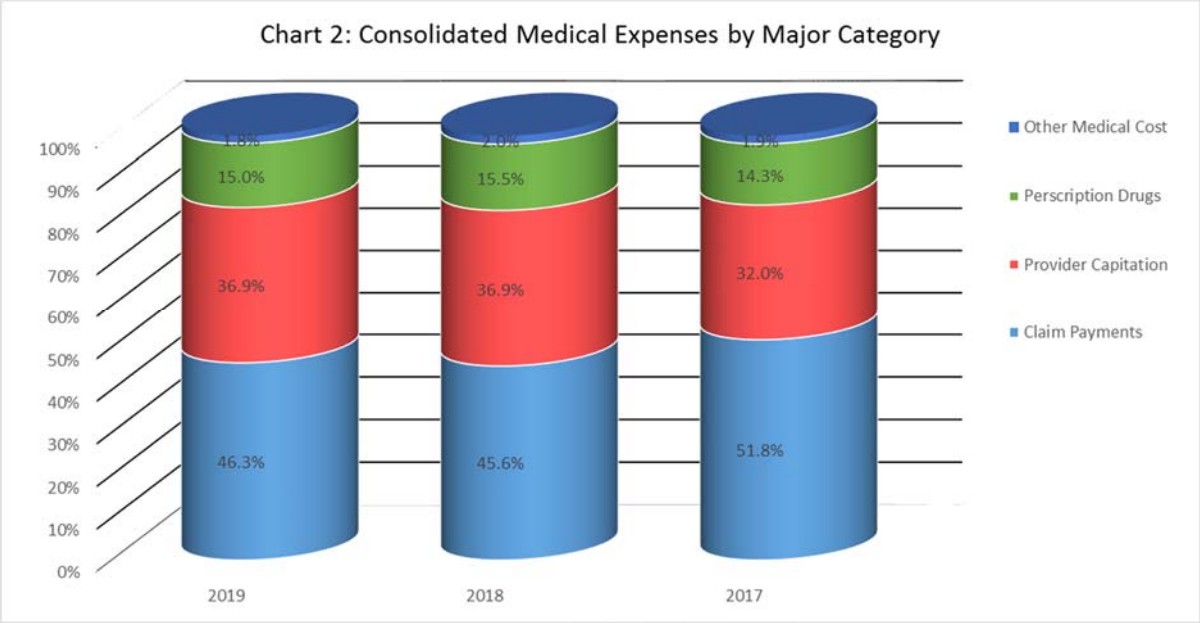
Below is a comparison chart of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year.



DRAFT

2019, 2018, and 2017 Consolidated Medical Expenses by Major Category

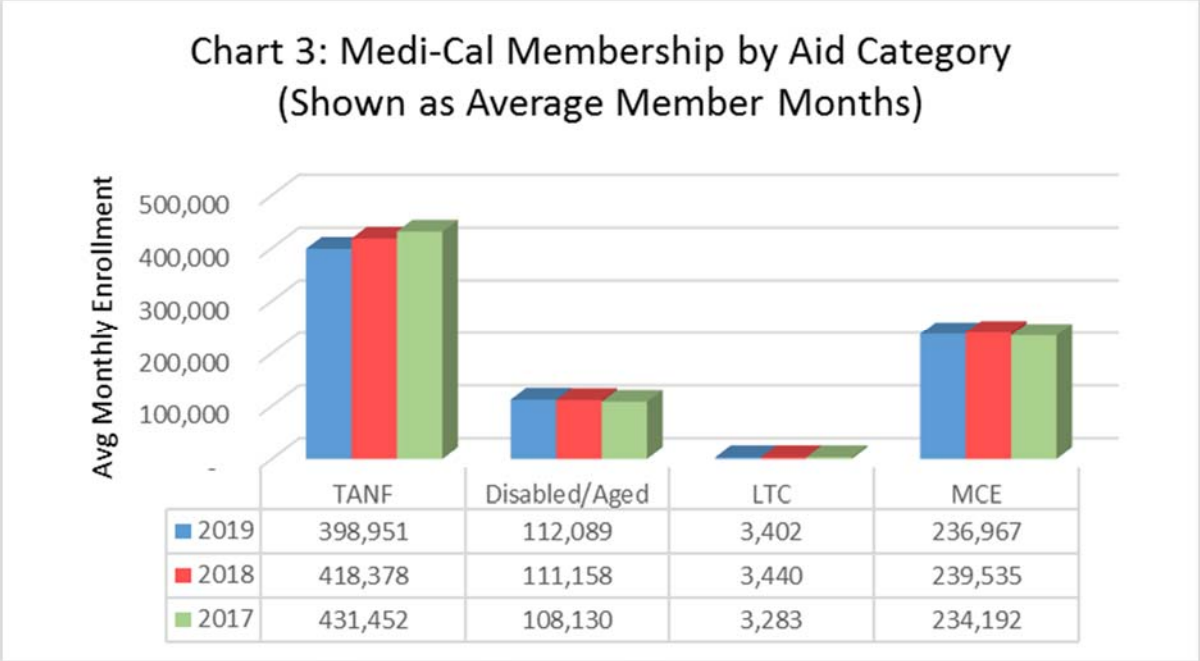
Below is a comparison chart of consolidated medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



DRAFT

2019, 2018, and 2017 Enrollment

During fiscal year 2019, CalOptima served an average of 751,409 Medi-Cal members per month compared to an average of 772,511 members per month in 2018 and 777,057 members per month in 2017. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2019, 2018, and 2017:



	TANF	Disabled/Aged	LTC	MCE
2019	398,951	112,089	3,402	236,967
2018	418,378	111,158	3,440	239,535
2017	431,452	108,130	3,283	234,192

Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children, and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from CalOptima, Health Net, and Kaiser Healthy Family programs.

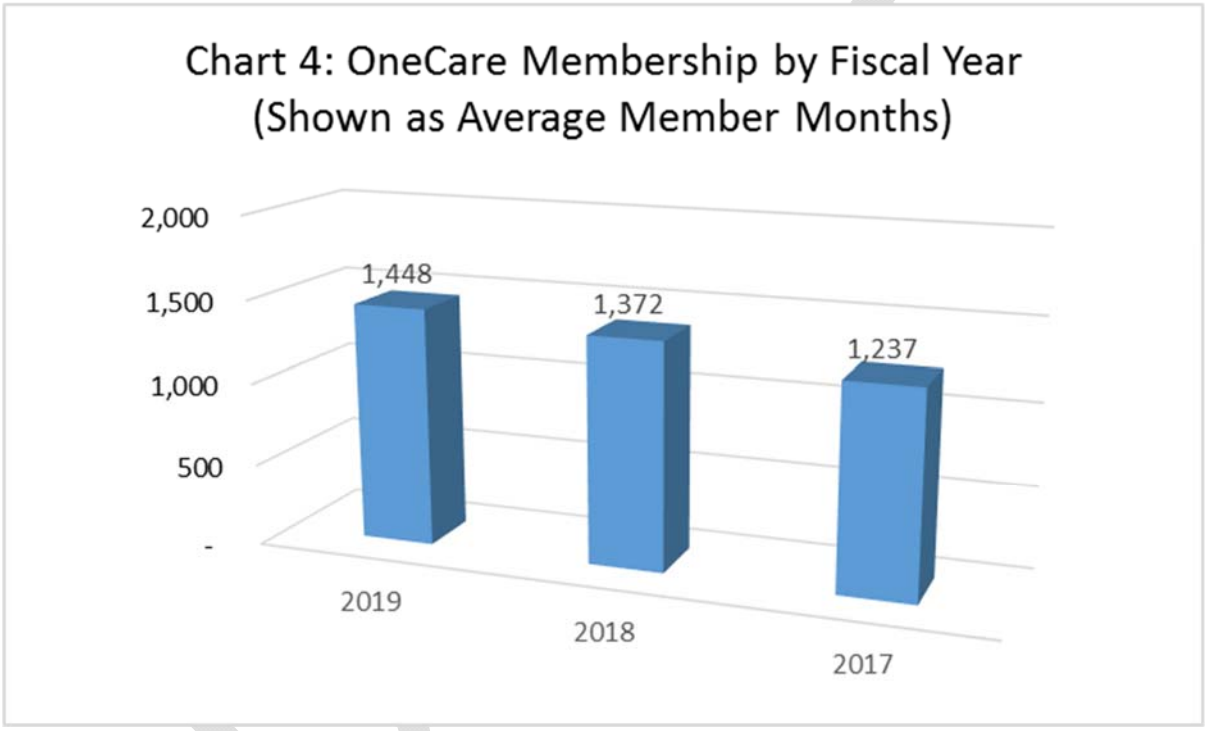
Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal poverty level.

LTC includes frail elderly, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions requiring long-term care services.

2019, 2018, and 2017 Enrollment (continued)

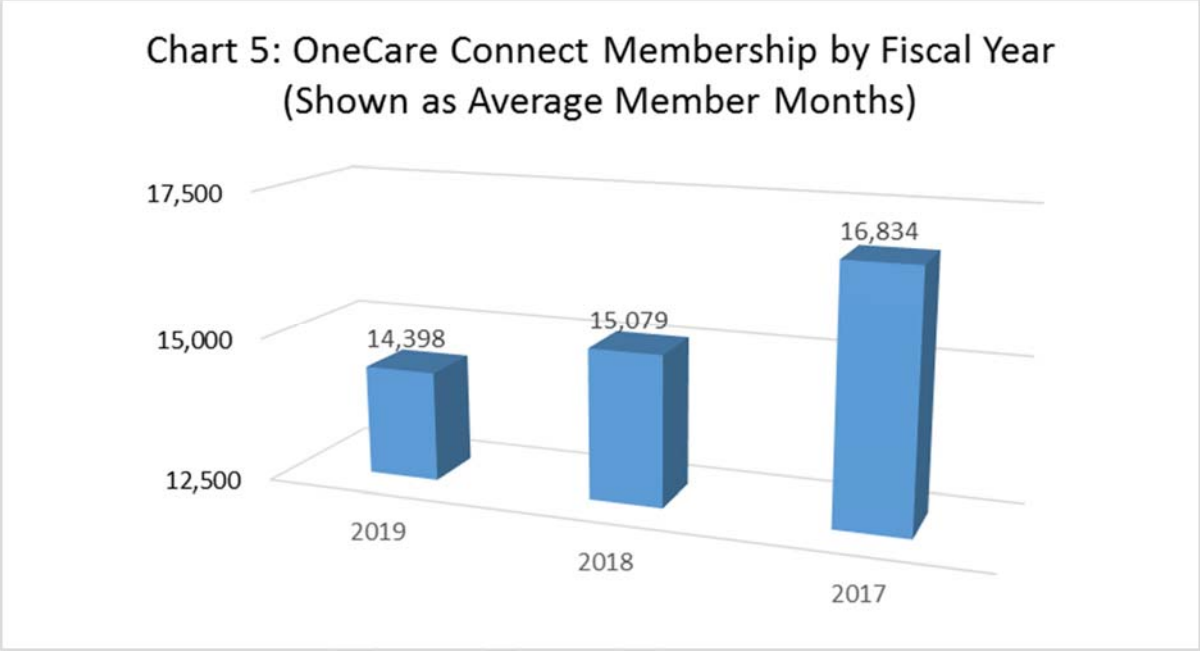
Medi-Cal Expansion (MCE) program includes adults without children, ages 19-64, qualified based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

OneCare was introduced in fiscal year 2006 to service the unique Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 1,448, 1,372, and 1,237 for the years ended June 30, 2019, 2018, and 2017, respectively. Members are eligible for both the Medicare and Medi-Cal programs. The chart below displays the average member months for the past three years.



2019, 2018, and 2017 Enrollment (continued)

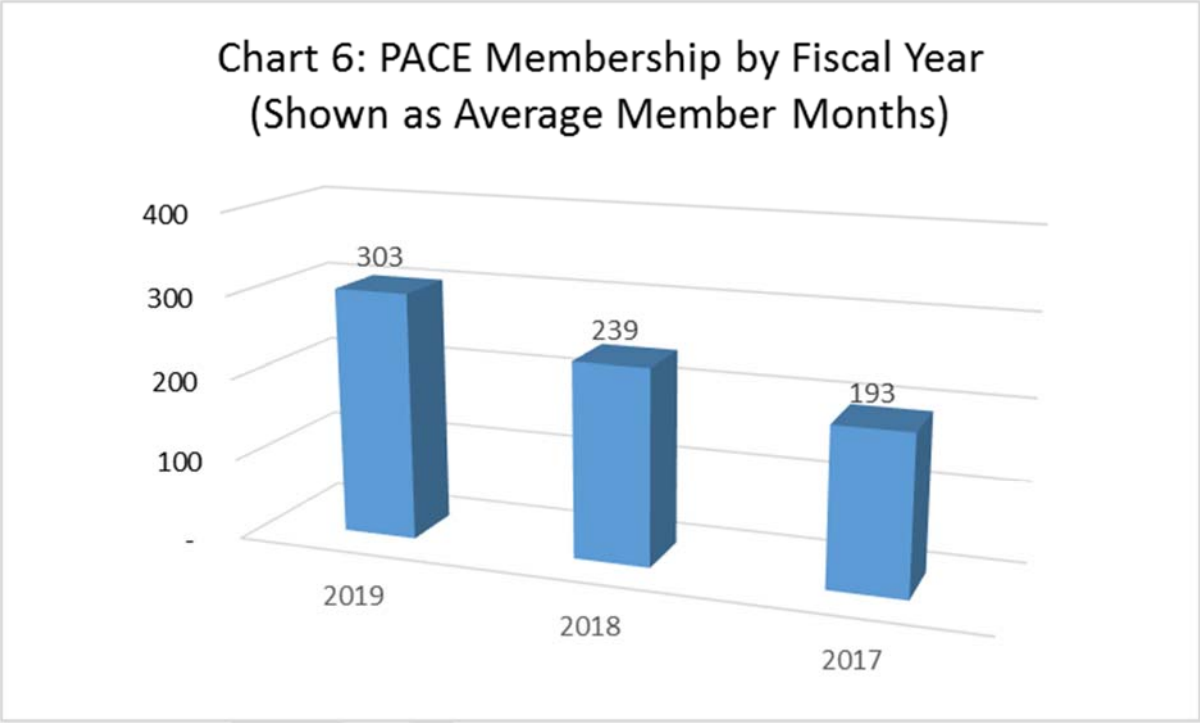
CalOptima launched OneCare Connect (OCC) program to serve dual eligible members in Orange County on July 1, 2015. This new program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. Average member months were 14,398 in fiscal year 2019. The chart below displays the average member months for the past three years.



DRAFT

2019, 2018, and 2017 Enrollment (continued)

PACE (Program of All-Inclusive Care for the Elderly) started operation in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community. It provides a full range of health care services to average member months of 303, 239, and 193 for the years ended June 30, 2019, 2018, and 2017, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2019-20 Budget

On June 27, 2019, Governor Gavin Newsom signed the Fiscal Year (FY) 2019-20 budget. The budget addresses risks while promoting investments to address affordability and economic opportunity for residents, builds budget resiliency and pays down unfunded retirement liabilities, promotes an effective government, and focuses on maintaining the state's fiscal health.

General Fund spending in the budget package is $147.8 billion, an increase of $5.1 billion or 3.6% from the FY 2018-19 budget. The budget includes $23.7 billion in General Fund spending for the Medi-Cal program, representing a $3.5 billion or 17.1% increase compared to last fiscal year. Major Medi-Cal policies adopted in the budget include: funding from Proposition 56 tobacco tax revenue to support Medi-Cal spending growth, expansion of full-scope Medi-Cal coverage to undocumented adults through age 25, restoration of previously eliminated Medi-Cal optional benefits, expansion of eligibility in the Medi-Cal Aged, Blind and Disabled program to 138% of the federal poverty level, and implementation of the Whole Person Care pilots.

The budget projects $146.0 billion in General Fund revenues and transfers in FY 2019-20, an increase of $4.4 billion or 3.1% compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) are projected to increase by 3.3%. The state is projected to end FY 2019-20 with $16.5 billion in total reserves.

Requests for information – This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the requests to CalOptima, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

DRAFT

Report of Independent Auditors

The Board of Directors
Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Report on Financial Statements

We have audited the accompanying consolidated statements of net position of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (a discrete component unit of the County of Orange, California) (CalOptima), as of June 30, 2019 and 2018, and the related consolidated statements of revenues, expenses, and changes in net position and cash flows for the years ended June 30, 2019 and 2018, and the related notes to the consolidated financial statements, which collectively comprise CalOptima's basic consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

DRAFT

Back to Agenda

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CalOptima as of June 30, 2019 and 2018, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedule of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of changes in total OPEB liability and related ratios, as listed in the table of contents, be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Irvine, California
[DATE]

DRAFT

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Consolidated Statements of Net Position

	June 30, 2019	June 30, 2018
CURRENT ASSETS		
Cash and cash equivalents	$ 347,627,785	$ 370,932,987
Investments	573,706,297	580,298,949
Premiums due from the State of California	302,964,503	296,371,640
Prepaid expenses and other	54,765,005	31,076,723
Total current assets	1,279,063,590	1,278,680,299
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	72,711,832	26,682,953
Investments	547,433,576	511,564,720
Restricted deposit	300,000	300,000
	620,445,408	538,547,673
CAPITAL ASSETS, NET	46,624,892	50,758,254
Total assets	1,946,133,890	1,867,986,226
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	10,534,449	10,573,050
Other postemployment benefit	556,000	560,000
Total deferred outflows of resources	11,090,449	11,133,050
Total assets and deferred outflows of resources	$ 1,957,224,339	$ 1,879,119,276

DRAFT

See accompanying notes to the consolidated financial statements.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Consolidated Statements of Net Position (continued)

	June 30, 2019	June 30, 2018
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	$ 287,288,604	$ 263,057,437
Provider capitation and withholds	108,903,139	96,448,891
Accrued reinsurance costs to providers	3,209,901	3,464,488
Due to State of California and the Centers for Medicare and Medicaid Services (CMS)	496,690,411	567,116,026
Unearned revenue	50,147,341	112,557,008
	946,239,396	1,042,643,850
Accounts payable and other	8,658,894	8,030,637
Accrued payroll and employee benefits and other	11,069,278	10,869,839
Total current liabilities	965,967,568	1,061,544,326
POSTEMPLOYMENT HEALTH CARE PLAN	24,705,000	24,565,000
NET PENSION LIABILITY	23,602,064	25,100,820
OTHER LONG-TERM LIABILITIES	-	100,000
Total liabilities	1,014,274,632	1,111,310,146
DEFERRED INFLOWS OF RESOURCES		
Net pension	4,903,835	1,028,380
Other postemployment benefit	2,503,000	2,301,000
Total deferred inflows of resources	7,406,835	3,329,380
NET POSITION		
Net investment in capital assets	46,580,380	50,637,437
Restricted by legislative authority	84,930,126	89,037,443
Unrestricted	804,032,366	624,804,870
Total net position	935,542,872	764,479,750
Total liabilities, deferred inflows of resources and net position	$ 1,957,224,339	$ 1,879,119,276

DRAFT

See accompanying notes to the consolidated financial statements.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Consolidated Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30, 2019	2018
REVENUES		
Premium revenues	$ 3,474,634,375	$ 3,445,699,268
Total operating revenues	3,474,634,375	3,445,699,268
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	1,287,230,443	1,403,275,064
Provider capitation	1,094,332,595	1,068,367,719
Prescription drugs	445,721,355	442,312,644
OneCare Connect	293,947,460	302,761,410
Other medical	53,871,235	42,215,978
Pace	23,297,732	18,341,424
OneCare	18,272,703	14,437,586
Total medical expenses	3,216,673,523	3,291,711,825
Administrative expenses		
Salaries, wages and employee benefits	84,618,793	85,386,751
Supplies, occupancy, insurance and other	22,975,749	25,070,349
Purchased services	12,584,719	11,460,353
Depreciation	7,226,723	7,499,203
Professional fees	3,167,619	2,430,578
Total administrative expenses	130,573,603	131,847,234
Total operating expenses	3,347,247,126	3,423,559,059
OPERATING INCOME	127,387,249	22,140,209
NON-OPERATING REVENUES (EXPENSES)		
Net investment income and other	43,675,873	21,714,051
Rental income, net of related expenses	-	1,985,919
Total non-operating revenues, net and expenses	43,675,873	23,699,970
Increase in net position	171,063,122	45,840,179
NET POSITION, beginning of year	764,479,750	718,639,571
NET POSITION, end of year	$ 935,542,872	$ 764,479,750

DRAFT

See accompanying notes to the consolidated financial statements.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Consolidated Statements of Cash Flows

	Years Ended June 30, 2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 3,335,206,230	$ 3,403,621,939
Payments to providers and facilities	(3,180,342,695)	(3,941,938,764)
Payments to vendors	(61,188,697)	(45,346,595)
Payments to employees	(81,658,054)	(74,227,628)
Net cash provided by (used in) operating activities	12,016,784	(657,891,048)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(3,692,776)	(3,956,422)
Net cash used in capital and related financing activities	(3,692,776)	(3,956,422)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	49,387,239	28,891,325
Purchases of securities	(13,023,305,579)	(12,243,048,906)
Sales of securities	12,942,289,130	12,736,875,055
Net cash (used in) provided by investing activities	(31,629,210)	522,717,474
Net decrease in cash and cash equivalents	(23,305,202)	(139,129,996)
CASH AND CASH EQUIVALENTS, beginning of year	370,932,987	510,062,983
CASH AND CASH EQUIVALENTS, end of year	$ 347,627,785	$ 370,932,987
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 127,387,249	$ 22,140,209
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES		
Depreciation	7,826,138	7,499,203
Changes in assets and liabilities		
Premiums due from the State of California	(6,592,863)	226,422,065
Prepaid expenses and other	(23,688,282)	(4,692,045)
Medical claims liability	24,231,167	(163,619,308)
Provider capitation and withholds	12,354,248	(484,390,819)
Accrued reinsurance costs to providers	(254,587)	(2,216,812)
Due to State of California and CMS	(70,425,615)	(278,772,167)
Unearned revenue	(62,409,667)	10,272,773
Accounts payable and other	628,257	(1,693,270)
Accrued payroll and employee benefits and other	199,439	768,606
Postemployment health care plan	346,000	28,000
Net pension liability	2,415,300	10,362,517
Net cash provided by (used in) operating activities	$ 12,016,784	$ (657,891,048)
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized appreciation on investments	$ 4,652,813	$ (5,492,336)

DRAFT

See accompanying notes to the consolidated financial statements.

Back to Agenda

Note 1 – Organization

Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima"), is a county-organized health system (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Pursuant to the California Welfare and Institutions Code, CalOptima was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima maintains an exclusive contract with the State of California Department of Health Care Services (DHCS) to arrange for the provision of health care services to Orange County's Med-Cal beneficiaries. Orange County had approximately 744,000 and 764,000 Medi-Cal beneficiaries for the years ended June 30, 2019 and 2018, respectively. CalOptima also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare, and Medicaid Services (CMS). OneCare served approximately 1,500 and 1,400 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2019 and 2018, respectively. In January 2016, CalOptima began offering OneCare Connect Cal MediConnect Plan (OCC), a Medicare-Medicaid Plan, via a contract with CMS. OCC served approximately 14,000 and 15,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2019 and 2018, respectively. In January 2016, CalOptima began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. CalOptima also contracts with the California Department of Aging to provide case management of social and health care services to approximately 300 Medi-Cal eligible seniors under California's Multipurpose Senior Services program. The Program of All-inclusive Care for the Elderly (PACE) provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding.

CalOptima in turn subcontracts the delivery of health care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia, and Shared Risk Groups. Additionally, CalOptima has direct contracts with hospitals and providers for its fee-for-service network.

CalOptima is Knox-Keene licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Act to the extent incorporated by reference into CalOptima's contract with DHCS. As such, CalOptima is subject to the regulatory requirements of the Department of Managed Health Care under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity, which CalOptima exceeded as of June 30, 2019 and 2018.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 dedicated to the betterment of public health care services in Orange County. The Foundation Board of Directors approved the dissolution of the Foundation in May 2019, and all assets of the Foundation were transferred back to CalOptima. CalOptima has sole control over the activities of the Foundation and as such, the activities of the Foundation are included in the consolidated financial statements of CalOptima.

DRAFT

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima is a county-organized health system governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. The CalOptima Board of Directors also serves as the Board of Directors of the Foundation. Effective for the fiscal year ended June 30, 2014, CalOptima began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the CalOptima Board of Directors.

Principle of consolidation – The consolidated financial statements include the accounts of CalOptima and the Foundation (collectively referred to herein as the "Organization").

Basis of accounting – CalOptima uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying consolidated financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows using current market rates applicable to the coupon rate, credit, and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – Board-designated assets include amounts designated by CalOptima's Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 1.4 and 2 months of premium revenues, and amounts designated by the Board of Directors for CalOptima's homeless health initiative (see Note 3). Restricted cash represents a $300,000 restricted deposit required by CalOptima as part of the Knox-Keene Health Care Service Plan Act (the Act) of 1975 (see Note 9).

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs and minor replacements are charged to expense when incurred.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

Fair value of financial instruments – The consolidated financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premium receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred but not yet reported (IBNR) claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

Provider capitation and withholds – CalOptima has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surplus or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately $40,167,000 and $44,660,000 as of June 30, 2019 and 2018, respectively, and are included in provider capitation and withholds on the consolidated statements of net position. During the years ended June 30, 2019 and 2018, CalOptima incurred approximately $1,243,391,000 and $1,212,059,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation, OneCare Connect, and OneCare line items in the consolidated statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2019 and 2018, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $108,903,000 and $96,449,000, respectively.

Premium deficiency reserves – CalOptima performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima's management determined that no premium deficiency reserves were necessary as of June 30, 2019 and 2018.

Accrued compensated absences – CalOptima's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. Unused PTO may be carried over into subsequent years, not to exceed two and a half times the annual accrual. If an employee reaches his/her PTO maximum accrual, a portion of the accrued PTO equal to half of the employees' annual PTO accruals will be automatically paid out to the employees. Accumulated PTO will be paid to the employees upon separation from service with CalOptima. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

Net position – Net position is reported in three categories, defined as follows:

- **Net investment in capital assets** – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) to the acquisition, construction, or improvement of those assets.

- **Restricted by legislative authority** – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see Note 9).

- **Unrestricted** – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets, net of related debt."

Operating revenues and expenses – CalOptima's consolidated statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Revenue recognition and due to or from the State of California and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State of California (the State) each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the consolidated statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima in the amount of approximately $104,724,000 and $75,511,000 related to retroactive capitation rate adjustments and receipt of new information from DHCS during the years ended June 30, 2019 and 2018, respectively.

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

The State pays CalOptima premium revenue retrospectively on an estimated basis each month. Premium revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the consolidated statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

Effective with the enrollment of the Medi-Cal expansion population per the Affordable Care Act (ACA), CalOptima is subject to DHCS requirements to meet the minimum 85% medical loss ratio (MLR) for this population. Specifically, CalOptima will be required to expend at least 85% of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima expends less than the 85% requirement, CalOptima will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. CalOptima's contract with CMS and DHCS requires for CalOptima to perform and submit the MLR calculations for periods beginning July 1, 2017 to DHCS. During 2018, DHCS completed their reconciliation of the MLR calculation for fiscal years 2014 through 2016. Based on the results of the reconciliation, CalOptima paid back premium revenue of approximately $102,000,000 during the year ended June 30, 2019. In April 2019, CalOptima was notified that CMS will be performing their own reconciliation of the MLR data. As of June 30, 2019 and 2018, approximately $125,563,000 and $227,362,000 was accrued, respectively. This liability is presented in the Due to State of California line item in the accompanying consolidated statements of net position.

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

Premium revenue and related net receivables as a percent of the totals were as follows:

	Years Ended June 30,			
	2019		2018	
Revenue	Revenue	%	Revenue	%
Medi-Cal	$ 3,134,181,615	90.2%	$ 3,093,733,298	89.8%
OneCare	20,613,604	0.6%	15,943,378	0.5%
OneCare Connect	292,428,409	8.4%	315,219,443	9.1%
PACE	27,410,747	0.8%	20,803,149	0.6%
	$ 3,474,634,375	100.0%	$ 3,445,699,268	100.0%

	As of June 30,			
	2019		2018	
Receivables	Receivables	%	Receivables	%
Medi-Cal	$ 290,217,790	95.8%	$ 279,765,285	94.4%
OneCare	-	0.0%	414,035	0.1%
OneCare Connect	10,638,887	3.5%	12,791,802	4.3%
PACE	2,107,826	0.7%	3,400,518	1.2%
	$ 302,964,503	100.0%	$ 296,371,640	100.0%

Intergovernmental transfer – CalOptima entered into an agreement with DHCS and Governmental Funding Entities to receive an intergovernmental transfer (IGT) through a capitation rate increase of approximately $124,714,000 and $130,700,000 during the years ended June 30, 2019 and 2018, respectively. Under the agreement, approximately $81,951,000 and $99,600,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the years ended June 30, 2019 and 2018, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the consolidated statements of revenues, expenses, and changes in net position or the consolidated statements of net position. CalOptima accounts for the IGT transfer for CalOptima purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. CalOptima retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. A retainer in the amount of approximately $45,565,000 and $50,564,000 as of June 30, 2019 and 2018, respectively, is included in unearned revenues in the consolidated statements of net position.

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

Medicare Part D – CalOptima covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima receives monthly from CMS and members, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which CalOptima is not at risk.

The risk corridor provisions compare costs targeted in CalOptima's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima or require CalOptima to refund to CMS a portion of the premiums CalOptima received. CalOptima estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying consolidated statements of net position based on the timing of expected settlement. As of June 30, 2019 and 2018, the Part D payable balance was approximately $1,240,000 and $1,374,000, respectively, and the Part D receivable balance was approximately $23,148,000 and $15,114,000, respectively.

Income taxes – CalOptima operates under the purview of the Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima is not subject to federal or state taxes on related income. The Foundation is operated as a tax-exempt organization under Section 501(c)(3) of the federal Internal Revenue Code and applicable sections of the California statutes. Accordingly, no provision for income tax has been recorded in the accompanying consolidated financial statements.

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2) *Managed Care Organization Tax* authorized Department of Health Care Services (DHCS) to implement a Managed Care Organization provider tax subject to approval by the federal Centers for Medicare and Medicaid Services. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. Using the approved structure, each MCO's total tax liability for years ended June 30, 2019 and 2018, were calculated. CalOptima recognized premium tax expense of approximately $136,649,000 and $143,156,000 as a reduction of premium revenues in the consolidated statements of revenue, expenses, and change in net position for the years ended June 30, 2019 and 2018, respectively.

DRAFT

Note 2 – Summary of Significant Accounting Policies (continued)

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of CalOptima's California Public Employees' Retirement System Plan (the "CalPERS Plan") and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by CalPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Reclassifications – Certain accounts in the prior year financial statements have been reclassified for comparative purposes to conform with the presentation in the current year financial statements.

Recent accounting pronouncements – In January 2017, the GASB issued Statement No. 84, Fiduciary Activities. The principal objective of this Statement is to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. This Statement also is intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. This Statement is effective for the Organization for the year ending June 30, 2020.

In June 2017, the GASB issued Statement No. 87, Leases. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement requires recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. This Statement is effective for the Organization for the year ending June 30, 2021.

DRAFT

Note 3 – Cash and Investments

Cash and investments are reported in the June 30 consolidated statements of net position as follows:

	June 30, 2019	June 30, 2018
Current assets:		
Cash and cash equivalents	$ 347,627,785	$ 370,932,987
Investments	573,706,297	580,298,949
Board-designated assets and restricted cash:		
Cash and cash equivalents	72,711,832	26,682,953
Investments	547,433,576	511,564,720
Restricted deposit	300,000	300,000

Board-designated assets and restricted cash are available for the following purposes:

	June 30, 2019	June 30, 2018
Board-designated assets and restricted cash:		
Contingency reserve fund	$ 560,145,408	$ 478,247,673
Homeless fund	60,000,000	60,000,000
Restricted deposit with DMHC	300,000	300,000
	$ 620,445,408	$ 538,547,673

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2019 and 2018, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage or asset-backed securities.

DRAFT

Note 3 – Cash and Investments (continued)

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2019 and 2018, CalOptima's investments, including cash equivalents, had the following modified duration:

	June 30, 2019			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. Treasury notes	$ 352,752,967	$ 177,383,066	$ 175,369,901	$ -
U.S. Agency notes	134,989,426	74,775,657	60,213,769	-
Corporate bonds	314,560,151	104,094,228	210,465,923	-
Asset-backed securities	115,144,277	24,318,946	90,825,331	-
Mortgage-backed securities	50,497,865	8,700,919	41,796,946	-
Municipal bonds	76,245,379	32,692,354	43,553,025	-
Supranational	51,319,797	10,022,104	41,297,693	-
Commercial paper	19,932,870	19,932,870	-	-
Cash equivalents	327,611,350	303,607,437	24,003,913	-
Cash	8,572,533	8,572,533	-	-
		$ 764,100,114	$ 687,526,501	$ -
Accrued interest receivable	5,711,366			
	$ 1,457,337,981			

DRAFT

Note 3 – Cash and Investments (continued)

	June 30, 2018			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. Treasury notes	$ 340,360,989	$ 209,773,924	$ 130,587,065	$ -
U.S. Agency notes	97,566,400	53,950,111	43,616,289	-
Corporate bonds	325,476,437	150,685,261	174,791,176	-
Asset-backed securities	98,081,726	40,122,896	57,958,830	-
Mortgage-backed securities	60,653,460	33,330,235	27,323,225	-
Municipal bonds	109,676,060	47,033,412	62,642,648	-
Supranational	27,385,479	11,916,356	15,469,123	-
Certificates of deposit	4,991,291	4,991,291	-	-
Commercial paper	22,564,481	22,564,481	-	-
Cash equivalents	335,013,724	335,013,724	-	-
Cash	1,375,213	1,375,213	-	-
		$ 910,756,904	$ 512,388,356	$ -
Accrued interest receivable	5,191,355			
	$ 1,428,336,615			

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima portfolio are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above:

	June 30,	
	2019	2018
Asset-backed securities	$ 115,144,277	$ 98,081,726
Mortgage-backed securities	50,497,865	60,653,460
	$ 165,642,142	$ 158,735,186

DRAFT

Note 3 – Cash and Investments (continued)

Credit risk – CalOptima's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation (S&P), Moody's Investor Service (Moody's), and Fitch Ratings (Fitch). For an issuer of short-term debt, the rating must be no less than A-1 (S&P), P-1 (Moody's), or F-1 (Fitch), while an issuer of long-term debt shall be rated no less than an "A."

DRAFT

Note 3 – Cash and Investments (continued)

As of June 30, 2019, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 399,269,103	N/A	$ 399,269,103	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	268,824,494	N/A	268,824,494	-	-	-	-	-	-
Corporate bonds	278,900,937	A-	-	507,778	12,097,150	40,140,811	70,968,175	91,142,880	64,044,143
Floating-rate note securities	83,274,478	A-	-	37,475,037	5,000,508	7,686,165	10,402,994	11,561,955	11,147,819
Asset-backed securities	86,471,404	AAA	-	86,014,136	457,268	-	-	-	-
Mortgage-backed securities	79,449,452	AAA	-	79,449,452	-	-	-	-	-
Municipal bonds	82,794,419	A	-	9,954,332	33,041,505	23,666,163	10,161,752	5,244,954	725,713
Supranational	17,332,313	AAA	-	17,332,313	-	-	-	-	-
Certificates of deposit	38,245,312	A1/P1	-	38,245,312	-	-	-	-	-
Commercial paper	78,248,965	A1/P1	-	78,248,965	-	-	-	-	-
Money market mutual funds	44,527,104	AAA	-	44,527,104	-	-	-	-	-
Total	$ 1,457,337,981		$ 668,093,597	$ 391,754,429	$ 50,596,431	$ 71,493,139	$ 91,532,921	$ 107,949,789	$ 75,917,675

DRAFT

Note 3 – Cash and Investments (continued)

As of June 30, 2018, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 424,083,688	N/A	$ 424,083,688	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	140,852,307	N/A	140,852,307	-	-	-	-	-	-
Corporate bonds	267,655,812	A-	-	2,096,170	20,135,711	32,266,114	70,432,536	100,078,443	42,646,838
Floating-rate note securities	119,715,104	A-	-	47,187,008	3,581,153	7,419,691	19,960,470	22,322,066	19,244,716
Asset-backed securities	147,203,018	AAA	-	100,674,207	20,251,534	19,999,921	1,000,903	2,856,173	2,420,280
Mortgage-backed securities	60,754,477	AAA	-	60,754,477	-	-	-	-	-
Municipal bonds	65,961,981	A	-	4,807,874	38,071,549	12,515,979	9,074,505	1,006,522	485,552
Supranational	15,384,685	AAA	-	15,384,685	-	-	-	-	-
Certificates of deposit	5,053,486	A1/P1	-	5,053,486	-	-	-	-	-
Commercial paper	64,431,291	A1/P1	-	64,431,291	-	-	-	-	-
Money market mutual funds	117,240,766	AAA	-	117,240,767	-	-	-	-	-
Total	$ 1,428,336,615		$ 564,935,995	$ 417,629,965	$ 82,039,947	$ 72,201,705	$ 100,468,414	$ 126,263,204	$ 64,797,386

DRAFT

Note 3 – Cash and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima's investment in a single issuer. CalOptima's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. As of June 30, 2019 and 2018, all holdings complied with the foregoing limitations. The following holdings exceeded 5 percent of the portfolio as of June 30, 2019 and 2018:

		Percentage of Portfolio June 30,	
Investment Type	Issuer	2019	2018
U.S. Treasury notes	United States Treasury	29.12	30.42
U.S. Agency notes	Federal Home Loan Bank	14.11	4.31

The Organization categorizes its fair value investments within the fair value hierarchy established by US GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying consolidated statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

DRAFT

Note 3 – Cash and Investments (continued)

The following table presents the fair value measurements of assets recognized in the accompanying consolidated statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

	Investment Assets at Fair Value as of June 30, 2019			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 352,752,967	$ -	$ -	$ 352,752,967
U.S. Agency notes	-	134,989,426	-	134,989,426
Corporate bonds	-	314,560,151	-	314,560,151
Asset-backed securities	-	115,144,277	-	115,144,277
Mortgage-backed securities	-	50,497,865	-	50,497,865
Municipal bonds	-	76,245,379	-	76,245,379
Supranational	-	51,319,797	-	51,319,797
Commercial paper	-	19,932,870	-	19,932,870
	$ 352,752,967	$ 762,689,765	$ -	$ 1,115,442,732

	Investment Assets at Fair Value as of June 30, 2018			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 340,360,989	$ -	$ -	$ 340,360,989
U.S. Agency notes	-	97,566,400	-	97,566,400
Corporate bonds	-	325,476,437	-	325,476,437
Asset-backed securities	-	98,081,726	-	98,081,726
Mortgage-backed securities	-	60,653,460	-	60,653,460
Municipal bonds	-	109,676,060	-	109,676,060
Supranational	-	27,385,479	-	27,385,479
Commercial deposits	-	4,991,291	-	4,991,291
Commercial paper	-	22,564,481	-	22,564,481
	$ 340,360,989	$ 746,395,334	$ -	$ 1,086,756,323

DRAFT

Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2019, consisted of the following:

	June 30, 2018	Additions	Retirements	Transfers	June 30, 2019
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	2,382,706	3,692,776	-	(5,575,850)	499,632
	8,258,708	3,692,776	-	(5,575,850)	6,375,634
Capital assets being depreciated:					
Furniture and equipment	6,420,961	-	(25,174)	205,558	6,601,345
Computers and software	27,907,888	-	(2,066,669)	4,640,091	30,481,310
Leasehold improvements	5,192,478	-	(138,515)	9,155	5,063,118
Building	43,867,940	-	-	721,046	44,588,986
	83,389,267	-	(2,230,358)	5,575,850	86,734,759
Less accumulated depreciation for:					
Furniture and equipment	4,978,434	716,158	(25,174)	-	5,669,418
Computers and software	21,935,365	4,565,533	(2,066,669)	-	24,434,229
Leasehold improvements	3,326,488	589,005	(138,515)	-	3,776,978
Building	10,649,434	1,955,442	-	-	12,604,876
	40,889,721	7,826,138	(2,230,358)	-	46,485,501
Total depreciable assets, net	42,499,546	(7,826,138)	-	5,575,850	40,249,258
Capital assets, net	$ 50,758,254	$ (4,133,362)	$ -	$ -	$ 46,624,892

DRAFT

Note 4 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2018, consisted of the following:

	June 30, 2017	Additions	Retirements	Transfers	June 30, 2018
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	702,535	3,956,429	-	(2,276,258)	2,382,706
	6,578,537	3,956,429	-	(2,276,258)	8,258,708
Capital assets being depreciated:					
Furniture and equipment	6,364,507	-	-	56,454	6,420,961
Computers and software	27,073,405	-	(1,051,408)	1,885,891	27,907,888
Leasehold improvements	5,180,143	-	-	12,335	5,192,478
Building	43,546,362	-	-	321,578	43,867,940
	82,164,417	-	(1,051,408)	2,276,258	83,389,267
Less accumulated depreciation for:					
Furniture and equipment	4,185,504	792,930	-	-	4,978,434
Computers and software	18,797,536	4,189,237	(1,051,408)	-	21,935,365
Leasehold improvements	2,730,279	596,209	-	-	3,326,488
Building	8,728,607	1,920,827	-	-	10,649,434
	34,441,926	7,499,203	(1,051,408)	-	40,889,721
Total depreciable assets, net	47,722,491	(7,499,203)	-	2,276,258	42,499,546
Capital assets, net	$ 54,301,028	$ (3,542,774)	$ -	$ -	$ 50,758,254

The Organization recognized depreciation expense of approximately $7,826,000 and $7,499,000 during the years ended June 30, 2019 and 2018, respectively. During the years ended June 30, 2019 and 2018, depreciation expense of approximately $599,000 and $0, respectively, was included within Pace medical expenses on the accompanying consolidated statements of revenues, expenses, and changes in net position.

DRAFT

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following:

	June 30, 2019	June 30, 2018
Claims payable or pending approval	$ 12,621,260	$ 13,347,460
Provisions for IBNR claims	274,667,344	249,709,977
	$ 287,288,604	$ 263,057,437

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. CalOptima estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed, and as settlements are made or estimates adjusted, differences are reflected in current operations.

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability:

	For the Years Ended June 30, 2019	For the Years Ended June 30, 2018
Beginning balance	$ 263,057,437	$ 426,676,745
Incurred:		
Current	1,942,000,378	1,609,946,348
Prior	(6,343,766)	(7,371,113)
	1,935,656,612	1,602,575,235
Paid:		
Current	1,669,760,655	1,541,304,218
Prior	241,664,790	224,890,325
	1,911,425,445	1,766,194,543
Ending balance	$ 287,288,604	$ 263,057,437

DRAFT

Note 5 – Medical Claims Liability (continued)

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The year ended June 30, 2019, results included a decrease of prior year incurred of approximately $6,344,000. The year ended June 30, 2018, results included a decrease of prior year incurred of approximately $7,371,000. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

The amounts accrued in Due to State of California and the Centers for Medicare and Medicaid Services (CMS) represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS is in process of recouping these overpayments as of June 30, 2019, and the remaining overpayments not yet recouped are included within Due to State of California and the CMS on the consolidated statement of net position. During the years ended June 30, 2019 and 2018, DHCS recouped approximately $152,799,000 and $636,927,000 related to dates of service of FY15 through FY19 for the Medi-Cal expansion population, respectively, presented as a reduction of premium revenues in the consolidated statements of revenue, expenses, and change in net position.

Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima's defined benefit pension plan, Miscellaneous Plan of the Orange County Health Authority (the "CalPERS Plan"), provides retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members and beneficiaries. The CalPERS Plan is part of the public agency portion of the California Public Employees Retirement Systems (CalPERS), an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the state of California. A menu of benefit provisions as well as other requirements is established by state statues within the Public Employees' Retirement Law. CalOptima selects optional benefit provisions from the benefit menu by contract with CalPERS and adopts those benefits through the Board of Directors' approval. CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: The Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the Public Employees' Retirement Law.

The CalPERS Plan's provisions and benefits in effect as of June 30, 2019, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2% at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	2.0% to 2.7%	1.0% to 2.5%
Required employee contribution rates	7.0%	7.3%
Required employer contribution rates	8.5%	8.5%

The following is a summary of plan participants:

	June 30, 2019	June 30, 2018
Active employees	1,305	1,219
Retirees and beneficiaries:		
Receiving benefits	72	59
Deferred Retirement benefits:		
Terminated employees	172	128
Surviving spouses	3	3
Beneficiaries	3	3

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

Contributions – Section 20814(c) of the California Public Employees' Retirement Law (PERL) requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 7.25 percent of annual pay for the years ended June 30, 2019 and 2018. The employer's contribution rate is 8.5 percent of annual payroll for the years ended June 30, 2019 and 2018.

CalOptima's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2018 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2017 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2018 and June 30, 2017, respectively:

Valuation Date	June 30, 2017
Measurement Date	June 30, 2018
Actuarial Cost Method	Entry Age Normal
Actuarial Assumptions:	
Discount Rate	7.15%
Inflation	2.50%
Salary Increases	Varies by Entry Age and Service
Investment Rate of Return	7.5% Net of Pension Plan Investment and Administrative Expenses; includes Inflation
Mortality Rate Table	Derived using CalPERS' Membership data for all funds
Post Retirement Benefit Increase	Contract COLA up to 2.0% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

The underlying mortality table was developed based on CalPERS' specific data. Pre-retirement and Post-retirement mortality rates include 5 years of projected mortality improvement using Scale AA published by the Society of Actuaries. The post-retirement mortality rates above include 20 years of projected ongoing mortality improvement using Scale BB published by the Society of Actuaries. All other actuarial assumptions used in the June 30, 2013 valuation were based on the results of an actuarial experience study for the period 1997 to 2011, including updates to salary increase mortality and retirement rates. The Experience Study report can be obtained at CalPERS' website.

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

Changes in the Net Pension Liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2018	$ 142,448,307	$ 117,347,487	$ 25,100,820
Changes during the year:			
Service Cost	13,491,596	-	13,491,596
Interest on the total pension liability	10,431,464	-	10,431,464
Changes of benefit terms	-	-	-
Differences between expected and actual experience	2,812,748	-	2,812,748
Changes of assumptions	(4,737,905)	-	(4,737,905)
Contributions from the employer	-	7,588,200	(7,588,200)
Contributions from employees	-	6,213,420	(6,213,420)
Net investment income	-	10,225,467	(10,225,467)
Benefit payments, including refunds of employee contributions	(2,748,699)	(2,748,699)	-
Administrative expenses	-	(530,428)	530,428
Net changes during the year	19,249,204	20,747,960	(1,498,756)
Balance at June 30, 2019	$ 161,697,511	$ 138,095,447	$ 23,602,064

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2017	$ 112,464,954	$ 97,034,191	$ 15,430,763
Changes during the year:			
Service Cost	13,118,795	-	13,118,795
Interest on the total pension liability	9,136,725	-	9,136,725
Changes of benefit terms	-	-	-
Differences between expected and actual experience	632,642	-	632,642
Changes of assumptions	9,163,547	-	9,163,547
Contributions from the employer	-	5,234,582	(5,234,582)
Contributions from employees	-	5,793,911	(5,793,911)
Net investment income	-	11,496,425	(11,496,425)
Benefit payments, including refunds of employee contributions	(2,068,356)	(2,068,356)	-
Administrative expenses	-	(143,266)	143,266
Net changes during the year	29,983,353	20,313,296	9,670,057
Balance at June 30, 2018	$ 142,448,307	$ 117,347,487	$ 25,100,820

Discount rate and long term rate of return – The discount rate used to measure the total pension liability was 7.15% for the CalPERS Plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.15% discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 7.15% will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report called “GASB Crossover Testing Report” that can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense, and inflation) are developed for each major asset class.

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11–60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These geometric rates of return are net of administrative expenses.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1-10 (a)	Years 11+ (b)
Global Equity	50.0%	4.80%	5.98%
Global Fixed Income	28.0%	1.00%	2.62%
Inflation Sensitive	0.0%	0.77%	1.81%
Private Equity	8.0%	6.30%	7.23%
Real Estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

(a) An expected inflation of 2.00% was used for this period
(b) An expected inflation of 2.92% was used for this period

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2019		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net Pension Liability	$ 50,790,772	$ 23,602,064	$ 1,662,185

	June 30, 2018		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net Pension Liability	$ 50,320,307	$ 25,100,820	$ 4,838,677

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima recognized pension expense of approximately $11,422,000 and $17,785,000, presented within salaries, wages, and employee benefits in the consolidated statements of revenue, expenses, and change in net position for the years ended June 30, 2019 and 2018, respectively. As of June 30, 2019 and 2018, CalOptima recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 686,962	$ -
Net differences between projected and actual earnings on plan investments	-	156,330
Changes in assumptions	6,428,159	4,747,505
Differences between expected and actual experiences	3,419,328	-
	$ 10,534,449	$ 4,903,835

	June 30, 2018	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 393,907	$ -
Net differences between projected and actual earnings on plan investments	1,017,387	-
Changes in assumptions	7,795,853	1,028,380
Differences between expected and actual experiences	1,365,903	-
	$ 10,573,050	$ 1,028,380

DRAFT

Note 6 – Defined Benefit Pension Plan (continued)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2019. The net differences reported as deferred outflows of resources related to pensions will be recognized as pension expense as follows:

Years Ending June 30,	Deferred Outflows (Inflows) of Resources
2019	$ 2,209,282
2020	1,288,653
2021	21,613
2022	889,095
2023	736,144
Thereafter	(201,135)
	$ 4,943,652

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the 457 Plan) under which employees are permitted to defer a portion of their annual salary until future years. CalOptima may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2019 and 2018, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima makes discretionary employer contributions to the PARS Plan as authorized by the CalOptima Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2019 and 2018, CalOptima contributed approximately $3,256,000 and $2,971,000, respectively.

Note 8 – Postemployment Health Care Plan

Plan description – CalOptima sponsors and administers a single-employer, defined benefit postemployment health care plan (the "Plan") to provide medical and dental insurance benefits to eligible retired employees and their beneficiaries. Benefit provisions are established and may be amended by the CalOptima Board of Directors.

DRAFT

Note 8 – Postemployment Health Care Plan (continued)

Effective January 1, 2004, CalOptima terminated postemployment health care benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan.

During the year ended June 30, 2006, CalOptima modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the CalOptima's plan and additions to/deductions from the OPEB Plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms.

US GAAP requires that the reported results must pertain to liability and asset information within certain defined timeframes. For this report, the following timeframes are used:

Measurement Date	June 30, 2018
Measurement Period	July 1, 2017 - June 30, 2018
Valuation Date	January 1, 2018

Covered employees – As of June 30, 2018, the measurement date, the following numbers of participants were covered by the benefit terms:

	Number of Covered Participants
Inactives currently receiving benefits	66
Inactives entitled to but not yet receiving benefits	-
Active employees	83
Total	149

DRAFT

Note 8 – Postemployment Health Care Plan (continued)

Contributions – The contribution requirements of plan members and CalOptima are established and may be amended by the CalOptima Board of Directors. CalOptima's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima contributed $556,000, including $523,000 in premium payments for retirees and $33,000 for implied subsidies for the year ended June 30, 2019. CalOptima contributed $560,000, including $529,000 in premium payments for retirees and $31,000 for implied subsidies for the year ended June 30, 2018. The most recent actuarial report for the plan was June 30, 2018. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $24,705,000.

Actuarial assumptions – CalOptima's total postemployment retirement liability was measured as of June 30, 2017, and the total postemployment retirement liability used to calculate the total postemployment retirement liability was determined by an actuarial valuation dated June 30, 2017, that was rolled forward to determine the June 30, 2018 total postemployment retirement liability, based on the following actuarial methods and assumptions:

Salary increases	3% per annum, in aggregate
Medical trend	Non-Medicare - 7.5% for 2019, decreasing to an ultimate rate of 4.0% in 2076 Medicare - 6.5% for 2019, decreasing to an ultimate rate of 4.0% in 2076
Discount rate	3.87% at June 30 2018, Bond Buyer 20 Index 3.58% at June 30 2017, Bond Buyer 20 Index
Mortality, retirement, disability, termination	CalPERS 1997-2015 Experience Study Post-retirement mortality projection Scale MP-2017
General inflation	2.75% per annum

Discount rate and long term rate of return – The discount rate used to measure the total OPEB liability was 3.87 percent for June 30, 2018. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

DRAFT

Note 8 – Postemployment Health Care Plan (continued)

Changes in the net OPEB liability – Changes in the net OPEB liability were as follows:

Balance at June 30, 2018	$ 24,565,000
Changes for the year	
Service cost	867,000
Interest	900,000
Benefit changes	-
Actual vs. expected experience	-
Assumption changes	(1,067,000)
Contributions - employer	-
Contributions - employee	-
Net investment income	-
Benefit payments	(560,000)
Administrative expenses	-
Net changes	140,000
Balance at June 30, 2019	$ 24,705,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (2.87%) or 1 percentage point higher (4.87%) than the current discount rate:

	1% Decrease (2.87%)	Current Rate (3.87%)	1% Increase (4.87%)
Total OPEB liability	$ 28,687,000	$ 24,705,000	$ 21,485,000

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 20,948,000	$ 24,705,000	$ 29,457,000

DRAFT

Note 8 – Postemployment Health Care Plan (continued)

For the year ended June 30, 2019, CalOptima recognized OPEB expense of approximately $902,000. As of June 30, 2019, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ -
Changes in assumptions	-	2,503,000
Employer contributions made subsequent to measurement date	556,000	-
Total	$ 556,000	$ 2,503,000

Amounts reported as deferred outflows of resources and deferred inflows of resources will be recognized in OPEB expense as follows:

	Deferred Outflows / (Inflows) of Resources
Year ending June 30,	
2020	$ (309,000)
2021	(865,000)
2022	(678,000)
2023	(95,000)
2024	-
Thereafter	-
	$ (1,947,000)

The required schedule of changes in total OPEB liability immediately following the notes to the consolidated financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

DRAFT

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima became a fully licensed health care service plan under the Act, as required by statues governing the Healthy Families program. Under the Act, CalOptima is required to maintain and meet a minimum level of tangible net equity (TNE) as of June 30, 2019 and 2018, of $84,930,126 and $89,037,443, respectively. As of June 30, 2019 and 2018, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima maintain a restricted deposit in the amount of $300,000. CalOptima met this requirement as of June 30, 2019 and 2018.

Note 10 – Lease Commitments

CalOptima leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

	Minimum Lease Payments
Years Ending June 30,	
2019	$ 531,411
2020	547,353
2021	277,721
2022	-
2023	-
Thereafter	-
	$ 1,356,485

Rental expense under operating leases was approximately $471,000 and $469,000 for the years ended June 30, 2019 and 2018, respectively.

Note 11 – Contingencies

Litigation – CalOptima is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima's financial position or results of operations.

DRAFT

Note 11 – Contingencies (continued)

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that CalOptima is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Medi-Cal Eligibility Discrepancies – During October 2018, the California State Auditor issued an audit report indicating that DHCS made $323,964,900 (aggregate) in questionable Medi-Cal payments to managed care plans in Orange County from 2014 to 2017 due to discrepancies between the state and county Medi-Cal eligibility systems. As of September __, 2019, which is the date the consolidated financial statements were available to be issued, the Organization has no means of reliably estimating the amounts of such questionable payments received, if any, and has received no formal communication from any agency that such questionable payments have been made to the Organization. Due to this inherent uncertainty, the range of potential loss, if any, is indeterminable, and no corresponding accrual was made as of June 30, 2019.

DRAFT

Note 12 – Consolidating Information

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position as of June 30, 2019, are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 347,627,785	$ -	$ -	$ 347,627,785
Investments	573,706,297	-	-	573,706,297
Premiums due from the State of California	302,964,503	-	-	302,964,503
Prepaid expenses and other	54,765,005	-	-	54,765,005
Total current assets	1,279,063,590	-	-	1,279,063,590
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH				
Cash and cash equivalents	72,711,832	-	-	72,711,832
Investments	547,433,576	-	-	547,433,576
Restricted deposit	300,000	-	-	300,000
	620,445,408	-	-	620,445,408
CAPITAL ASSETS, NET	46,624,892			46,624,892
Total assets	1,946,133,890	-	-	1,946,133,890
DEFERRED OUTFLOWS OF RESOURCES				
Net pension	10,534,449	-	-	10,534,449
Other postemployment benefit	556,000	-	-	556,000
Total deferred outflows of resources	11,090,449	-	-	11,090,449
Total assets and deferred outflows of resources	$ 1,957,224,339	$ -	$ -	$ 1,957,224,339
LIABILITIES AND NET POSITION				
CURRENT LIABILITIES				
Medical claims liability and capitation payable				
Medical claims liability	$ 287,288,604	$ -	$ -	$ 287,288,604
Provider capitation and withholds	108,903,139	-	-	108,903,139
Accrued reinsurance costs to providers	3,209,901	-	-	3,209,901
Due to State of California and the Centers for Medicare and Medicaid Services (CMS)	496,690,411	-	-	496,690,411
Unearned revenue	50,147,341	-	-	50,147,341
	946,239,396	-	-	946,239,396
Accounts payable and other	8,658,894	-	-	8,658,894
Accrued payroll and employee benefits and other	11,069,278	-	-	11,069,278
Total current liabilities	965,967,568	-	-	965,967,568
POSTEMPLOYMENT HEALTH CARE PLAN	24,705,000	-	-	24,705,000
NET PENSION LIABILITY	23,602,064	-	-	23,602,064
Total liabilities	1,014,274,632	-	-	1,014,274,632
DEFERRED INFLOWS OF RESOURCES				
Net pension	4,903,835	-	-	4,903,835
Other postemployment benefit	2,503,000	-	-	2,503,000
Total deferred inflows of resources	7,406,835	-	-	7,406,835
NET POSITION				
Net investment in capital assets	46,580,380	-	-	46,580,380
Restricted by legislative authority	84,930,126	-	-	84,930,126
Unrestricted	804,032,366	-	-	804,032,366
Total net position	935,542,872	-	-	935,542,872
Total liabilities, deferred inflows of resources and net position	$ 1,957,224,339	$ -	$ -	$ 1,957,224,339

DRAFT

Note 12 – Consolidating Information (continued)

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position as of June 30, 2018, are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 368,089,848	$ 2,843,139	$ -	$ 370,932,987
Investments	580,298,949	-	-	580,298,949
Premiums due from the State of California	296,371,640	-	-	296,371,640
Prepaid expenses and other	31,076,723	-	-	31,076,723
Total current assets	1,275,837,160	2,843,139	-	1,278,680,299
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH				
Cash and cash equivalents	26,682,953	-	-	26,682,953
Investments	511,564,720	-	-	511,564,720
Restricted deposit	300,000	-	-	300,000
	538,547,673	-	-	538,547,673
CAPITAL ASSETS, NET	50,758,254	-		50,758,254
Total assets	1,865,143,087	2,843,139	-	1,867,986,226
DEFERRED OUTFLOWS OF RESOURCES				
Net pension	10,573,050	-	-	10,573,050
Other postemployment benefit	560,000	-	-	560,000
Total deferred outflows of resources	11,133,050	-	-	11,133,050
Total assets and deferred outflows of resources	$ 1,876,276,137	$ 2,843,139	$ -	$ 1,879,119,276
LIABILITIES AND NET POSITION				
CURRENT LIABILITIES				
Medical claims liability and capitation payable				
Medical claims liability	$ 263,057,437	$ -	$ -	$ 263,057,437
Provider capitation and withholds	96,448,891	-	-	96,448,891
Accrued reinsurance costs to providers	3,464,488	-	-	3,464,488
Due to State of California and the Centers for Medicare and Medicaid Services (CMS)	567,116,026	-	-	567,116,026
Unearned revenue	112,557,008	-	-	112,557,008
	1,042,643,850	-	-	1,042,643,850
Accounts payable and other	8,030,637	-	-	8,030,637
Accrued payroll and employee benefits and other	10,869,839	-	-	10,869,839
Total current liabilities	1,061,544,326	-	-	1,061,544,326
POSTEMPLOYMENT HEALTH CARE PLAN	24,565,000	-	-	24,565,000
NET PENSION LIABILITY	25,100,820	-	-	25,100,820
OTHER LONG-TERM LIABILITIES	100,000	-	-	100,000
Total liabilities	1,111,310,146	-	-	1,111,310,146
DEFERRED INFLOWS OF RESOURCES				
Net pension	1,028,380	-	-	1,028,380
Other postemployment benefit	2,301,000	-	-	2,301,000
Total deferred inflows of resources	3,329,380	-	-	3,329,380
NET POSITION				
Net investment in capital assets	50,637,437	-	-	50,637,437
Restricted by legislative authority	89,037,443	-	-	89,037,443
Unrestricted	621,961,731	2,843,139	-	624,804,870
Total net position	761,636,611	2,843,139	-	764,479,750
Total liabilities, deferred inflows of resources and net position	$ 1,876,276,137	$ 2,843,139	$ -	$ 1,879,119,276

DRAFT

Note 12 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2019, are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
OPERATING REVENUES				
Premium revenues	$ 3,474,634,375	$ -	$ -	$ 3,474,634,375
Total operating revenues	3,474,634,375	-	-	3,474,634,375
OPERATING EXPENSES				
Medical expenses				
Claims expense to providers and facilities	1,287,230,443	-	-	1,287,230,443
Provider capitation	1,094,332,595	-	-	1,094,332,595
Prescription drugs	445,721,355	-	-	445,721,355
OneCare Connect	293,947,460	-	-	293,947,460
Other medical	53,871,235	-	-	53,871,235
Pace	23,297,732	-	-	23,297,732
OneCare	18,272,703	-	-	18,272,703
Total medical expenses	3,216,673,523	-	-	3,216,673,523
Administrative expenses				
Salaries, wages and employee benefits	84,618,793	-	-	84,618,793
Supplies, occupancy, insurance and other	22,963,749	12,000	-	22,975,749
Purchased services	12,584,719	-	-	12,584,719
Depreciation	7,226,723	-	-	7,226,723
Professional fees	3,167,619	-	-	3,167,619
Total administrative expenses	130,561,603	12,000	-	130,573,603
Total operating expenses	3,347,235,126	12,000	-	3,347,247,126
Operating income (loss)	127,399,249	(12,000)	-	127,387,249
NON-OPERATING REVENUES				
Net investment income and other	43,640,102	35,771	-	43,675,873
Total non-operating revenues	43,640,102	35,771	-	43,675,873
Increase in net position	171,039,351	23,771	-	171,063,122
NET POSITION, beginning of year	761,636,611	2,843,139	-	764,479,750
Transfer of Foundation assets to CalOptima	2,866,910	(2,866,910)	-	-
NET POSITION, end of year	$ 935,542,872	$ -	$ -	$ 935,542,872

DRAFT

Note 12 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2018, are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
OPERATING REVENUES				
Premium revenues	$ 3,445,699,268	$ -	$ -	$ 3,445,699,268
Total operating revenues	3,445,699,268	-	-	3,445,699,268
OPERATING EXPENSES				
Medical expenses				
Provider capitation	1,068,367,719	-	-	1,068,367,719
Claim expense to providers and facilities	1,403,275,064	-	-	1,403,275,064
Prescription drugs	442,312,644	-	-	442,312,644
Other medical	42,215,978	-	-	42,215,978
OneCare Connect	302,761,410	-	-	302,761,410
OneCare	14,437,586	-	-	14,437,586
Pace	18,341,424	-	-	18,341,424
Total medical expenses	3,291,711,825	-	-	3,291,711,825
Administrative expenses				
Salaries, wages and employee benefits	85,386,751	-	-	85,386,751
Professional fees	2,430,578	-	-	2,430,578
Purchased services	11,460,353	-	-	11,460,353
Supplies, occupancy, insurance and other	25,045,349	25,000	-	25,070,349
Depreciation	7,499,203	-	-	7,499,203
Total administrative expenses	131,822,234	25,000	-	131,847,234
Total operating expenses	3,423,534,059	25,000	-	3,423,559,059
Operating income (loss)	22,165,209	(25,000)	-	22,140,209
NON-OPERATING REVENUES AND EXPENSES				
Net investment income and other	21,714,051	-	-	21,714,051
Rental income, net of related expenses	1,985,919	-	-	1,985,919
Total non-operating revenues and expenses	23,699,970	-	-	23,699,970
Increase in net position	45,865,179	(25,000)	-	45,840,179
NET POSITION, beginning of year	715,771,432	2,868,139	-	718,639,571
NET POSITION, end of year	$ 761,636,611	$ 2,843,139	$ -	$ 764,479,750

DRAFT

Note 12 – Consolidating Information (continued)

The consolidating statement of cash flows for the year ended June 30, 2019, is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,335,206,230	$ -	$ -	$ 3,335,206,230
Payment to providers and facilities	(3,180,342,695)	-	-	(3,180,342,695)
Payments to vendors	(61,176,697)	(12,000)	-	(61,188,697)
Payments to employees	(81,658,054)	-	-	(81,658,054)
Net cash provided by (used in) operating activities	12,028,784	(12,000)	-	12,016,784
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES				
Purchases of capital assets	(3,692,776)	-	-	(3,692,776)
Net cash used in capital and related financing activities	(3,692,776)	-	-	(3,692,776)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	49,351,468	35,771	-	49,387,239
Purchases of securities	(13,023,305,579)	-	-	(13,023,305,579)
Sales of securities	12,942,289,130	-	-	12,942,289,130
Net cash (used in) provided by investing activities	(31,664,981)	35,771	-	(31,629,210)
Net (decrease) increase in cash and cash equivalents	(23,328,973)	23,771	-	(23,305,202)
CASH AND CASH EQUIVALENTS, beginning of year	368,089,848	2,843,139	-	370,932,987
Transfer of Foundation assets to CalOptima	2,866,910	(2,866,910)	-	347,627,785
CASH AND CASH EQUIVALENTS, end of year	$ 347,627,785	$ -	$ -	$ 695,255,570

The consolidating statement of cash flows for the year ended June 30, 2018, is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,403,621,939	$ -	$ -	$ 3,403,621,939
Payments to providers and facilities	(3,941,938,764)	-	-	(3,941,938,764)
Payments to vendors	(45,296,595)	(50,000)	-	(45,346,595)
Payments to employees	(74,227,628)	-	-	(74,227,628)
Net cash used in operating activities	(657,841,048)	(50,000)	-	(657,891,048)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES				
Purchases of capital assets	(3,956,422)	-	-	(3,956,422)
Net cash used in capital and related financing activities	(3,956,422)	-	-	(3,956,422)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	28,891,325	-	-	28,891,325
Purchases of securities	(12,243,048,906)	-	-	(12,243,048,906)
Sales of securities	12,736,875,055	-	-	12,736,875,055
Net cash provided by investing activities	522,717,474	-	-	522,717,474
Net decrease in cash and cash equivalents	(139,079,996)	(50,000)	-	(139,129,996)
CASH AND CASH EQUIVALENTS, beginning of year	507,169,844	2,893,139	-	510,062,983
CASH AND CASH EQUIVALENTS, end of year	$ 368,089,848	$ 2,843,139	$ -	$ 370,932,987

DRAFT

Supplementary Information

DRAFT

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Changes in Net Pension Liability and Related Ratios

	June 30,				
	2019	2018	2017	2016	2015
Total Pension Liability					
Service Cost	$ 13,491,596	$ 13,118,795	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	10,431,464	9,136,725	7,702,198	6,620,025	5,661,111
Changes in Benefit Terms	-	-	-	-	-
Differences Between Expected and Actual Experience	(4,737,905)	9,163,547	102,384	1,444,808	-
Changes in Assumptions	2,812,748	632,642	-	(1,963,270)	-
Benefit Payments, Including Refunds of Employee Contributions	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Net Change in Total Pension Liability	19,249,204	29,983,353	15,965,410	12,788,080	10,798,852
Total Pension Liability - Beginning	142,448,307	112,464,954	96,499,544	83,711,464	72,912,613
Total Pension Liability - Ending	$ 161,697,511	$ 142,448,307	$ 112,464,954	$ 96,499,544	$ 83,711,465
Plan Fiduciary Net Position					
Contributions - Employer	$ 7,588,200	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions - Employee	6,213,420	5,793,911	4,951,820	4,142,126	3,385,296
Net Investment Income	10,225,467	11,496,425	498,498	1,913,380	12,062,654
Benefit Payments, Including Refunds of Employee Contrbutions	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Other Changes in Fiduciary Net Position	(530,428)	(143,264)	(54,828)	(101,246)	-
Net Change in Fiduciary Net Position	20,747,960	20,313,296	7,071,456	7,310,765	17,241,390
Plan Fiduciary Net Position - Beginning	117,347,487	97,034,191	89,962,735	82,651,970	65,410,580
Plan Fiduciary Net Position - Ending	$ 138,095,447	$ 117,347,487	$ 97,034,191	$ 89,962,735	$ 82,651,970
Plan Net Pension Liability - Ending	$ 23,602,064	$ 25,100,820	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan Fiduciary Net Position as Percentage of the Total Liability	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-Employee Payroll	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan Net Pension Liability as a Percentage of Covered Employee Payroll	27.52%	31.29%	22.50%	11.74%	2.59%

DRAFT

See accompanying report of independent auditors.

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Schedule of Plan Contributions

	Years Ended June 30,				
	2019	2018	2017	2016	2015
Actuarially Determined Contributions	$ 7,588,200	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contr butions in Relation To the Actuarially Determined Contribution	(7,588,200)	(5,234,580)	(3,787,544)	(3,033,171)	(3,119,804)
Contr bution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Covered-Employee Payroll	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Contr butions as a Percentage of Covered-Employee Payroll	8.85%	6.53%	5.52%	5.45%	7.62%

DRAFT

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Changes in Total OPEB Liability and Related Ratios

	2018-2019 (Measurement Period 2017-2018)	2017-2018 (Measurement Period 2016-2017)
Changes in Total OPEB Liability		
Service cost	$ 867,000	$ 1,012,000
Interest	900,000	770,000
Benefit changes	-	-
Actual vs. expected experience	-	-
Assumption changes	(1,067,000)	(2,923,000)
Benefit payments	(560,000)	(572,000)
Net changes	140,000	(1,713,000)
Total OPEB Liability (beginning of year)	24,565,000	26,278,000
Total OPEB Liability (end of year)	$ 24,705,000	$ 24,565,000
Total OPEB Liability	$ 24,705,000	$ 24,565,000
Covered employee payroll	8,150,000	9,135,000
Total OPEB Liability as a percentage of covered employee payroll	303.1%	268.9%

DRAFT

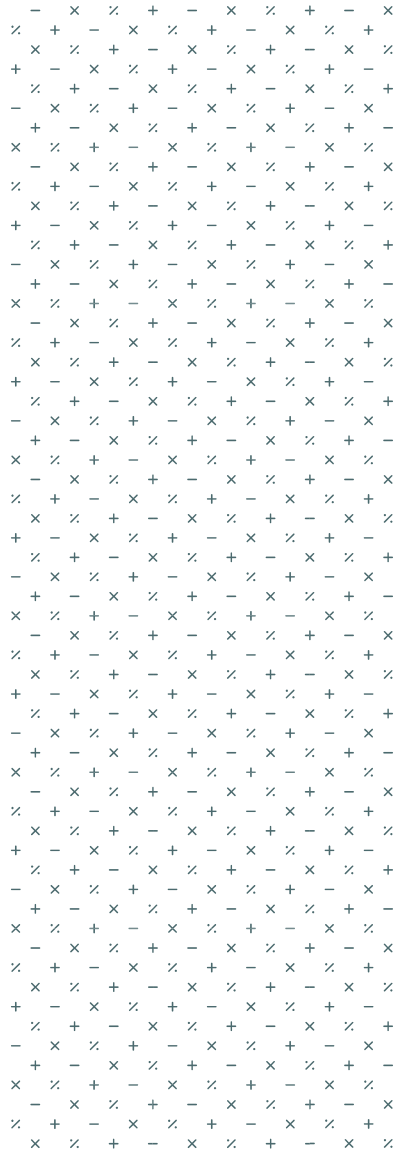
See accompanying report of independent auditors.

Back to Agenda

MOSSADAMS

2019 Audit Results: CalOptima

October 3, 2019



Back to Agenda

Board of Directors

CalOptima

Dear Board of Directors (the “Board”) Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the consolidated financial statements of CalOptima (“the Organization”) for the year ended June 30, 2019.

The accompanying report, which is intended solely for the use of the Board and management, presents important information regarding CalOptima’s consolidated financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We conducted our audit with the objectivity and independence that you expect. We received the full support and assistance of the Organization’s personnel. We are pleased to serve and be associated with the Organization as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Back to Agenda

Agenda

- Auditor Opinions and Reports
- Communication with the Board of Directors
- Other Information

Back to Agenda

MOSSADAMS

Auditor Opinions & Reports

Better Together: Moss Adams & CalOptima

Back to Agenda

Scope of Services

We have performed the following services for CalOptima:

- Annual consolidated financial statement audit as of and for the year ended June 30, 2019

We have also performed the following nonattest services:

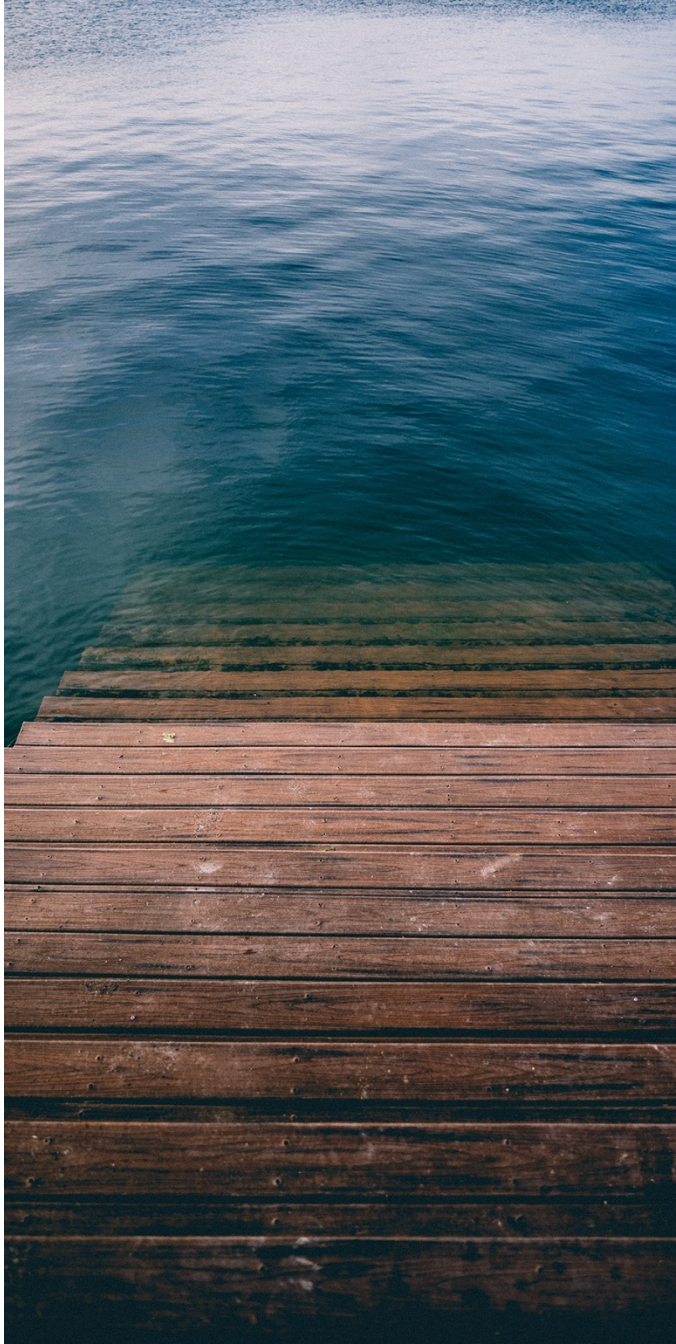
- Assisted in the drafting the consolidated financial statements of CalOptima, excluding Management's Discussion and Analysis
- Assisted in the drafting of the financial statements of the Foundation, excluding Management's Discussion and Analysis
- Assisted in the completion of the Organization portion of the Data Collection Form

Back to Agenda

Auditor Report on the Consolidated Financial Statements

Unmodified Opinion

- Consolidated financial statements are presented fairly and in accordance with U.S. Generally Accepted Accounting Principles (GAAP)



Back to Agenda

Other Auditor Reports

GAGAS Report on ***Internal Control Over Financial Reporting*** and on ***Compliance*** and ***Other Matters***

- No financial reporting findings reported
- No compliance findings reported

Report on Compliance with Requirements that could have a ***Direct and Material Effect on Each Major Federal Program*** and on ***Internal Control Over Compliance*** required by the ***Uniform Guidance***

- No control findings reported
- No compliance findings reported

Back to Agenda

MOSSADAMS

Communication with the Board

Better Together: Moss Adams & CalOptima

Back to Agenda

COMMUNICATION WITH THE BOARD OF DIRECTORS

Our Responsibility

Our responsibility under U.S. Generally Accepted Auditing Standards and Government Auditing Standards.

1	2	3	4
To express our opinion on whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the AICPA and Government Auditing Standards issued by the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.	To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Agenda

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing, and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with the Board an overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to the FAC at the audit entrance meeting on May 16, 2019.

Back to Agenda

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the Board is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the Board is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Organization are described in the footnotes to the consolidated financial statements. Throughout the course of an audit, we reviewed changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2019.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Back to Agenda

Management Judgements & Accounting Estimates

The Board should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We applied audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the consolidated financial statements.
- Significant management estimates impacted the consolidated financial statements, including the following: **fair value of investments; fixed asset lives; actuarially determined accruals for incurred but not reported (IBNR) medical claims liabilities, other non-IBNR medical liabilities; and pension, and other post-employment liabilities.**
- We deem them to be reasonable.

Back to Agenda

COMMUNICATION WITH THE BOARD OF DIRECTORS

Areas of Audit Emphasis

- Medical Claims Liability and Claims Expense
- Capitation Revenue and Receivables
- Amounts due to the state of California or DHCS
- Pension liability
- Other Postemployment Benefits (OPEB) liability

Back to Agenda

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the consolidated financial statements were clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:
  - Note 2 – Summary of Significant Accounting Policies
  - Note 3 – Cash and Investments
  - Note 5 – Medical Claims Liability
  - Note 6 – Defined Benefit Pension Plan
  - Note 8 – Postemployment Health Care Plan

Back to Agenda

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The Board should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the Organization's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future consolidated financial statements to be materially misstated.

The Board should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the consolidated financial statements as a whole.

OUR COMMENTS

There were no corrected or uncorrected audit adjustments.

Back to Agenda

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the Board.

OUR COMMENTS

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

Back to Agenda

Potential Effect on the Consolidated Financial Statements of Any Significant Risks & Exposures

The Board should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the consolidated financial statements.

OUR COMMENTS

- CalOptima is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the consolidated financial statements.

Back to Agenda

Difficulties Encountered in Performing the Audit

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Organization's consolidated financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

Back to Agenda

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the Board.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the consolidated financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention.
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Back to Agenda

Other Material Written Communications

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Organization's consolidated financial statements, or the auditor's report.

OUR COMMENTS

- We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.
- Other than the management representation letter and communication to those charged with governance, there have been no other significant communications.

Back to Agenda

Management's Consultation with Other Accountants

In some cases, management may decide to consult other accountants about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the Organization's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant the facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

Back to Agenda

Stacy Stelzriede, Partner
Stacy.Stelzriede@mossadams.com
(310) 295-3772

Aparna Venkateswaran, Senior Manager
Aparna.Venkateswarn@mossadams.com
(949) 517-9473

THANK YOU

Back to Agenda

CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Meeting of the CalOptima Foundation Board of Directors

Report Item

11. Consider Accepting and Receiving and Filing the Fiscal Year 2019 CalOptima Foundation Audited Financial Statements

Contact

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

Recommended Action

Recommend accepting and receiving and filing the Fiscal Year (FY) 2019 CalOptima Foundation audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Background

CalOptima has contracted with financial auditors Moss-Adams, LLP since May 21, 2015, to complete the CalOptima Foundation's annual financial audit. At the May 16, 2019, meeting of the CalOptima Foundation Board of Directors' Audit Committee, Moss-Adams presented the 2019 Audit Plan. The plan included performing the mandatory annual consolidated financial statement audit and drafting the consolidated financial statements for the year ending June 30, 2019.

On December 6, 2018, the CalOptima Foundation Board of Directors approved the dissolution of CalOptima Foundation.

Discussion

Moss-Adams performed the interim audit from May 20, 2019, through May 24, 2019, and the year-end on-site audit from July 22, 2019, through August 9, 2019.

Results from the CalOptima Foundation's FY 2019 Audit were positive. The auditor made no changes in the Foundation's approach to applying the critical accounting policies, nor did they report having encountered any significant difficulties during the audit. Additionally, there were no material misstatements identified by the auditor. As such, Management recommends that the Foundation Board to accept the CalOptima Foundation FY 2019 audited financial statements, as presented.

Fiscal Impact

There is no fiscal impact related to this recommended action.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel
CalOptima Foundation Audit Committee

Attachments
FY 2019 CalOptima Foundation Audited Financial Statements
Presentation by Moss Adams, LLP

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

REPORT OF INDEPENDENT AUDITORS AND
FINANCIAL STATEMENTS

CALOPTIMA FOUNDATION

June 30, 2019 and 2018

DRAFT

Back to Agenda

Table of Contents

DRAFT

Back to Agenda

Introduction

CalOptima Foundation (the "Foundation") is a not-for-profit organization and foundation established by Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") in June 2010. It was formed for the benefit of CalOptima members and others in the Orange County community. One of the primary objectives for the Foundation is to take advantage of health-related programs and funding opportunities that are not available to governmental entities.

The Foundation was incorporated in 2010 and was awarded the HITECH grant to support the implementation of electronic health record systems in provider offices. This grant brought in revenues in excess of $6.6 million, with the majority of funding completed in fiscal year 2015. Separate and apart from the Foundation, CalOptima applied for and was awarded a $4.3 million CalOptima Technical Assistance Program (COTAP) state grant, which did not require a 501(c)(3) nonprofit charitable organization to apply for the funds. CalOptima's Board of Directors approved the dissolution of the Foundation in the current 2019 fiscal year since the original HITECH grant that prompted the Foundation's establishment has been completed and since research demonstrated that most Medi-Cal health plans conduct community health benefit activities, such as grant making, directly from the plan, and do not have a separate foundation. As a result of the dissolution, the assets of the Foundation were transferred from the Foundation to CalOptima.

The following discussion and analysis of the Foundation's financial statements presents an overview of the financial position and activities as of June 30, 2019 and 2018. This discussion has been prepared by management and should be read in conjunction with the accompanying financial statements and related notes.

Using the Financial Statements

The Foundation's annual report contains three financial statements: the statement of net position; the statement of revenues, expenses, and changes in net position; and the statement of cash flows. The report was prepared using the accrual basis of accounting. These statements provide information on the Foundation as a whole and present the Foundation's financial position and results of operations. In the opinion of management, the financial statements represent accurately the financial situation of the Foundation as of June 30, 2019 and 2018. The various components of the financial statements document financial position of the Foundation and its ability to meet its financial obligations as they come due.

Financial Highlights

The total assets and liabilities as of June 30, 2019 and 2018, were $0 and $2,843,139, respectively. Total assets of $2,866,910 were transferred from the Foundation to CalOptima during the year ended June 30, 2019.

DRAFT

Statements of Net Position

The statements of net position are point-in-time financial statements. The purpose of these statements is to present a fiscal snapshot of the Foundation to the readers of the financial statements at June 30, 2019 and 2018. The statements of net position include year-end information concerning current and noncurrent assets, current and noncurrent liabilities, and net position (assets less liabilities). Current assets and liabilities include other assets and obligations that can reasonably expect to be sold, collected, consumed, or paid within 12 months of the date of the statement. The statements also present the available assets that can be used to satisfy those liabilities.

The following table summarizes the Foundation's assets, liabilities, and net position as of June 30, 2019 and June 30, 2018:

	2019	2018
Current assets	$ -	$ 2,843,139
Total assets	$ -	$ 2,843,139
Current liabilities	$ -	$ -
Net position	-	2,843,139
Total liabilities and net position	$ -	$ 2,843,139

Statements of Revenues, Expenses, and Changes in Net Position

Changes in net position as presented on the statements of net position are based on the activity presented in the statements of revenues, expenses, and changes in net position. The purpose of the statements is to present the revenue earned by the Foundation, both operating and nonoperating, and the expenses incurred by the Foundation, both operating and nonoperating, and any other revenues, expenses, gains, and losses earned or incurred by the Foundation.

DRAFT

Statements of Revenues, Expenses, and Changes in Net Position (continued)

The following table summarizes the Foundation's revenues, expenses, and changes in net position for the years ended June 30:

	2019	2018	2017
Revenues:			
Operating revenues			
Grant revenue	$ -	$ -	$ 27,164
Contributions	-	-	53,665
Total revenues	-	-	80,829
Operating expenses	12,000	25,000	107,535
Non-operating revenues			
Investment income	35,771	-	-
Total non-operating revenues	35,771	-	-
Change in net position	23,771	(25,000)	(26,706)
Net position:			
Beginning	2,843,139	2,868,139	2,894,845
Transfer of Foundation assets to Orange County Health Authority	(2,866,910)	-	-
Ending	$ -	$ 2,843,139	$ 2,868,139

Operating revenues – For the years ended June 30, 2019, 2018, and 2017, operating revenues totaled $0, $0, and $80,829, respectively. The revenues are from HITECH grant activities and contributions from CalOptima. CalOptima provided $0, $0, and $53,665, respectively, of staff services that are recognized as non-exchange transactions for the years ended June 30, 2019, 2018, and 2017.

Operating expenses – For the years ended June 30, 2019, 2018, and 2017, operating expenses totaled $12,000, $25,000, and $107,535, respectively.

Non-Operating Revenues – For the years ended June 30, 2019, 2018, and 2017, non-operating revenues totaled $35,771, $0, and $0, respectively.

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Foundation's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the request to CalOptima Foundation, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

DRAFT

Report of Independent Auditors

The Board of Directors
CalOptima Foundation

Report on the Financial Statements

We have audited the accompanying statements of net position of CalOptima Foundation (the "Foundation"), a component unit of the Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima"), as of June 30, 2019 and 2018, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements, which collectively comprise the Foundation's basic financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

DRAFT

Back to Agenda

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Foundation as of June 30, 2019 and 2018, and the respective changes in financial position and cash flows thereof for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 1 to the financial statements, the Foundation was dissolved during the year ended June 30, 2019 and all assets were transferred to CalOptima. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 3 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Irvine, California
[DATE]

DRAFT

Back to Agenda

CalOptima Foundation
Statements of Net Position

ASSETS

	June 30, 2019	June 30, 2018
CURRENT ASSETS		
Cash	$ -	$ 2,843,139
Total assets	$ -	$ 2,843,139
LIABILITIES AND NET POSITION		
UNRESTRICTED NET POSITION	$ -	$ 2,843,139
Total liabilities and net position	$ -	$ 2,843,139

DRAFT

See accompanying notes.

Back to Agenda

CalOptima Foundation
Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30, 2019	2018
OPERATING REVENUES		
Grant revenue	$ -	$ -
Total operating revenues	-	-
OPERATING EXPENSES		
Supplies and other	12,000	25,000
Total operating expenses	12,000	25,000
Operating loss	(12,000)	(25,000)
NON-OPERATING REVENUES		
Investment income	35,771	-
Total nonoperating revenues	35,771	-
Change in net position	23,771	(25,000)
NET POSITION		
Beginning	2,843,139	2,868,139
Transfer of Foundation assets to Orange County Health Authority	(2,866,910)	-
Ending	$ -	$ 2,843,139

DRAFT

See accompanying notes.

Back to Agenda

CalOptima Foundation
Statements of Cash Flows

	Years Ended June 30, 2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments to vendors	(12,000)	(50,000)
Net cash used in operating activities	(12,000)	(50,000)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Transfer of Foundation assets to Orange County Health Authority	(2,866,910)	-
Net cash provided by noncapital financing activities	(2,866,910)	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	35,771	-
Net cash provided by investing activities	35,771	-
Net change in cash	(2,843,139)	(50,000)
CASH		
Beginning	2,843,139	2,893,139
Ending	$ -	$ 2,843,139
RECONCILIATION OF OPERATING LOSS TO NET CASH USED IN OPERATING ACTIVITIES		
Operating loss	$ (12,000)	$ (25,000)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Changes in assets and liabilities		
Payable to CalOptima	-	(25,000)
Net cash used in operating activities	$ (12,000)	$ (50,000)

DRAFT

See accompanying notes.

Back to Agenda

Note 1 – Nature of Operations, Reporting Entity, and Significant Accounting Policies

Nature of operations – CalOptima Foundation (the "Foundation") is a nonprofit organization formed in June 2010 in the state of California. The operations of the Foundation include, but are not limited to, applying for and administering grants dedicated to the betterment of public health care services. The Foundation is organized and operated exclusively to benefit Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") program needs. During the year ended June 30, 2019, CalOptima's Board of Directors approved the dissolution of the Foundation and all assets were transferred to CalOptima.

Reporting entity – The Foundation has no component units, but is a component unit of CalOptima because the Foundation's governing body is the same as the governing body of CalOptima. The financial statements present only the Foundation, and do not purport to, and do not present, the financial position of CalOptima as of June 30, 2019 and 2018, or the changes in its financial position, or its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Basis of accounting – The financial statements of the Foundation have been prepared using the economic resource management focus and the accrual basis of accounting. Revenues are recognized when earned, and expenses and liabilities are recognized when incurred.

The Foundation considers grant revenues earned as operating revenue. Expenses associated with managing the grant and the Foundation are considered operating expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Net position – Net position represents the difference between assets and liabilities. Net position is reported as restricted if there are limitations imposed on their use. When an expense is incurred for purposes for which both restricted and unrestricted net positions are available, the Foundation first applies restricted resources. The Foundation had no restricted net position at June 30, 2019 or 2018.

Revenue recognition – Grant revenue and contributions are recorded as earned over the period covered in accordance with the grant provisions.

Income tax status – The Internal Revenue Service has recognized the Foundation as exempt from federal and state income tax on related income under Section 501(c)(3) of the Internal Revenue Code. The Foundation is not classified as a private foundation. The Foundation has reviewed its tax positions for all open tax years and has concluded that no liabilities exist as of June 30, 2019 and 2018. The Foundation files tax returns with the U.S. federal and the State of California jurisdictions.

Note 2 – Cash and Custodial Credit Risk

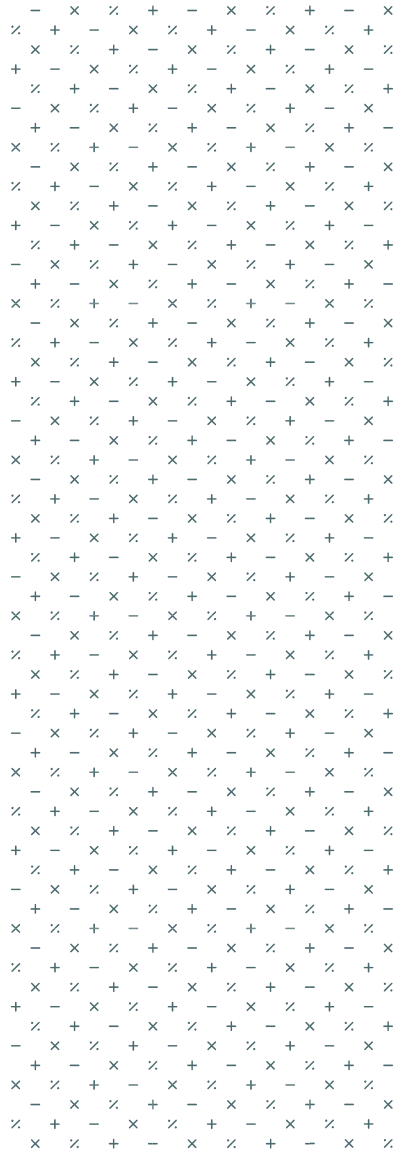
As of June 30, 2018, all cash deposits held with financial institutions were insured by the Federal Deposit Insurance Corporation and through securities pledged by the financial institutions held in an individual collateral pool by a depository regulated under California state law. As of June 30, 2019, all assets of the Foundation had been transferred to CalOptima (See Note 1).

DRAFT

MOSSADAMS

2019 Audit Results: CalOptima Foundation

October 3, 2019



Back to Agenda

Audit Committee

CalOptima Foundation

Dear Board of Directors (the “Board”) Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of CalOptima Foundation (“the Foundation”) for the year ended June 30, 2019.

The accompanying report, which is intended solely for the use of the Board and management, presents important information regarding the Foundation’s financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We conducted our audit with the objectivity and independence that you expect. We received the full support and assistance of the Foundation’s personnel. We are pleased to serve and be associated with the Foundation as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Back to Agenda

Agenda

- Auditor Opinion and Report
- Communication with the Board of Directors
- Other Information

Back to Agenda

MOSSADAMS

Auditor Opinion & Report

Better Together: Moss Adams & CalOptima Foundation

Back to Agenda

Scope of Services

We have performed the following services for the CalOptima Foundation:

- Annual financial statement audit as of and for the year ended June 30, 2019

We have also performed the following nonattest services:

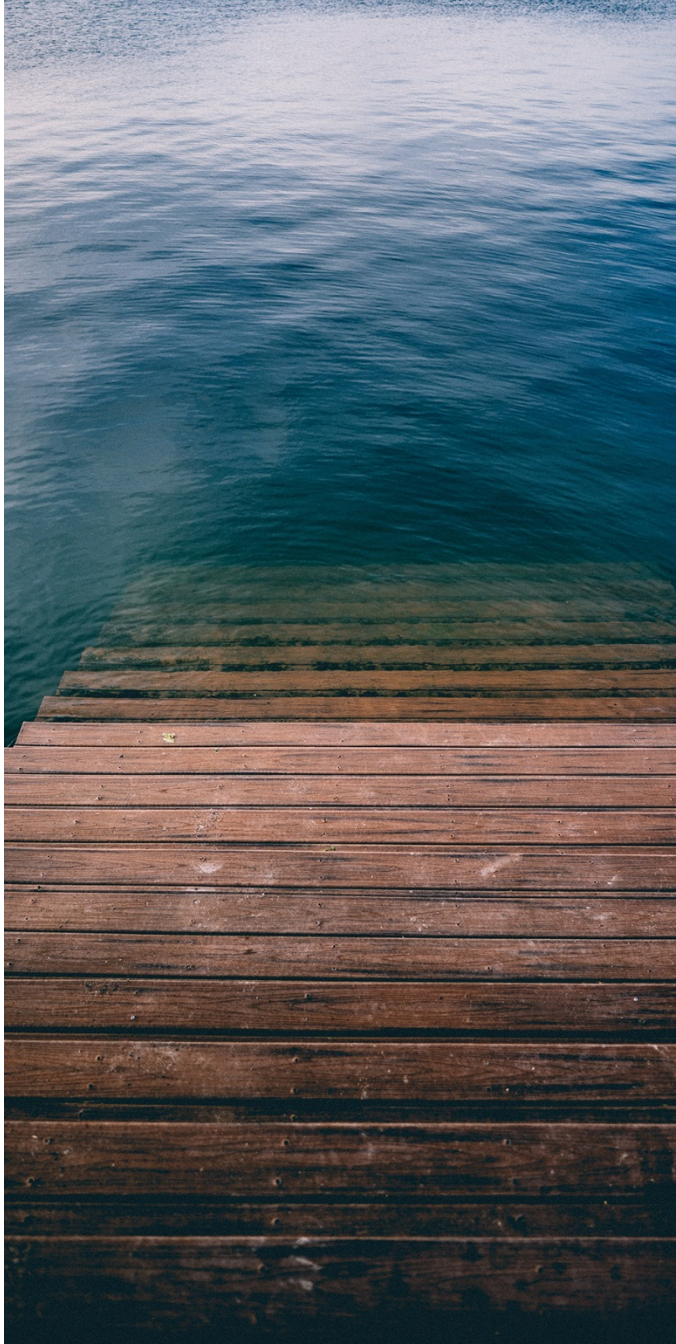
- Assisted in the drafting of the financial statements of the Foundation, excluding Management's Discussion and Analysis

Back to Agenda

Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with U.S. Generally Accepted Accounting Principles (GAAP)
- Emphasis of a Matter Paragraph – Dissolution of Foundation and transfer of assets to CalOptima



Back to Agenda

MOSSADAMS

Communication with the Board

Better Together: Moss Adams & CalOptima Foundation

Back to Agenda

COMMUNICATION WITH THE BOARD

Our Responsibility

Our responsibility under U.S. Generally Accepted Auditing Standards.

1	2	3	4
To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.	To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Agenda

COMMUNICATION WITH THE BOARD

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing, and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with the Board an overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to the Foundation Audit Committee at the audit entrance meeting on May 16, 2019.

Back to Agenda

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the audit committee is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the audit committee is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Foundation are described in the footnotes to the financial statements. Throughout the course of an audit, we reviewed changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2019.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Back to Agenda

Management Judgements & Accounting Estimates

The audit committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We applied audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.
- No significant estimates noted.

Back to Agenda

COMMUNICATION WITH THE BOARD

Areas of Audit Emphasis

- Cash
- Dissolution of CalOptima Foundation

Back to Agenda

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the financial statements were clear and consistent. Certain financial statement disclosures were particularly sensitive because of their significance to financial statements users. We call your attention to the following note:
  - Note 1 – Nature of Operations, Reporting Entity and Significant Accounting Policies

Back to Agenda

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The Board should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the Foundation's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future financial statements to be materially misstated.

The Board should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the financial statements as a whole.

OUR COMMENTS

There were no corrected or uncorrected audit adjustments.

Back to Agenda

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the Board.

OUR COMMENTS

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

Back to Agenda

Potential Effect on the Financial Statements of Any Significant Risks & Exposures

The Board should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the financial statements.

OUR COMMENTS

- The Foundation is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Back to Agenda

Difficulties Encountered in Performing the Audit

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Foundation's financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

Back to Agenda

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the Board.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention.
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Back to Agenda

Other Material Written Communications

The Board should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Foundation's financial statements, or the auditor's report.

OUR COMMENTS

- We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.
- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

Back to Agenda

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the Foundation's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

Back to Agenda

Stacy Stelzriede, Partner
Stacy.Stelzriede@mossadams.com
(310) 295-3772

Aparna Venkateswaran, Senior Manager
Aparna.Venkateswarn@mossadams.com
(949) 517-9473

THANK YOU

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services

Contact

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

Recommended Actions

1. Award IGT 5 funds in the amount of up to ~~$1 million~~ $500,000 to Coalition of Orange County Community Health Centers and up to $500,000 to Healthy Smiles for Kids of Orange County ~~for a~~ for community ~~grant(s)~~ grants for Access to Children's Dental Services; and
2. Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant ~~contract(s)~~ contracts with the selected community ~~grantee(s)~~ grantees.

Rev. 10/3/19

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 its April 7, 2016 meeting, the CalOptima Board of Directors approved priority areas for IGT 5 to guide CalOptima's community support, including the priority area "Strengthening the Safety Net." To gain greater awareness of the unique healthcare needs of CalOptima members, the Board authorized staff to contract with a vendor to conduct a Member Health Needs Assessment in December 2016. The health needs assessment was completed in February 2018, and in June 2018, the Board authorized release of eight Requests for Information (RFI) to help inform development of scopes of work for Requests for Proposals (RFP) under IGT 5, including an RFP related to Children's Dental Services. In July 2018, 93 RFI responses were received. At its December 6, 2018 meeting, the Board approved a prepayment of $11.4 million for services to be provided to CalOptima members at the Be Well Wellness Hub, and the release of three RFPs, including one involving up to $1 million to support Access to Children's Dental Services within the Strengthening the Safety Net priority area.

Five responses to the Access to Children's Dental Services RFP were received, and an external subject matter expert and staff evaluated and scored the responses. These results were shared with the IGT 5 Board Ad Hoc Committee comprised of Vice Chair Khatibi and Director Nguyen. On July 23, 2019, this Ad Hoc Committee met to consider the RFP responses. Following the review of the evaluation results and the site visit comments, the Ad Hoc Committee recommended that $1 million be awarded to Healthy Smiles for Kids of Orange County. On August 1, 2019, the Board considered the Ad Hoc Committee's recommendation and deferred action, directing staff to return to the full Board with additional information. The item was then agendized and subsequently continued from the agenda for the September 5, 2019 Board meeting.

Discussion

During the August 1, 2019 meeting, the Board directed staff to provide additional information on the RFP development and evaluation process, as well as the findings of the evaluation and final scores of the proposals submitted in response to the Access to Children's Dental Services RFP.

RFP Development

The Access to Children's Dental Services Scope of Work (attached) was based on responses to the RFIs received in July 2018 and required applicants to address the following topics in their proposals:

- 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 services in addition to exams and screenings as needed; and,
- Include integration with medical care for early childhood through referral for well-check visits.

RFP Evaluation Process

The RFP evaluations were based on an Evaluation Matrix (attached) including the weighted categories below:

- Organization Information (10%)
- Project Information (55%)
  - Statement of Need (5%)
  - Project Description (20%)
  - Evidence Supporting Approach (5%)
  - Outreach and Education (10%)
  - Sustainability Plan (5%)
  - Population Served (10%)
- Project Staffing (10%)
- Project Budget (10%)
- Work Plan information (15%)

Listed below are the two highest rated RFP responders along with their scores based on evaluation of their respective written RFP responses.

	Evaluation Criteria										
	Organization	Statement	Description	Evidence	Outreach	Sustainability	Population	Staffing	Budget	Workplan	Grand Total
Coalition of Orange County Community Health Centers											
Score	15	15	15	14	15	14	14	13	15	15	145
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.5	0.75	3	0.7	1.5	0.7	1.4	1.3	1.5	2.25	4.87
Healthy Smiles for Kids of Orange County											
Score	14	15	14	13	13	11	15	15	14	14	138
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.4	0.75	2.8	0.65	1.3	0.55	1.5	1.5	1.4	2.1	4.65

Some highlights from their applications are summarized below.

	Coalition of Orange County Community Health Centers (Coalition)	Healthy Smiles for Kids of Orange County (Healthy Smiles)
Title	Mouths Matter: Establishing a Dental Home for All Children	Full Cycle Dentistry
Requested Amount	$1 million	$1 million
Score	4.87	4.65
Description	• Will establish a new mobile unit to be shared by five community health clinics ○ Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People, and Southland Integrated Services • Adds a new provider for dental services, as one of these clinics does not provide dental services	• Enhances four mobile units and a mini clinic to ramp-up restorative care (e.g., staff, equipment, supplies, outreach and engagement materials) • Will increase access to preventive and restorative care • Have provided dental services to children in Orange County through clinics and school-based programs since 2003 • Expects to collaborate with 11 school districts

	○ The other four clinics provide pediatric dental services at their fixed sites • Expects to collaborate with six school districts	
Use of Funds (examples)	• Purchase and equipping mobile unit • Consulting (coordinating with clinics for HRSA change in scope/licensing and curriculum development) • Staff • Supplies (e.g., dental, oral hygiene kits)	• Restorative and portable equipment expansion • Recruitment and training for 20 new clinical positions, as well as portion (less than 20%) salary and other costs • Service fees (contract reviews and move costs for mini clinic) • Supplies for mobile units, mini clinic, staff, outreach materials
Term and Population Served	• During the three-year term: Will serve additional 9,000 CalOptima members ○ First year focusing on infrastructure development (e.g., acquisition of three chair mobile unit, staffing, etc. ○ Services delivery begins in Year 2	• During the one-year term: Will serve 13,500 additional CalOptima members ○ Impact begins immediately upon funding with service delivery begins within three-months

After the evaluations of the written RFP responses were scored and discussed by the RFP review team, site visits were conducted by staff with the top two scoring RFP responders. During the site visits, the applicants had the opportunity to respond to additional questions and share further details on their submitted proposals. Areas for discussion include the following:

- The RFP responding organization's understanding of the project and impact, as well as consistency to its mission and fit with current services provided;
- The RFP responder's leadership capacity and skills to effectively provide the proposed services and address foreseeable challenges;
- Whether services may be duplicative or complementary of those provided by others and opportunities for collaboration; and,
- Any other concerns with, or benefits of awarding, a grant to the organization.

Following the site visit with the Coalition of Orange County Community Clinics, it was noted that the collaborating clinics are very passionate about their work; in addition to the required build out of the mobile unit itself, one of the clinics did not have a dental practice within its fixed site to leverage and, thus, would have to establish a dental practice. Additionally, the grant program implementation was not

entirely clear. Following the site visit with Healthy Smiles for Kids of Orange County, it was noted that the grant would augment an existing program within an established organizational structure; the presentation demonstrated that project goals and objectives were well understood. RFP responses were not rescored after the site visits.

Request for Proposal Evaluation Process – Ad Hoc Review

The IGT 5 Board Ad Hoc discussed the two highest scoring written proposals: Coalition of Orange County Community Health Centers and Healthy Smiles for Kids of Orange County, and considered information from the written proposals, scoring results and site visits. Both organizations submitted strong proposals, with the Coalition being more focused on acquisition of a mobile unit, services and outreach, and Healthy Smiles being more focused on enhancing the current delivery system by ramping up of mobile restorative services e.g., through acquisition of restorative equipment, portable equipment and supplies, and recruitment of new clinicians.

Information considered by the Ad Hoc Committee included whether the respective proposed approaches would expand an established program or add a new program, ramp-up time for services to start and completion time, access and outreach through school districts and other community partners, and new members expected to be served during and beyond the term of the grant.

The Ad Hoc Committee also considered options to split the grant award. At the Ad Hoc's direction, Staff reached out to the two organizations with the highest scoring applications to obtain their feedback related to use of funds if 100% of their proposed grant funding amounts were not awarded, and if they were instead offered 75%, 50%, or 25% of their proposed funding levels. Based on feedback from these two applicants, splitting the amount did not appear to be a viable option. Subsequently, based on the Board's direction, staff again reached out to the applicants following the August 1, 2019 Board meeting to ask them to confirm their ability to accept a smaller grant award amount. Each applicant expressed scalability:

- *Coalition of Orange County Community Clinics*: Two clinics participating in the collaborative have recently acquired additional funding commitment to support purchase and equipping two three-chair mobile clinics. As a result, the initial proposed funding amount could be significantly reduced, ramp up time would be reduced to five months, with the Coalition still achieving the deliverables included in its RFP response (e.g., number of schools engaged, outreach conducted, members served).

- *Healthy Smiles for Kids of Orange County:* In the event the award amount is reduced, the number of children served would be reduced proportionately, for example, 50% award, half of the 13,500 children would be served, while otherwise meeting all deliverables. Services would begin immediately upon receipt of grant funding.

Previous Awards
Below is information about prior IGT awards to the two highest scoring RFP responders:

- *Coalition of Orange County Community Clinics*: Prior to IGT 6/7, had not previously received a grant. The Board awarded $6,000,000 for Medication Assisted Treatment under IGT 6/7 to the Coalition on August 1, 2019; contracting is in progress and the funds have not yet been released.

- *Healthy Smiles for Kids of Orange County*: Previously received a grant under IGT 2 for $400,000 in June 2015 to use two mobile units (one then recently acquired) to expand school-based dental service from 36 to 50 schools including dental screenings, education and preventive care. Activities included developing proposals and enlisting support of school principals and nurses to attain school district approval, developing proposals for school boards, identifying target schools, educating school principals, nurses, teachers and parents, professional and administrative staff, and supplies for a recently acquired mobile unit. The final report on this grant reflecting the objectives, activities, evaluation indicators and timeline was submitted on June 20, 2017 reflecting that by the end of the first year, 56 new sites had been added (some lower volume schools were removed from the program). Total screenings and sealants per year prior to the grant term were 8-10,000 and 3,000 respectively; during the two-year grant term, nearly 30,000 students were screened and more than 31,000 sealants applied.

Fiscal Impact
The recommended action to award up to $1 million in grant funding from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT 5 funds are accounted for separately. Expenditure of IGT 5 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 of working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, continues to work with our provider and community partners to address the health needs of Orange County Medi-Cal beneficiaries, filling in gaps and working to improve the availability, access and quality of health care services CalOptima members receive.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Covered Entities
2. PowerPoint Presentation: IGT 5 Community Grant Award Consideration: Children's Dental.
3. Scope of Work IGT 5 RFP 1 Children's Dental
4. Evaluation Matrix
5. 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)
6. 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
7. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards Community Grants
8. Healthy Smiles for Kids of Orange County Final Report dated June 30, 2017 with referenced spreadsheet
9. IGT 5 Community Grant Application Summary Ad Hoc Top 2 Proposals

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment 1 to October 3, 2019 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Coalition of Orange County Community Health Centers	515 N. Cabrillo Park Dr. Ste. 225	Santa Ana	CA	92701
Healthy Smiles for Kids of Orange County	10602 Chapman Ave., Ste. 200	Garden Grove	CA	92840
	2010 E. Fourth Street, Ste. A220	Santa Ana	CA	92705
Kha Dang Le Dental Corporation	2121 East Coast Hwy, # 220	Corona Del Mar	CA	92625
	146 S Main St Ste M	Orange	CA	92868
	9900 McFadden Ave, Ste 101	Westminster	CA	92683
Vista Community Clinic	1000 Vale Terrace Drive	Vista	CA	92084
	201 S Harbor Blvd	La Habra	CA	90631

IGT 5 Community Grant Award Consideration: Children's Dental Services

Board of Directors Meeting

October 3, 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

IGT 5 Background

- April 2016: Board approved five priority areas
- December 2016: Authorized Member Health Needs Assessment
  - February 2018: Assessment completed
- June 2018: Released Requests for Information (RFI)
  - July 2018: Received 93 RFI responses
- December 2018: Board approved $11.4 million for Be Well Wellness Hub and the release of three RFPs
  - Access to Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Access to Adult Dental Services
- February 2019: Received 20 RFP responses
- August 2019: Awarded grants for Primary Care Services and Programs Addressing Social Determinants of Health, and Access to Adult Dental Services, and deferred the grant for Access to Children's Dental Services

Children's Dental Services: Scope of Work

- 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 services in addition to exams and screenings as needed
- Include integration with medical care for early childhood through referral for well-check visits

RFP Evaluation Process: Scoring

- Review RFP proposals based on set criteria
  - Organization Information (10%)
  - Project Information (55%)
    - Statement of Need (5%)
    - Project Description (20%)
    - Evidence Supporting Approach (5%)
    - Outreach and Education (10%)
    - Sustainability Plan (5%)
    - Population Served (10%)
  - Project Staffing (10%)
  - Project Budget (10%)
  - Work Plan Information (15%)

RFP Evaluation Process: Site Visit

- Purpose of a site visit is to augment the quantitative evaluation of written proposals with qualitative information
  - Better understand the organization and its current programs
  - Learn more about the proposed project and how it fits with the organization's mission
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
- Site visits conducted with top two applicants
- Observations from site visits included in staff report

Proposal Descriptions

- Coalition of Orange County Community Health Centers (COCCC)
  - Establish a new mobile unit to serve five community health centers
    - Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People and Southland Integrated Services
  - Support a new provider of dental services
    - Four of the five centers currently have dental clinics, and this proposal will support the fifth so all can provide preventive and restorative services
- Healthy Smiles for Kids of Orange County (Healthy Smiles)
  - Enhance four mobile units and a mini clinic to ramp up restorative care (e.g., staff, equipment, supplies, outreach and engagement)
  - Increase access to preventive and restorative care

Top Applicants' Evaluation Scores

	Evaluation Criteria										
	Organization	Statement	Description	Evidence	Outreach	Sustainability	Population	Staffing	Budget	Workplan	Grand Total
Coalition of Orange County Community Health Centers											
Score											145
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.5	0.75	3	0.7	1.5	0.7	1.4	1.3	1.5	2.25	4.87
Healthy Smiles for Kids of Orange County											
Score											138
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.4	0.75	2.8	0.65	1.3	0.55	1.5	1.5	1.4	2.1	4.65

Key Considerations

- Ramp-up time for service delivery
  - COCCC: One year of capacity building
  - Healthy Smiles: Immediate expansion of current program
- Number of children served during grant term
  - COCCC: 9,000 children via 6 school districts and other partners
  - Healthy Smiles: 13,500 children via 11 school districts and other partners
- Sustainability plan
  - COCCC: Services are sustainable through reimbursement since all participating health centers are FQHCs or FQHC Look-Alikes
  - Healthy Smiles: Advocate for support from government agencies and local grant programs; and advocate for reimbursement/ increased coverage for vulnerable populations through Denti-Cal

August Board Meeting Follow-Up

- Board directed staff to follow up with finalists regarding a potential adjustment of the grant amounts
  - COCCC: Organization shared new information since the August Board meeting. Coalition received funding commitment from another source for two mobile dental units, reducing in funding needs and ramp up time to five months. With $500,000 in IGT 5 funding, Coalition would serve all 9,000 children and meet all deliverables
  - Healthy Smiles: Organization responded that the proposal is scalable. A reduced award would result in a proportionate reduction in children served (e.g., 50% award, half of 13,500 children served) while otherwise meeting all deliverables

Recommended Board Actions

1. Award IGT 5 funds in the amount of up to $1 million for a community grant(s) for Access to Children's Dental Services; and
2. Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contract(s) with the selected community grantee(s)

CalOptima's Mission

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

SCOPE OF WORK

IGT 5 Children's Health: Expand Access to Children's Dental Services and Provide Outreach

I. OBJECTIVE

In 2017, CalOptima conducted one of the most extensive and inclusive Member Health Needs Assessment (MHNA) in its 20-plus year history. The results provided critical data to ensure 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. Having the data means CalOptima and the community can make more informed decisions about where to focus improvements.

The MHNA highlighted some key findings that included social determinants of health, mental health, primary care access, provider access and dental care. Overall considerations included:

- Members are culturally diverse and want providers who both speak their language and understand their culture;
- Lack of knowledge and fear of stigma are key barriers to utilizing mental health services;
- Most member are connected to primary care but unsure about what oral health services are covered by CalOptima;
- Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

To help decrease the number/percentage of children who have not seen a dentist within the past 12 months as indicated in CalOptima's Member Health Needs Assessment (MHNA), CalOptima's Board of Directors allocated funds for community grants to support local organizations with expanding access to children's dental services and provide outreach.

Grant funds must be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of grant funds, thus funding is best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

CalOptima is awarding $1 million for children's dental services program(s) that 1) includes partnership/collaboration with other organizations to increase the number of CalOptima members served, 2) provides outreach and education as part of their program to promote awareness, and 3) has the ability to be self-sustainable after grant funds have been exhausted.

II. SCOPE OF WORK BASICS

1) PRODUCTS/SERVICES

a) Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
b) Assist children/families with establishing a dental home close to their home for emergency and regular dental care
c) Provide or partner with other community dental providers to ensure patients receive restorative services in addition to exams and screenings as needed.
d) Include integration with medical care for early childhood through referral for well-check visits

2) SUPPLIER'S RESPONSIBILITIES

(a) Provide a workplan with SMART (specific, measurable, achievable, realistic and time-bound) goals, objectives and major activities.
(b) Perform the specific measure objectives/outcomes and submit tracking towards the results.
(c) Create and demonstrate an outreach and education plan for promoting and connecting proposed services to CalOptima members.
(d) Identify, track and report how many additional CalOptima members will be served.
(e) Identify, track and report how staffing will be allocated to the program/project.
(f) Provide services and activities in a culturally competent and relevant manner.

3) CALOPTIMA'S RESPONSIBILITIES

CalOptima will provide the following templates:
(a) Progress, Annual and Final Report templates;
(b) Project Budget form;
(c) Staffing Plan form;
(d) Coordination and scheduling periodic site visit with grantees.

4) DELIVERABLES

Submit and participate in the following to CalOptima:

(a) **Quarterly Progress Reports**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of each project quarter.
(b) **Annual Progress Report**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of the first year of this Grant Contract.
(c) **Final Report**, submitted via CalOptima's grant management system, will be due within. thirty (30) calendar days after the end of this Grant Contract. The template for this report is also provided through CalOptima's grant management system.

(d) Payment(s) are contingent upon the receipt and acceptance of timely reports and positive progress in identified goals and objectives**.**
(e) Participate in a pre-scheduled site visit(s) with grantee at location of project services.

5) PERFORMANCE MEASURES

(a) CalOptima actively monitors and evaluates grant progress and requires submission of progress reports with demonstrated positive progress in achieving the identified goals and objectives.
(b) CalOptima may perform additional site visits to evaluate performance.

2019 RFP SCORING MATRIX

Section	Criteria	Excellent		Good		Poor
		5	4	3	2	1
A. Organization Information (10%)	Organizational Capacity/Financial Condition/Completeness of Application: -Board/Advisory Members Roster -IRS Determination Letter (if applicable) -Form 990 (if applicable) -Most Recent Audited Financial Statements -Completed IRS W-9 Form -Project Staffing Plan -Project Budget Plan	Organization is in excellent financial standing with high liquidity and minimal risk of insolvency (e.g., revenue is higher than expenses, no debt, healthy cash savings, etc.); demonstrates an excellent track record of service to the community and has the capacity to effectively provide proposed services; all requested items included with application. Board/Advisory Members roster is complete and highly organized/robust.		Organization is in good financial standing with minimal liquidity and moderate risk of insolvency (e.g., revenue is slightly higher than expenses, low debt, satisfactory cash savings, etc.); demonstrates a good track record of service to the community and has the capacity to adequately provide proposed services; some or all requested items included with application. Board/Advisory Members roster is satisfactory.		Organization is in poor financial standing with little to no liquidity and high risk of insolvency (e.g., expenses are higher than revenue, high debt, insufficient cash savings, etc.); demonstrates a poor track record of service to the community and lacks the capacity to effectively provide proposed services; some or none of the requested items included with application. Board/Advisory Members roster is incomplete and not organized/robust.
B. Project Information (55%)	Statement of Need (5%)	Provides a clear and realistic explanation of the issue and need(s) in the community; need(s) identified is supported by local statistics and data.		Provides a basic explanation of the issue and need(s) in the community; need(s) identified is supported by non-local statistics and data.		Provides a poor explanation of the issue and need(s) in the community; need(s) identified are not supported by any statistics or data.
	Project Description (20%)	Provides clear and insightful project information; detailed and sensible plan on how goals and outcomes will be achieved. Proposed project has significant potential to address the identified unmet need in the community. Seeks very appropriate collaborations to increase the effectiveness of proposed project.		Provides basic project information; adequate plan on how goals and outcomes will be achieved. Proposed project has minor potential to address the identified unmet need in the community. Seeks basic collaborations to increase the effectiveness of proposed project.		Provides unclear and poor project information; poor plan on how goals and outcomes will be achieved. Proposed project has little to no potential to address the identified unmet need in the community. Seeks little to no collaborations to increase the effectiveness of proposed project.
	Evidence Supporting Approach (5%)	Provides clear and relevant evidence regarding promising practices to support the efficacy of the proposed project.		Provides some generalized evidence regarding promising practices to support the efficacy of the proposed project.		Provides unclear and irrelevant evidence regarding promising practices to support the efficacy of the proposed project.

2019 RFP SCORING MATRIX

Section	Criteria	Excellent		Good		Poor
		5	4	3	2	1
B. Project Information (55%)	Outreach and Education Strategy (10%)	Provides clear and specific information on how applicant will promote and connect CalOptima members to proposed services; clear and detailed description on how applicant will specifically track the number of CalOptima members reached.		Provides basic information on how applicant will promote and connect CalOptima members to proposed services; adequate description on how applicant will specifically track the number of CalOptima members reached.		Provides insufficient and unclear information on how applicant will promote and connect CalOptima members to proposed services; poor and unclear description on how applicant will specifically track the number of CalOptima members reached.
	Sustainability Plan (5%)	Provides clear and specific information on how the project will be sustained after grant support has ended; plan is very compelling and feasible.		Provides basic information on how the project will be sustained after grant support has ended; plan is adequate and slightly feasible.		Provides poor information on how the project will be sustained after grant support has ended; plan is not compelling and feasible.
	Population Served (10%)	The number of additional CalOptima members served is relatively high and is greater than or equal to 25% of CalOptima members currently served; demonstrates a strong awareness of the demographics and diverse needs throughout Orange County.		The number of additional CalOptima members served is less than 25% of CalOptima members currently served; demonstrates an adequate awareness of the demographics and diverse needs throughout Orange County.		The number of additional CalOptima members served is relatively low and is less than 10% of CalOptima members currently served; demonstrates a poor awareness of the demographics and diverse needs throughout Orange County.
C. Project Staffing Plan (10%)	Project Staffing Plan	Provides a complete staffing plan that is appropriate and reasonable for the proposed project. Provides a clear and detailed explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.		Provides a basic staffing plan that lacks detail for the proposed project. Provides a basic explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.		Provides a poor staffing plan that is not appropriate and realistic for the proposed project. Provides a poor explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.
D. Project Budget Plan (10%)	Project Budget Plan	Provides a complete budget plan that is appropriate and realistic for the proposed project and timeframe; indirect costs do not exceed the 10% limit.		Provides a basic budget plan that lacks detail for the proposed project and timeframe; indirect costs do not exceed the 10% limit.		Provides a budget plan that is not appropriate and realistic for the proposed project and timeframe; indirect costs exceed the 10% limit.
E. Workplan Information (15%)	Workplan Information	Provides a detailed workplan for implementation that is appropriate to the goals and length of the project; activities for objectives are clear and realistic; demonstrates a high likelihood of achieving objectives.		Provides a basic workplan for implementation that is moderately appropriate to the goals and length of the project; activities for objectives are satisfactory; demonstrates an adequate likelihood of achieving objectives.		Provides a poor workplan that is not appropriate to the goals and length of the project; activities for objectives are weak; demonstrates a low likelihood of achieving objectives.

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.

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 — *5/30/2018*
Authorized Signature — **Date**

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.

#	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

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 — *1/25/2018*
Authorized Signature — **Date**

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

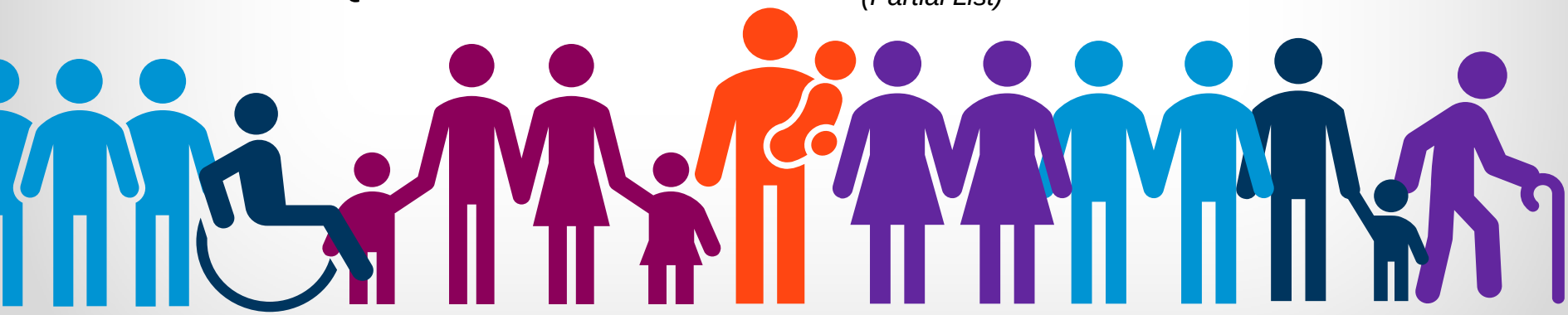
- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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.)

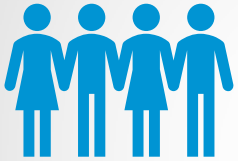
- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In 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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

A Public Agency
CalOptima
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

A Public Agency
CalOptima
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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)

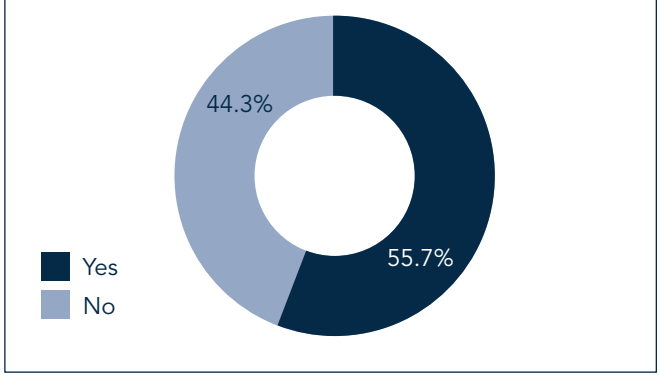
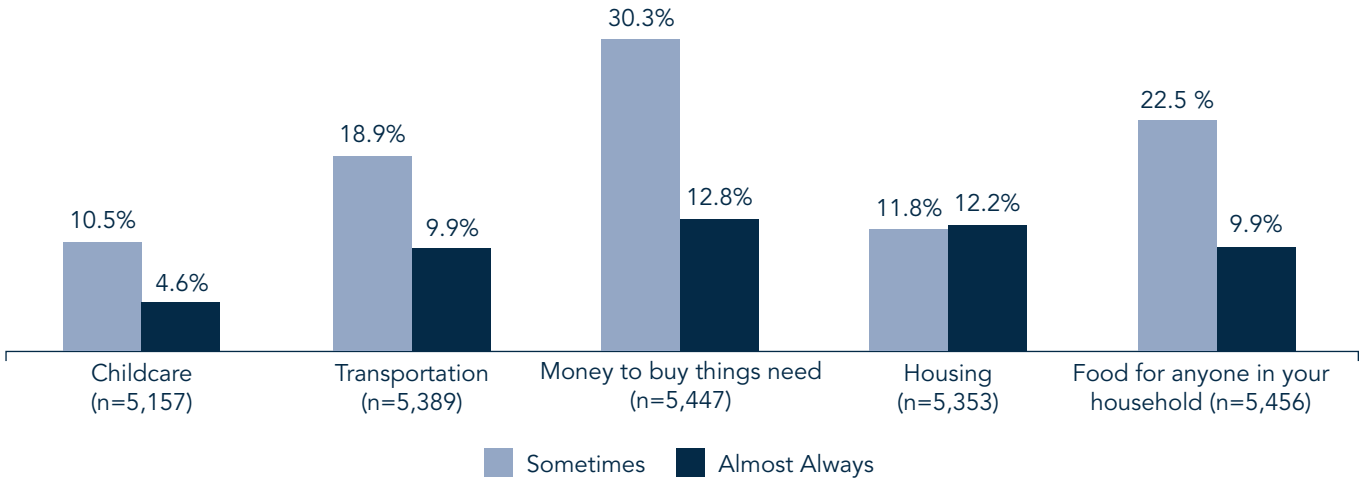
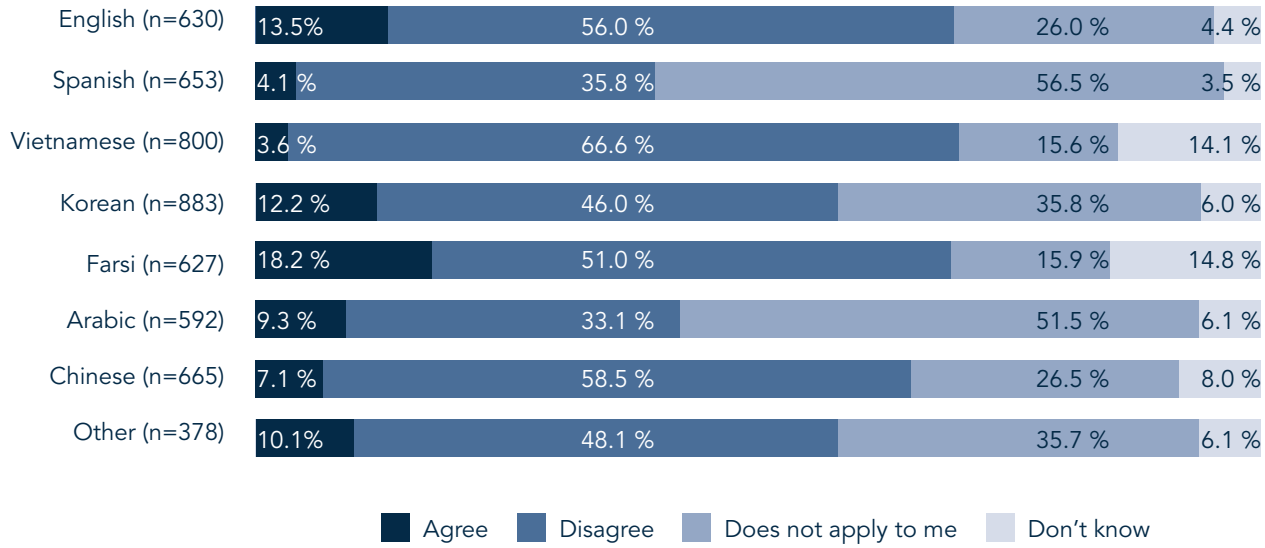


Exhibit 3: Percent of members who needed help with basic needs in the past six months



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)

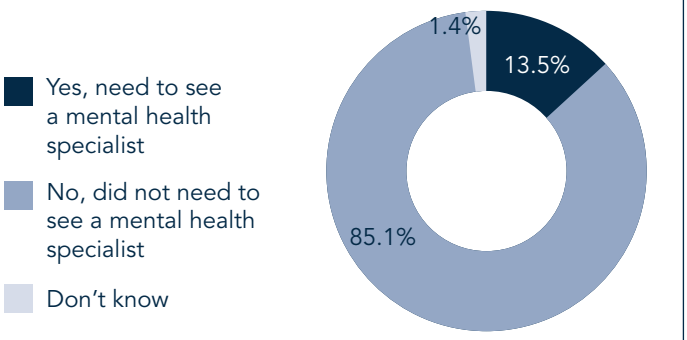
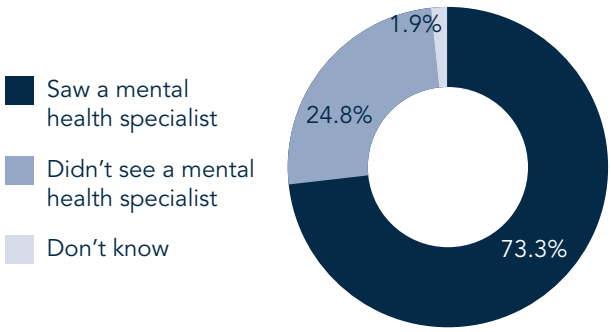
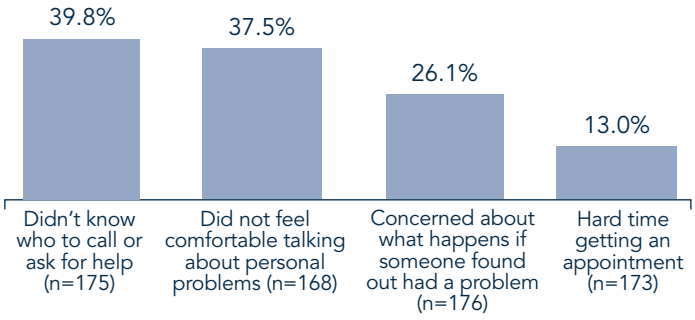


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



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)

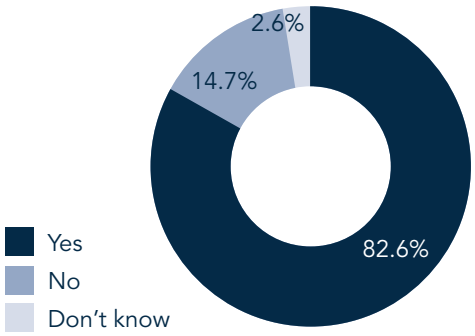
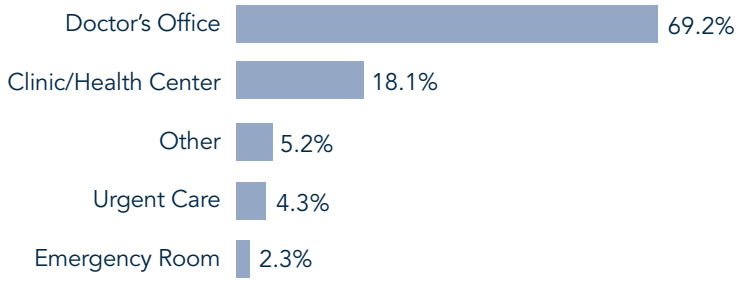


Exhibit 9: Where respondents go to see their doctor (n=5,743)

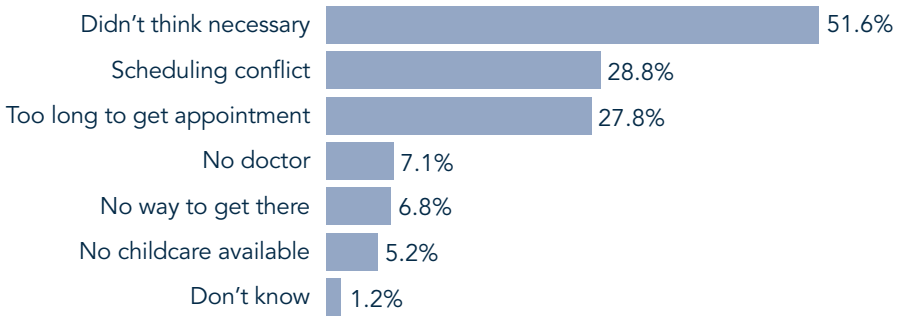


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited 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)

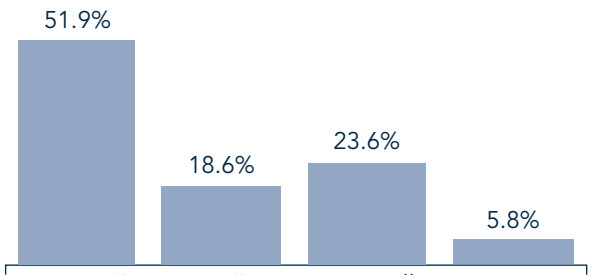
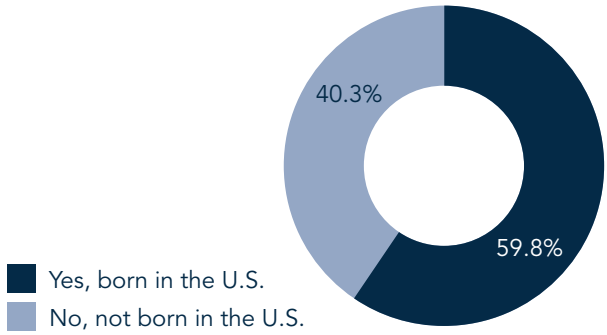


Exhibit 12: Percent of members who were born in the United States (n=5,599)



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)

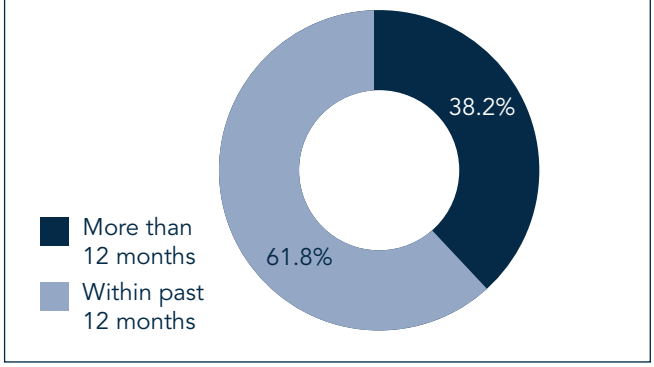
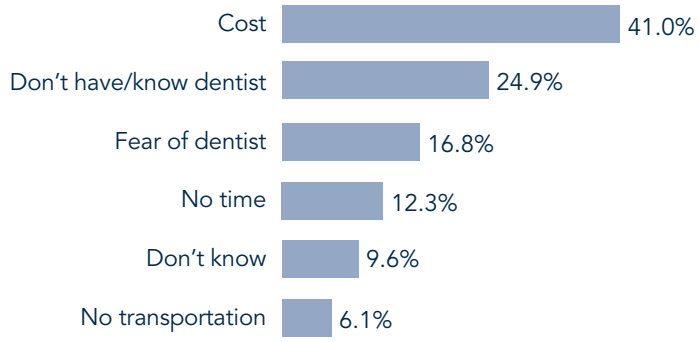


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



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

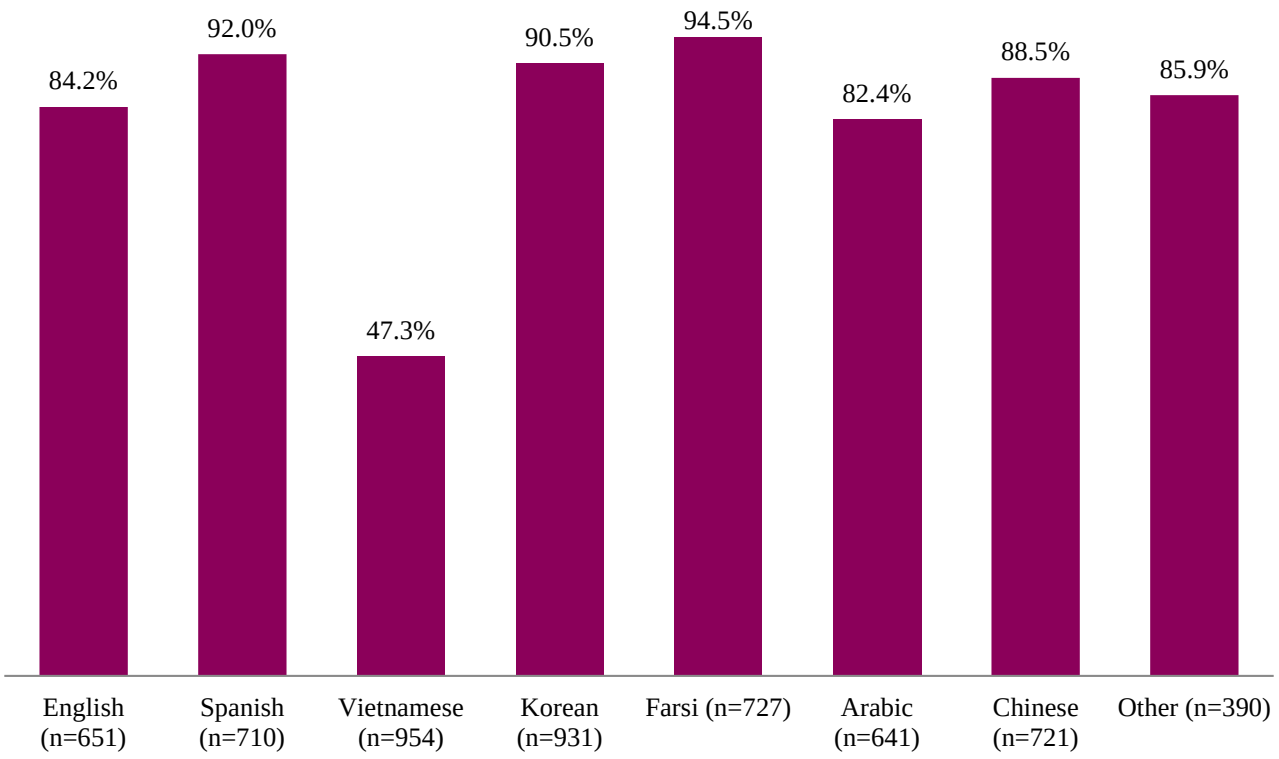
harder + co | community research

CalOptima
A Public Agency
Better. Together.

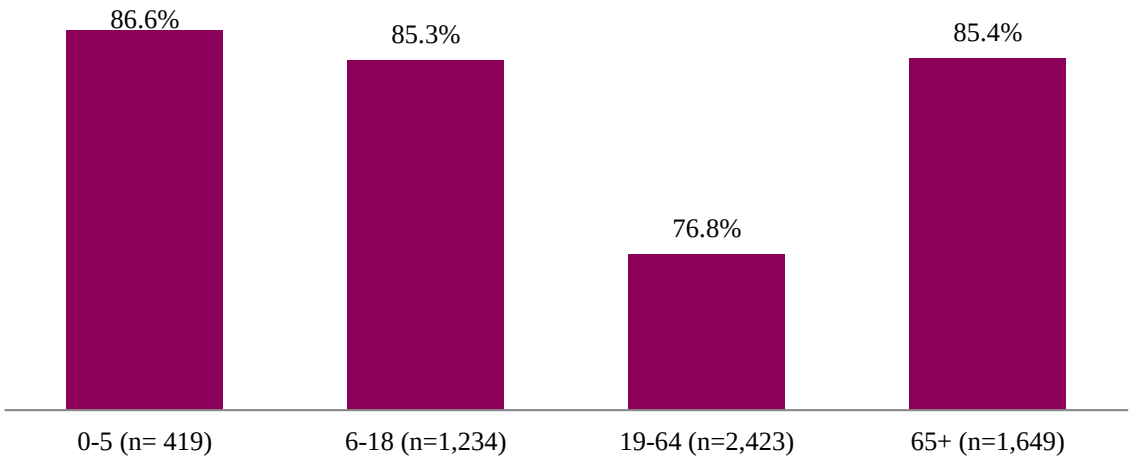
Navigating the Healthcare System

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.

Region:

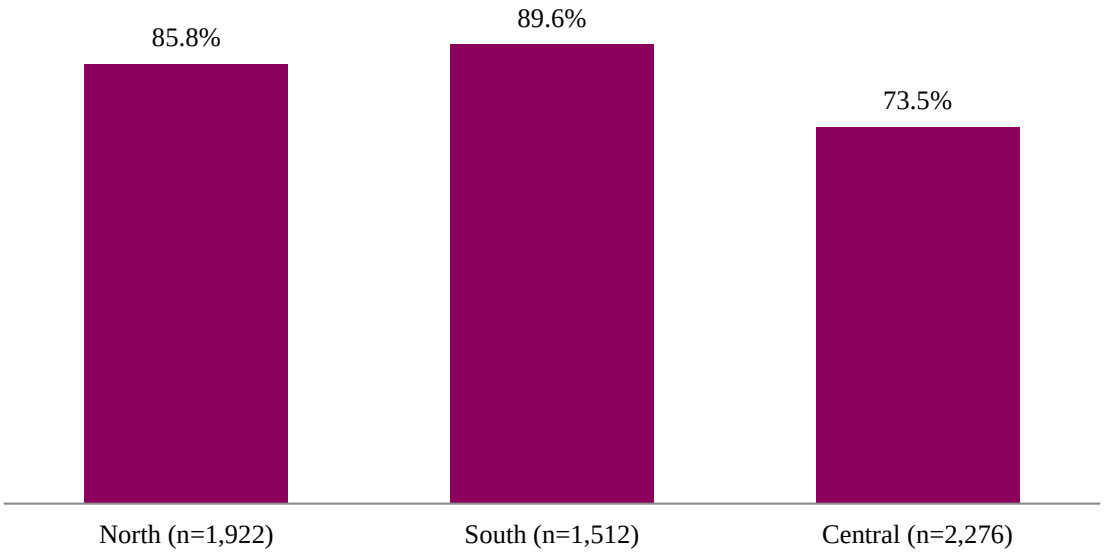


Exhibit 2. Where respondents go to see their doctor

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

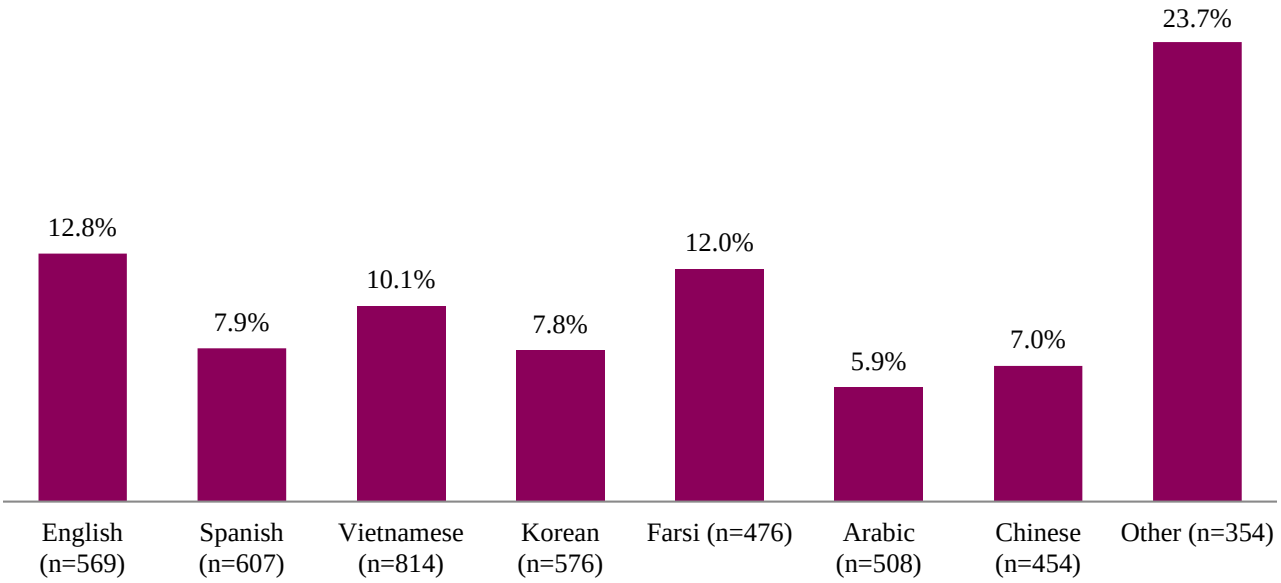
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

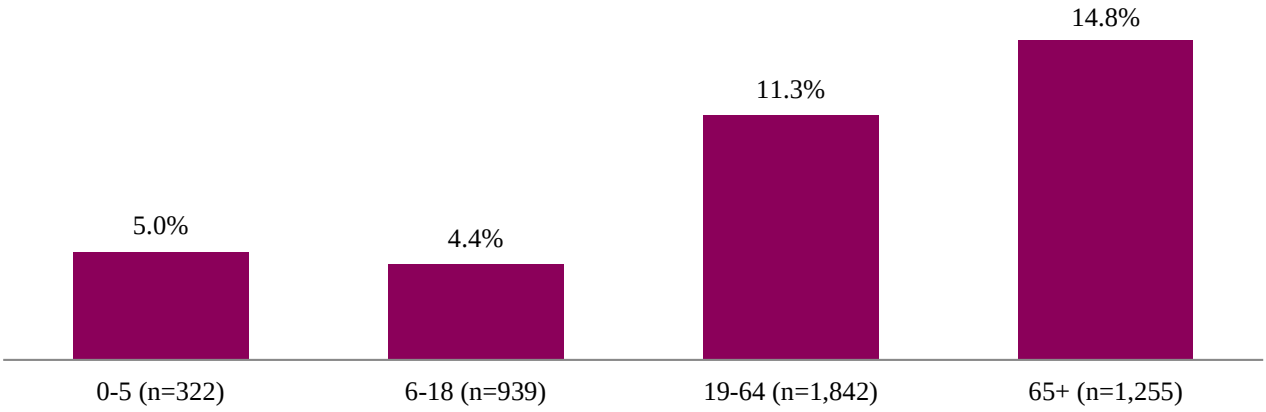
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

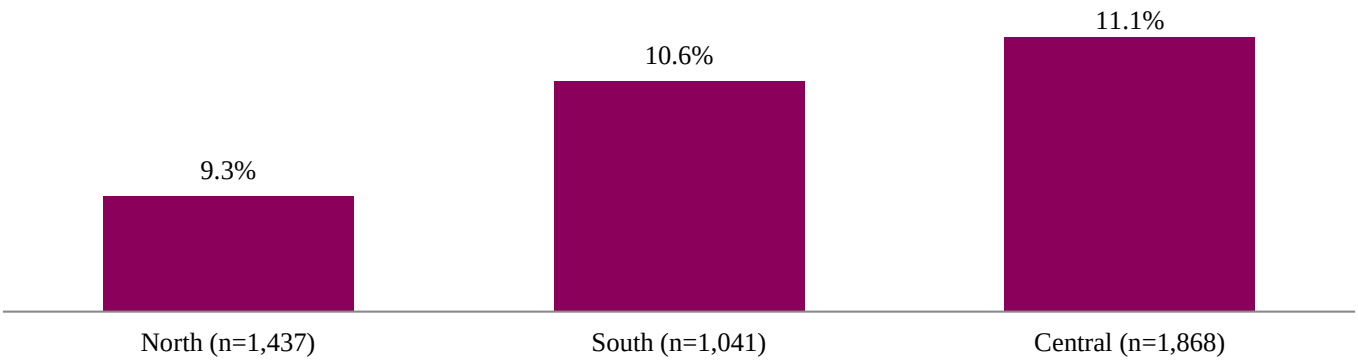
CalOptima language:



Age Category:



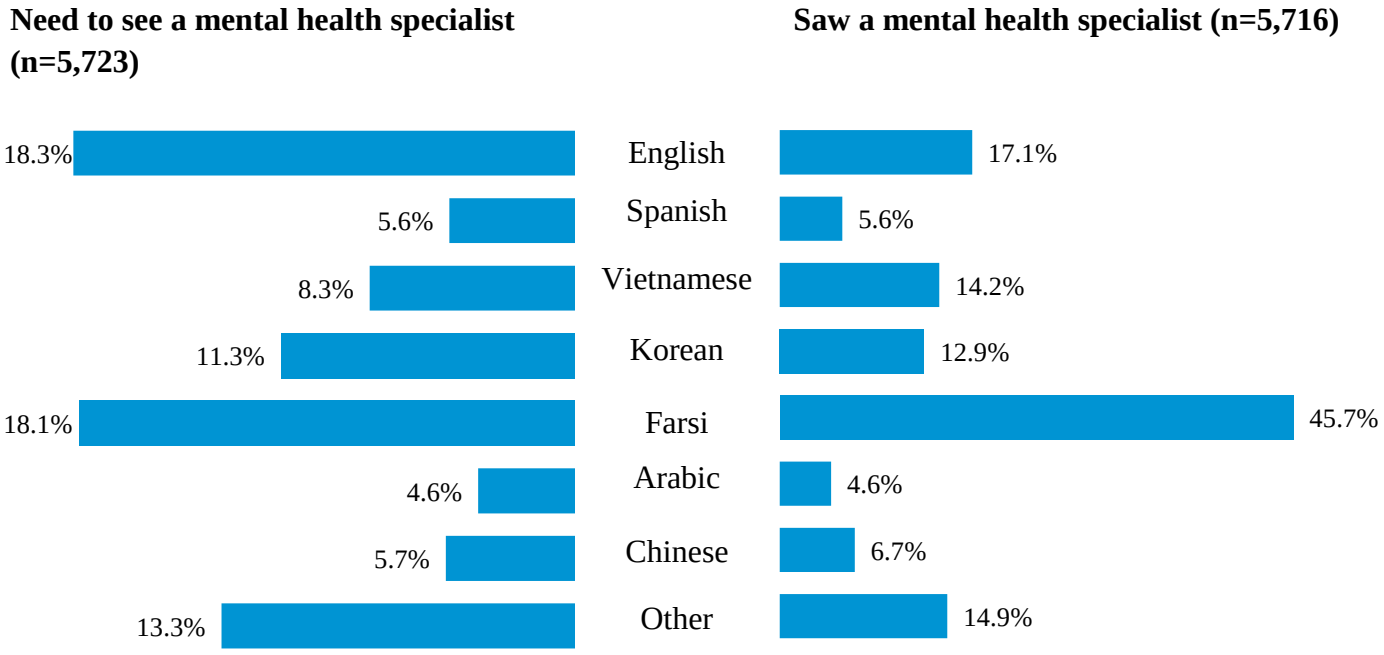
Region:



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:

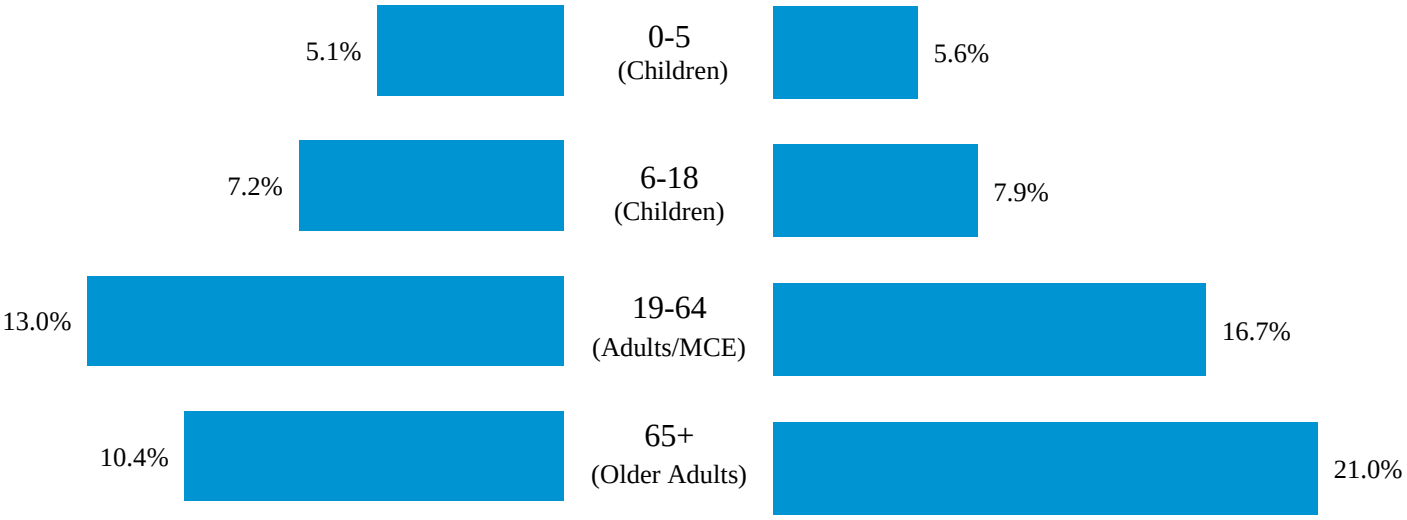


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

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)

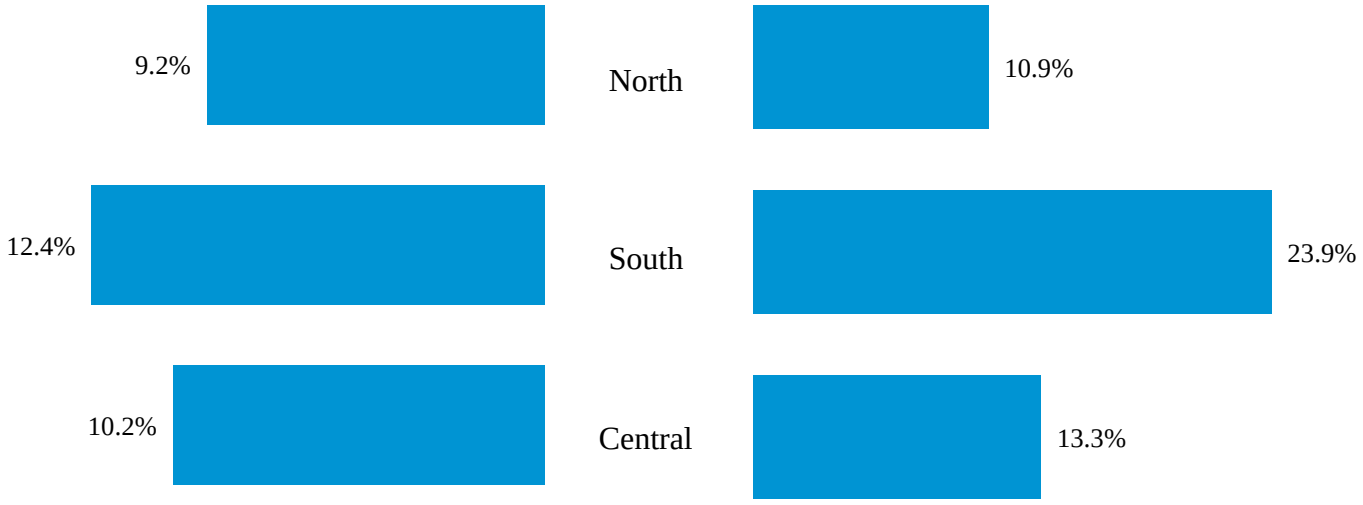
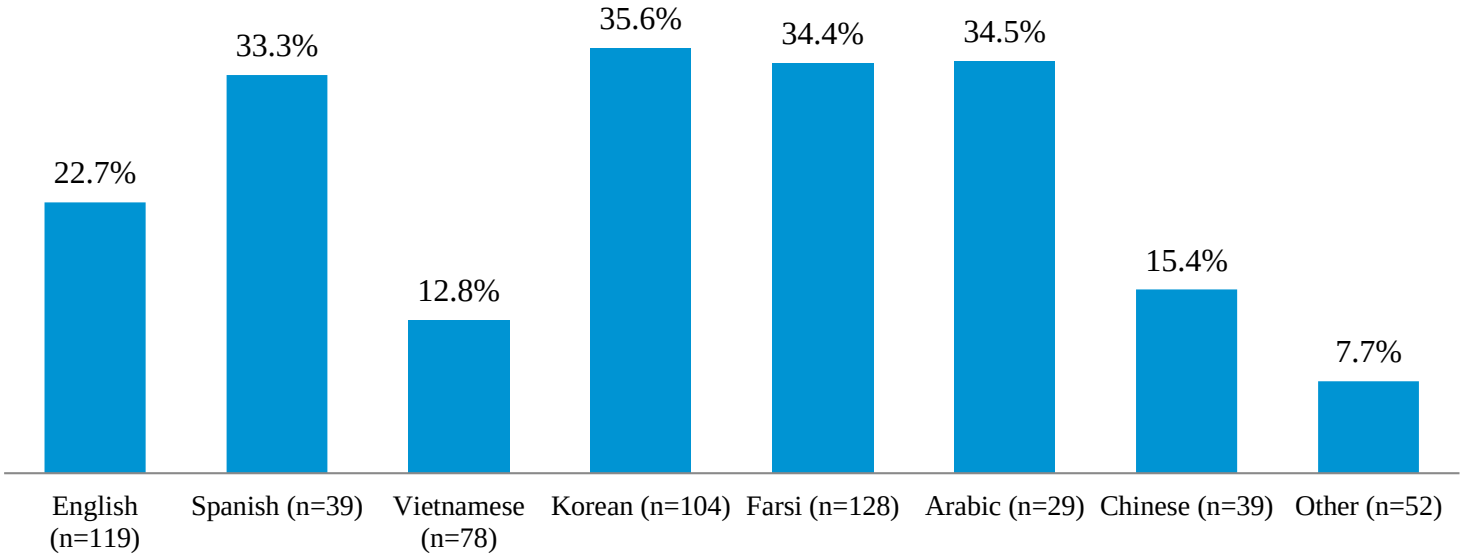
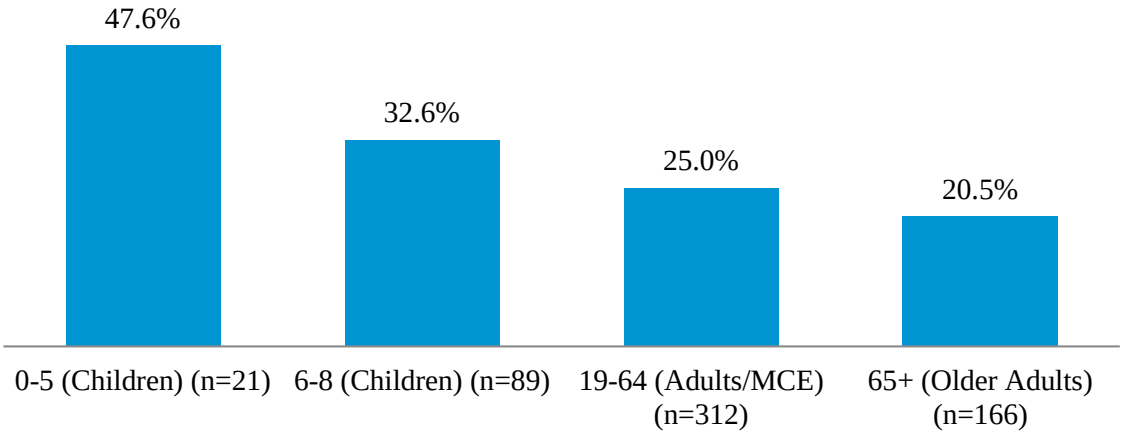


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

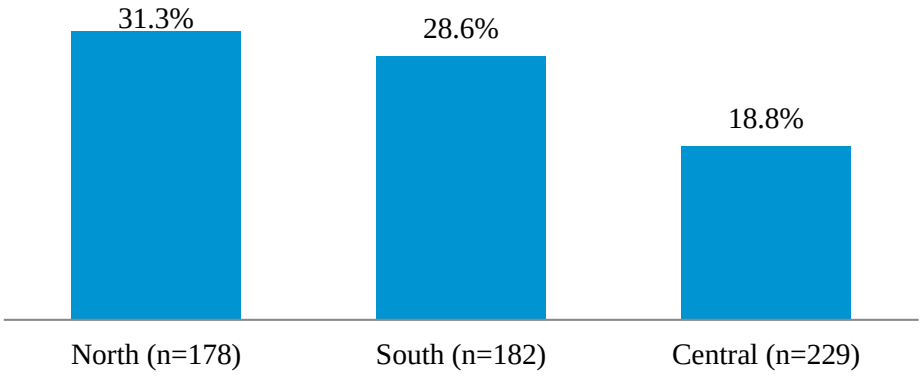
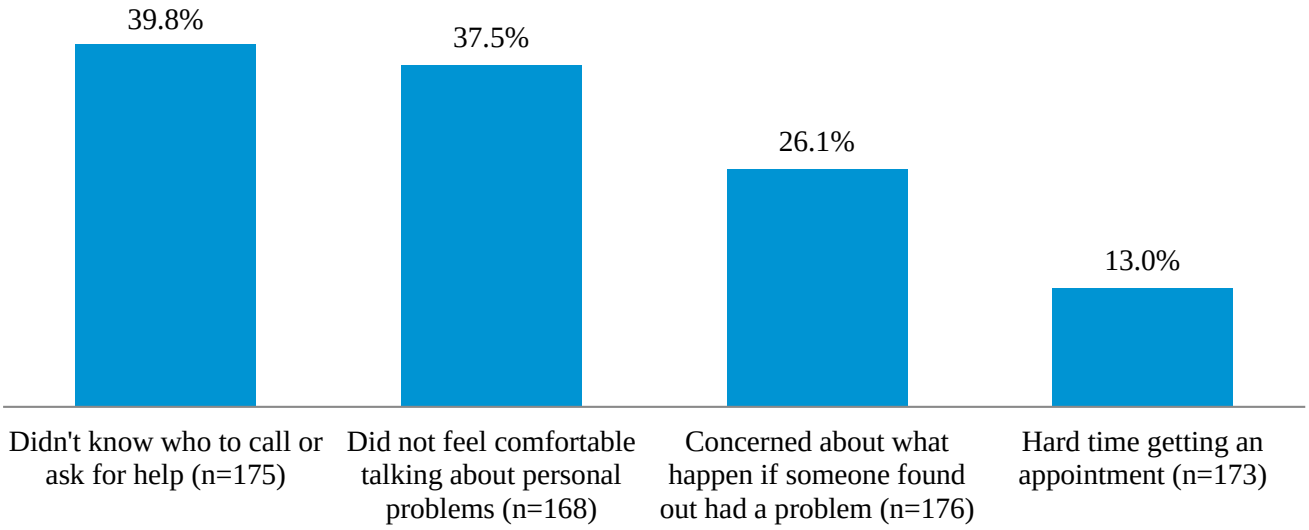


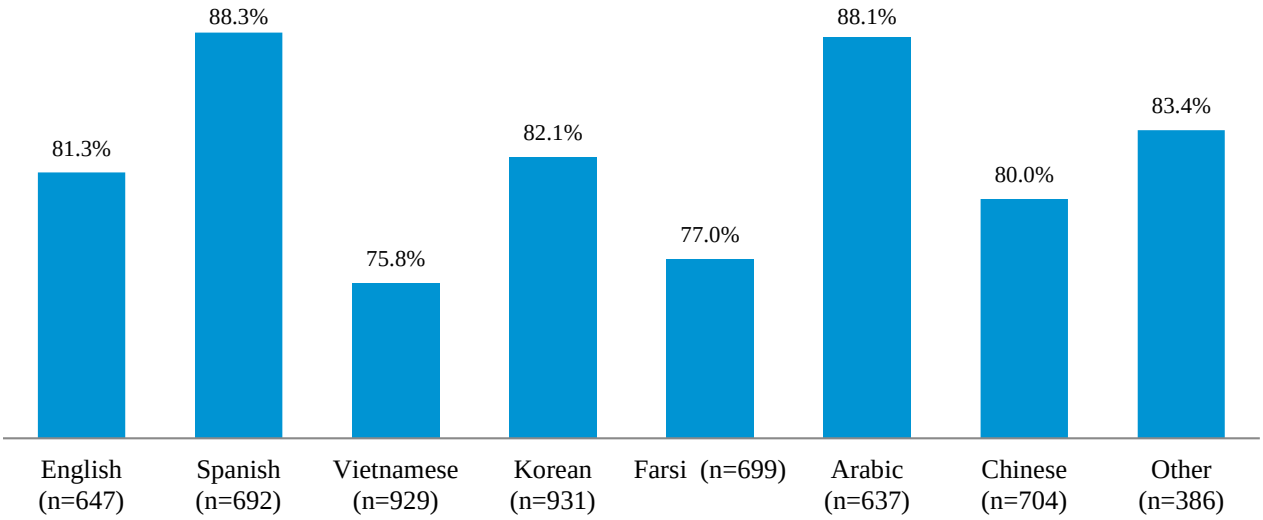
Exhibit 11. Reasons why members didn't see mental health specialist[7]



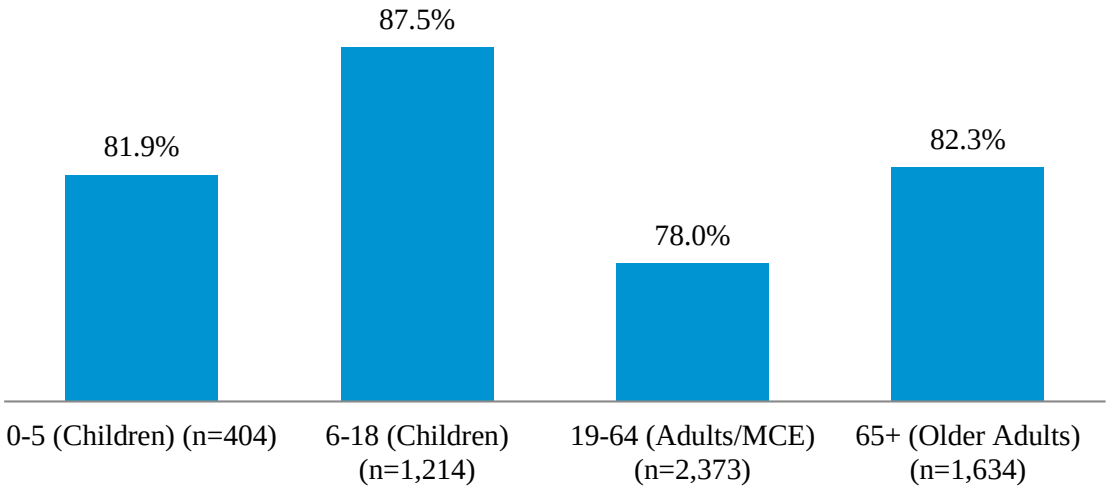
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

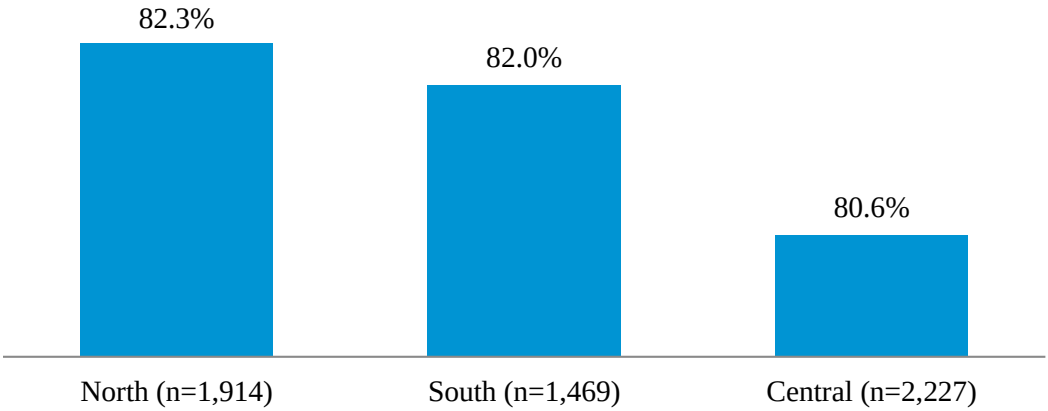
CalOptima language:



Age Category:



Region:

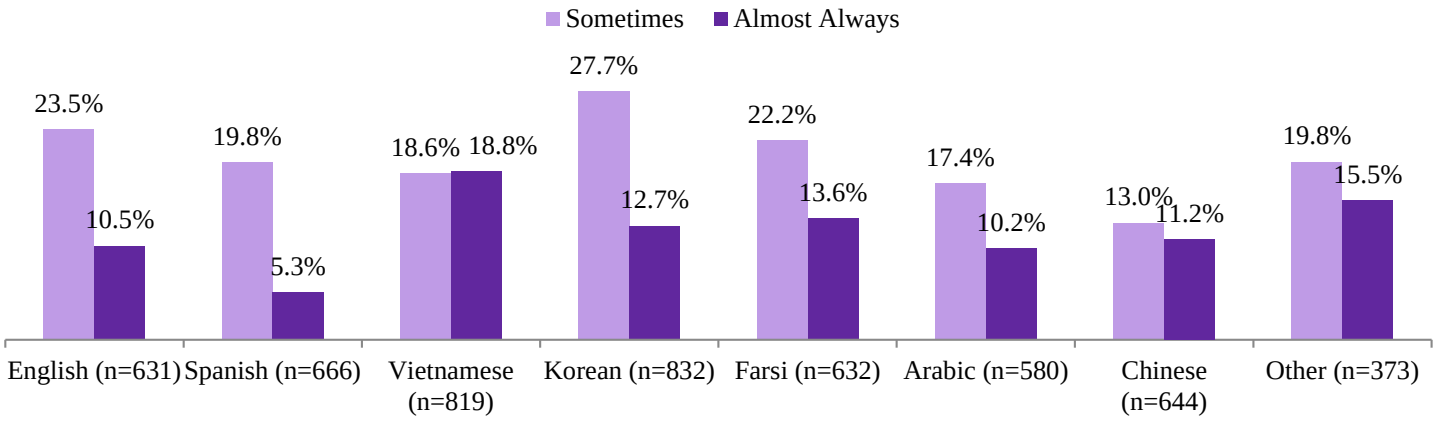


Social Determinants of Health

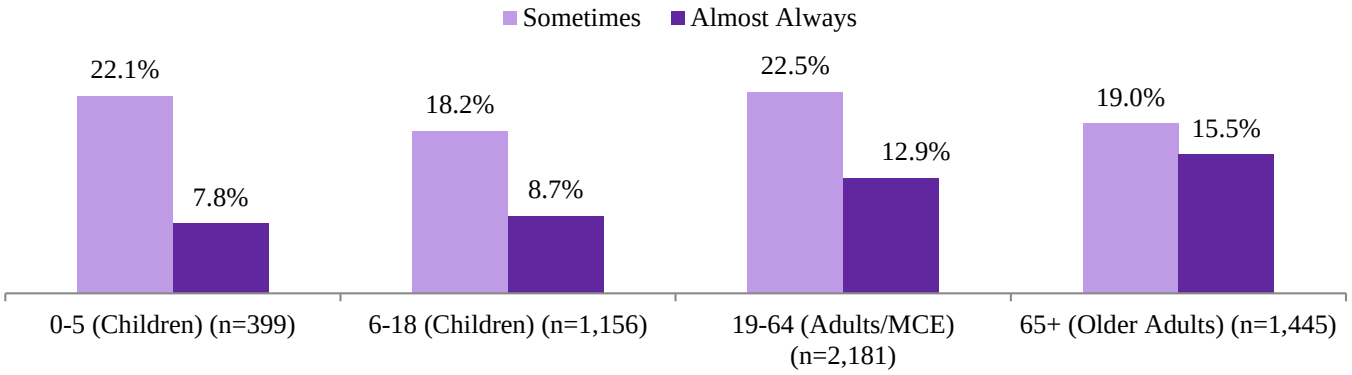
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

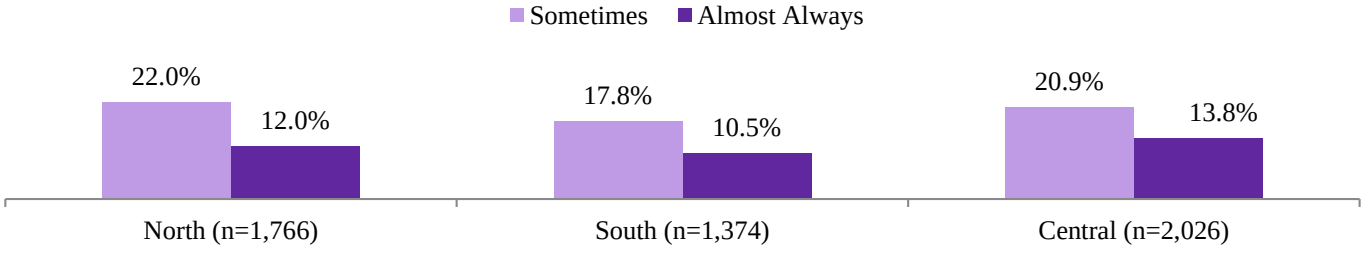
CalOptima language:



Age Category:

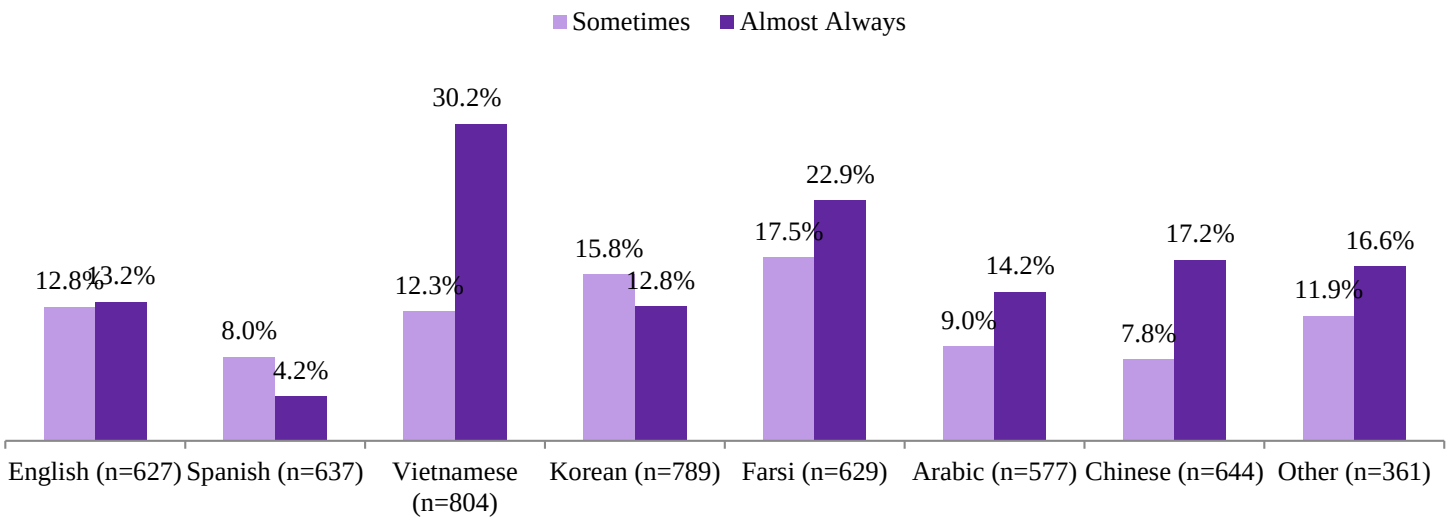


Region:

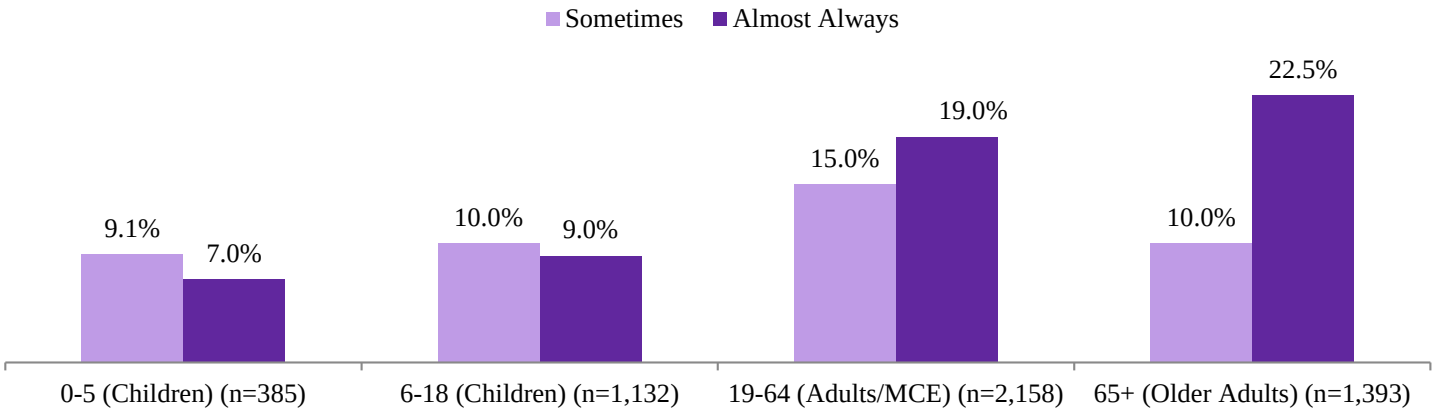


Housing:

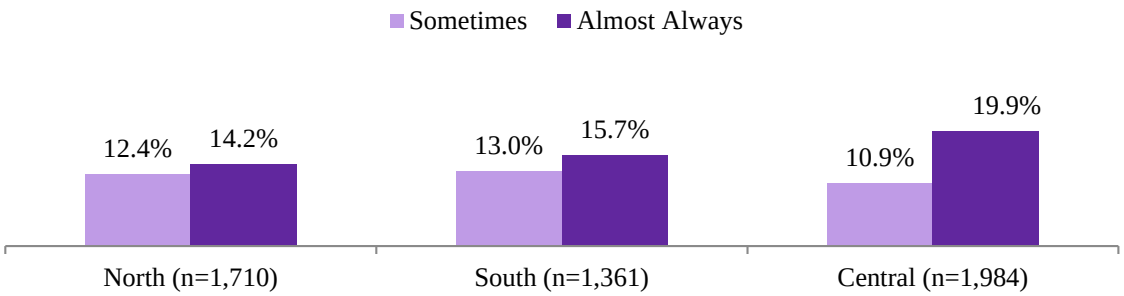
CalOptima language:



Age Category:

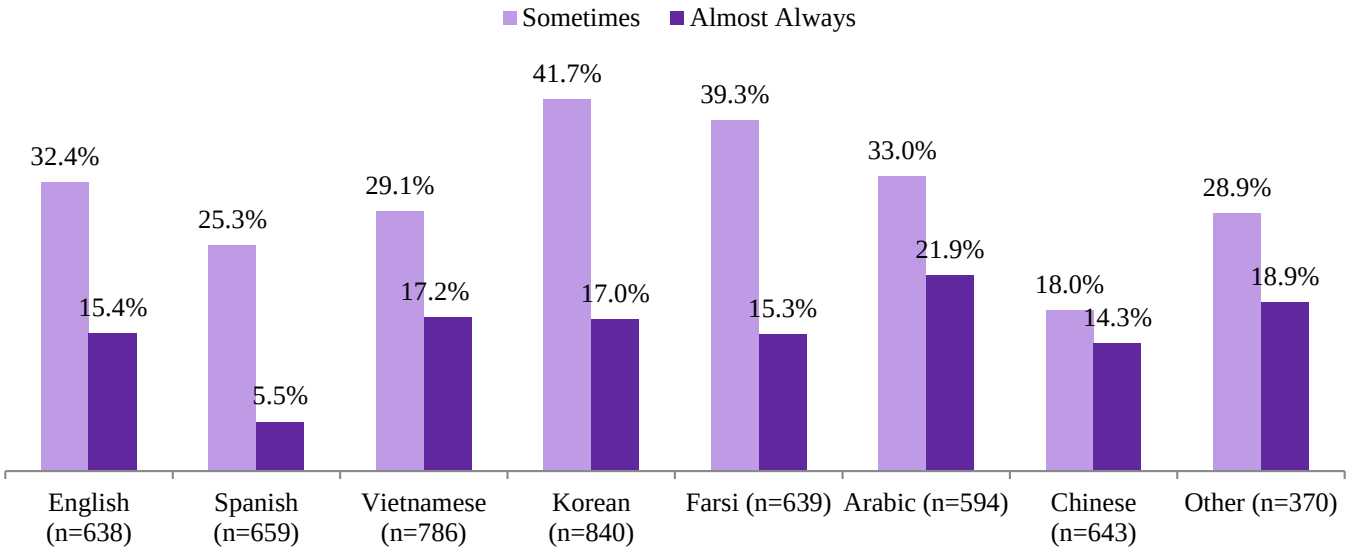


Region:

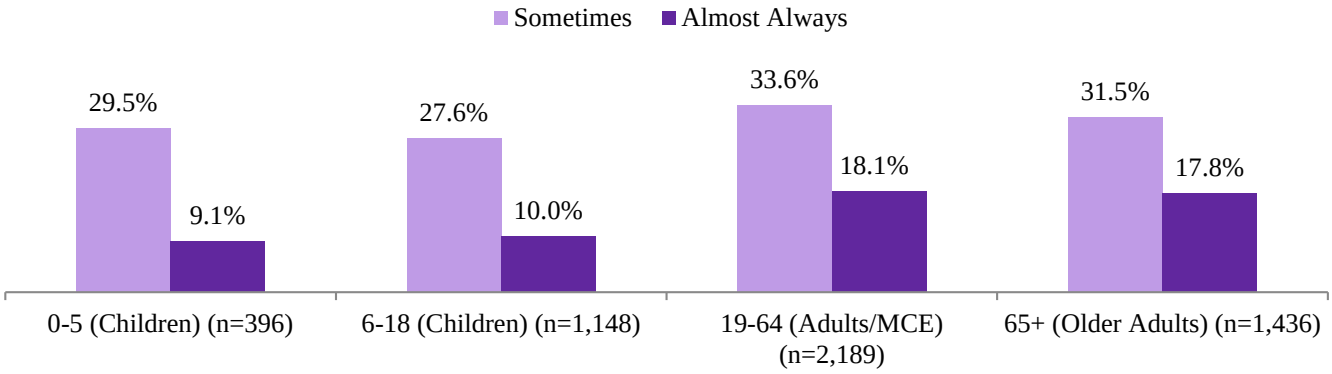


Money to buy things need:

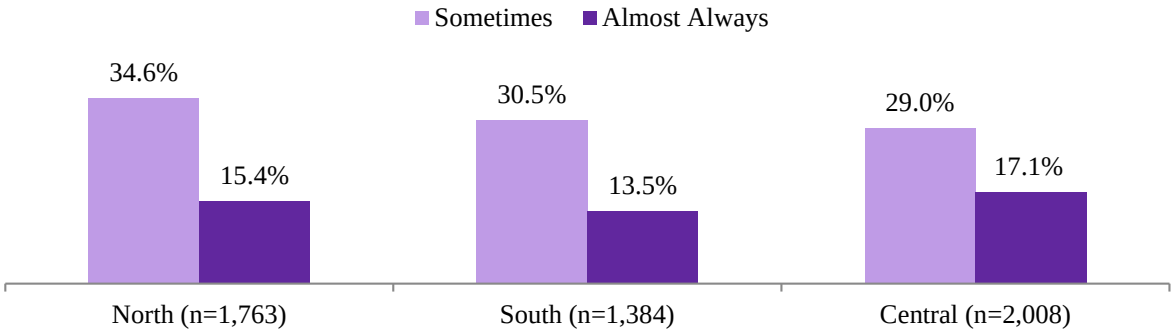
CalOptima language:



Age Category:

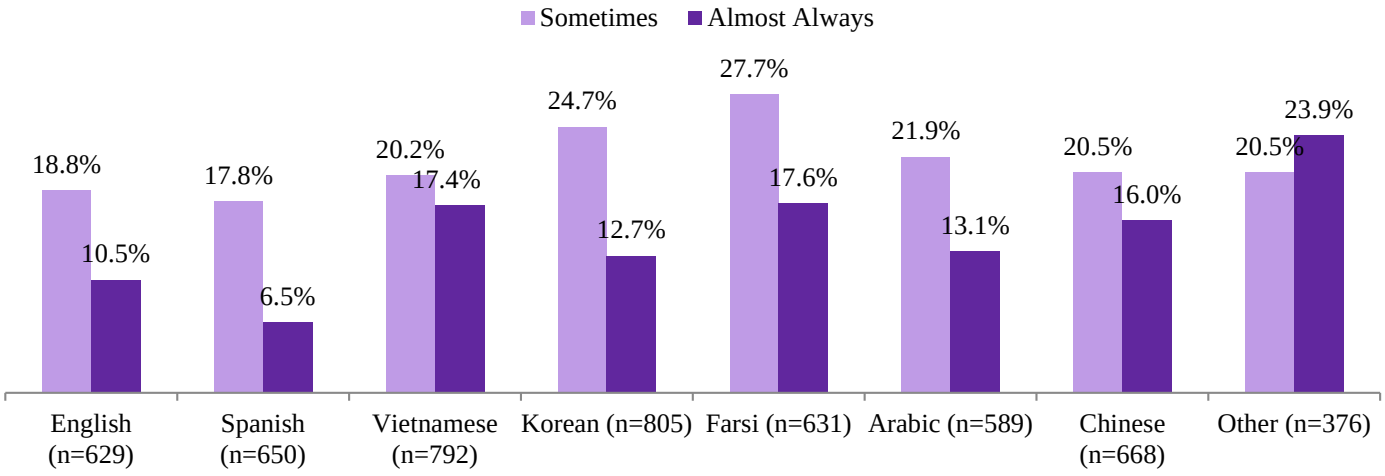


Region:

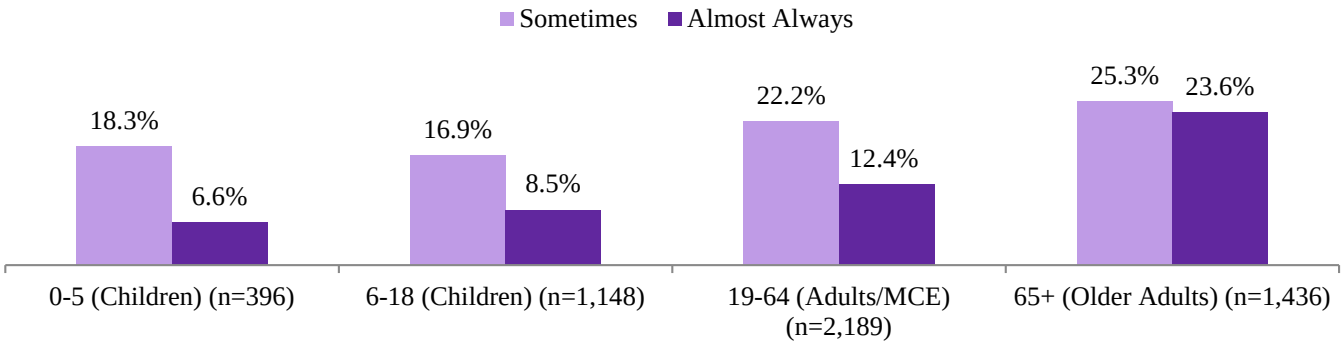


Transportation:

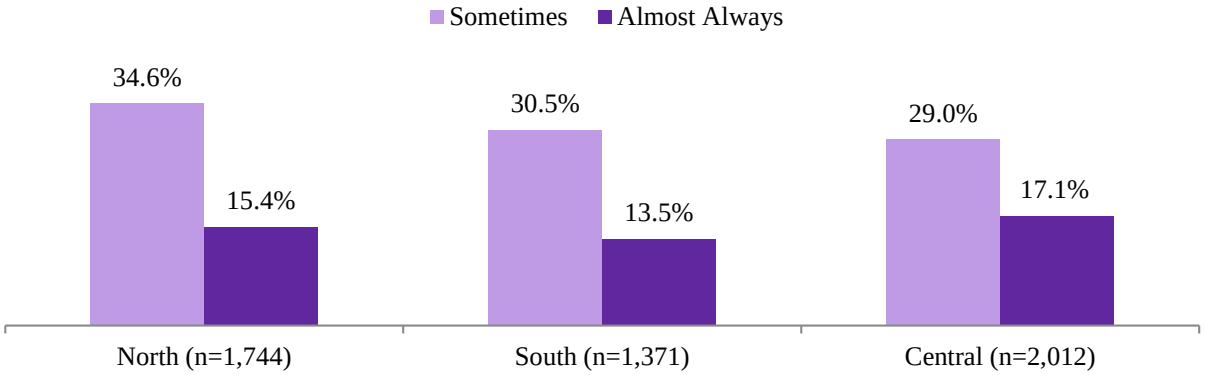
CalOptima language:



Age Category:

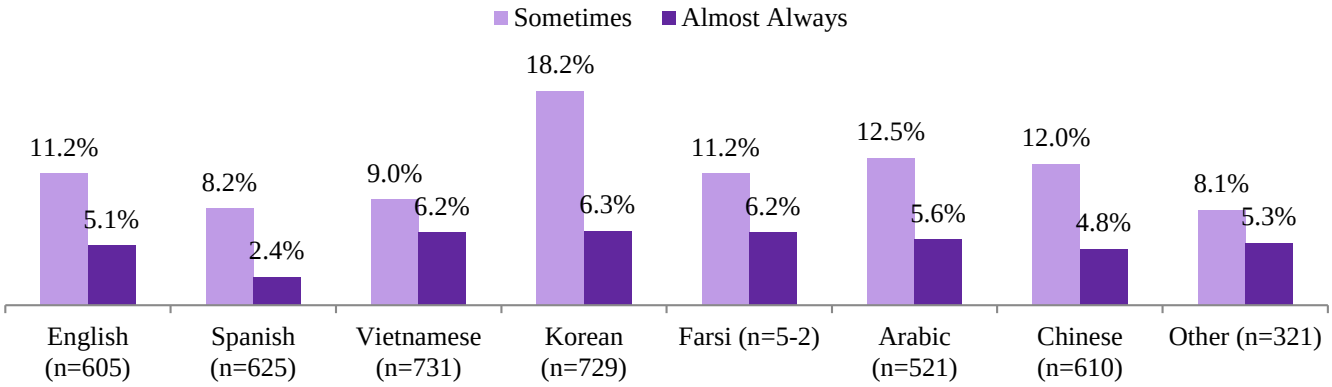


Region:

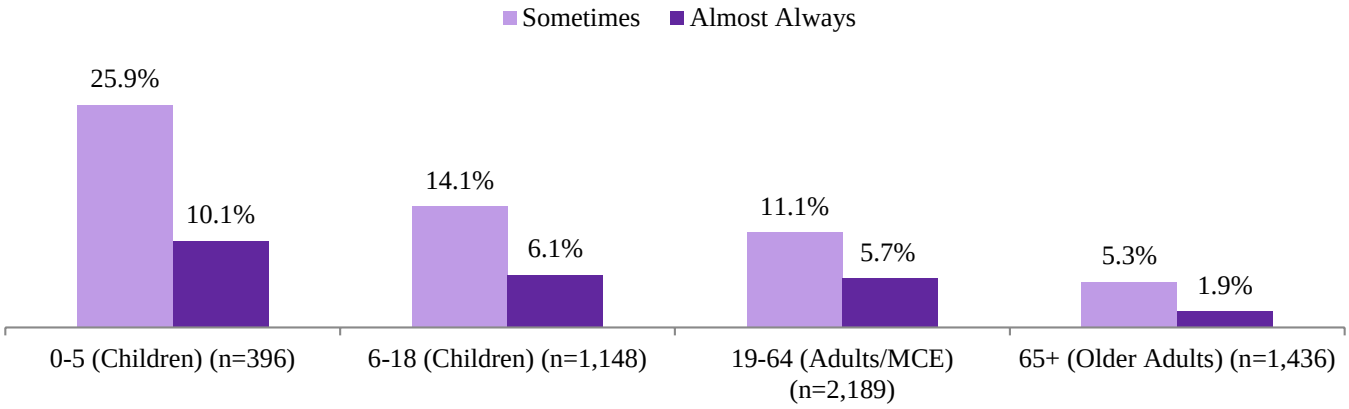


Child care:

CalOptima language:



Age Category:



Region:

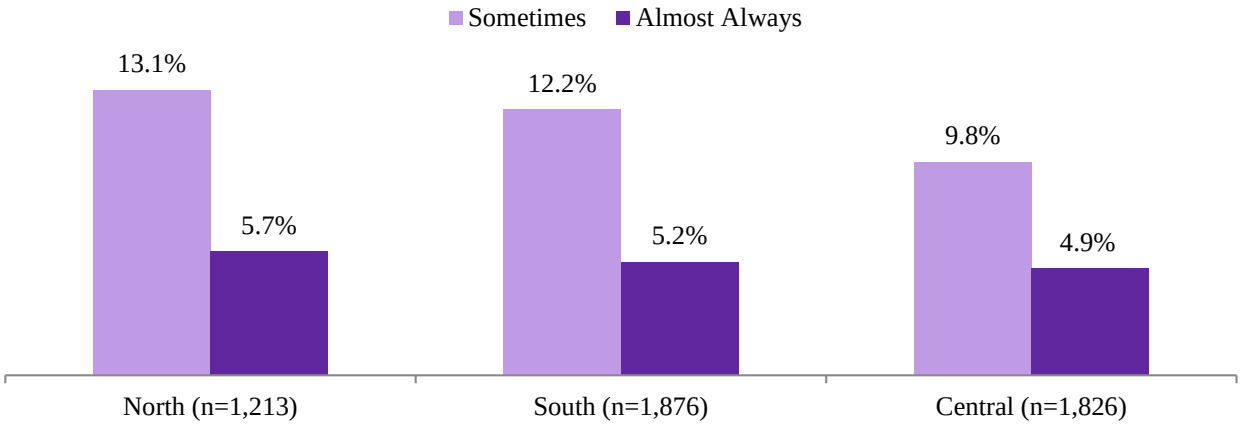
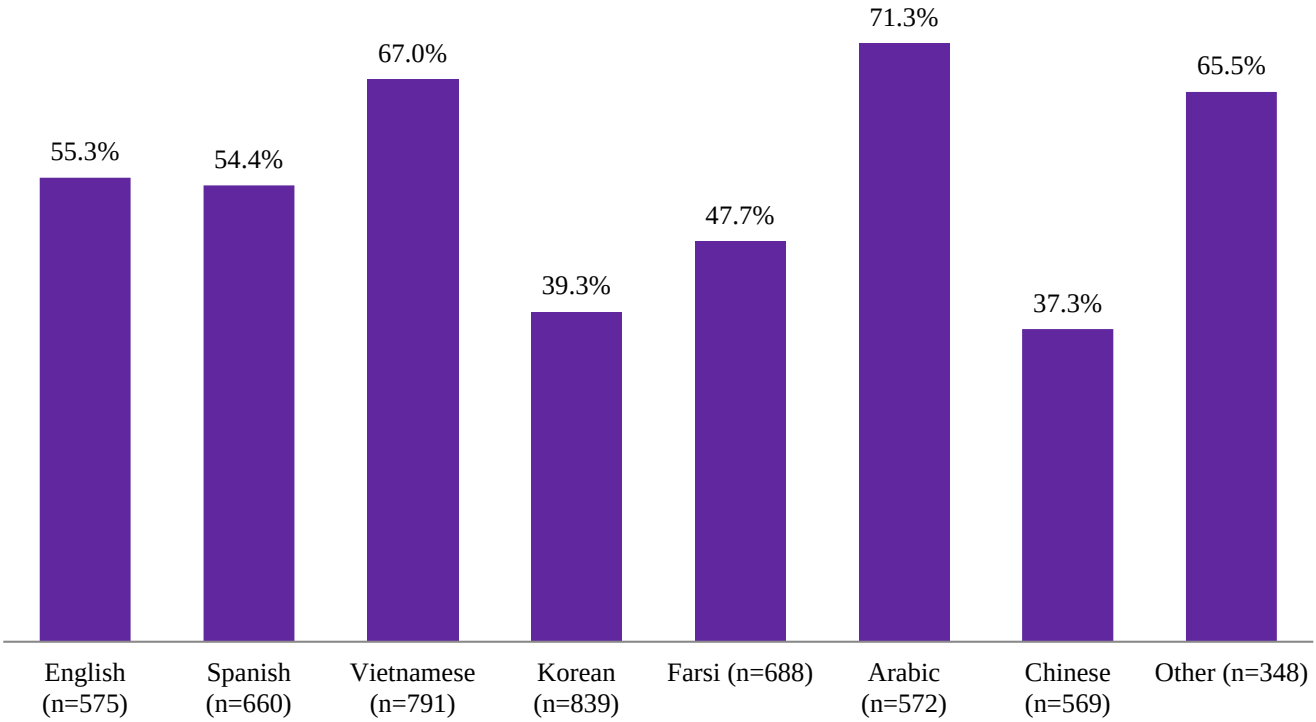


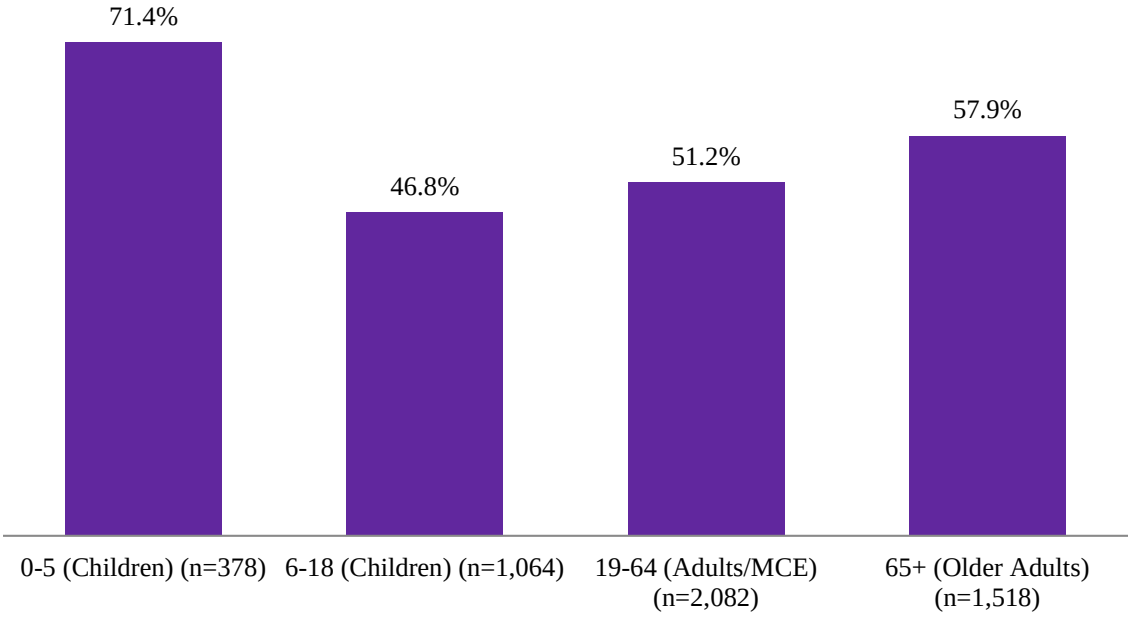
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

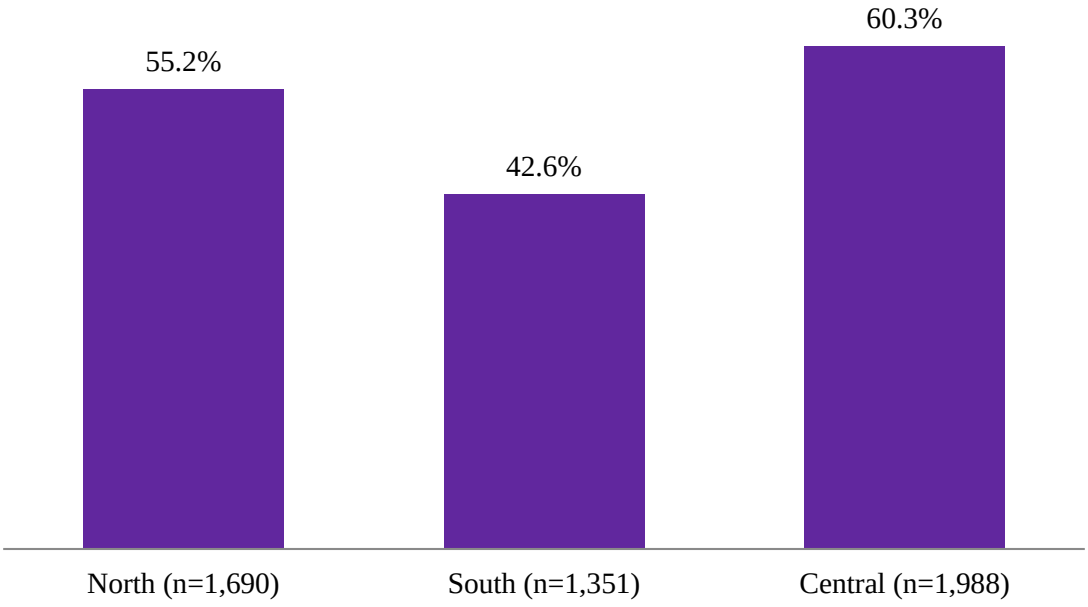
CalOptima language:



Age Category:



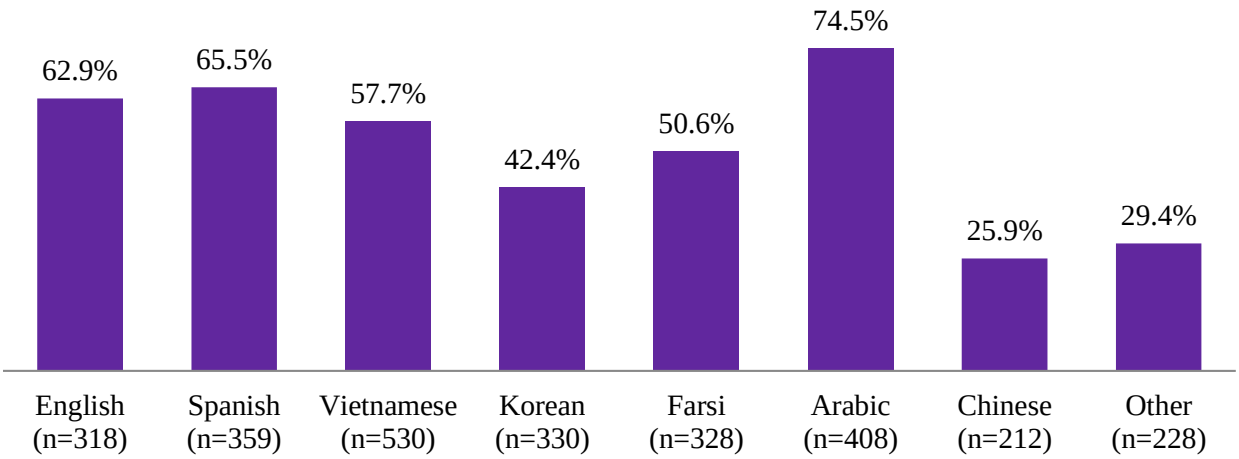
Region:



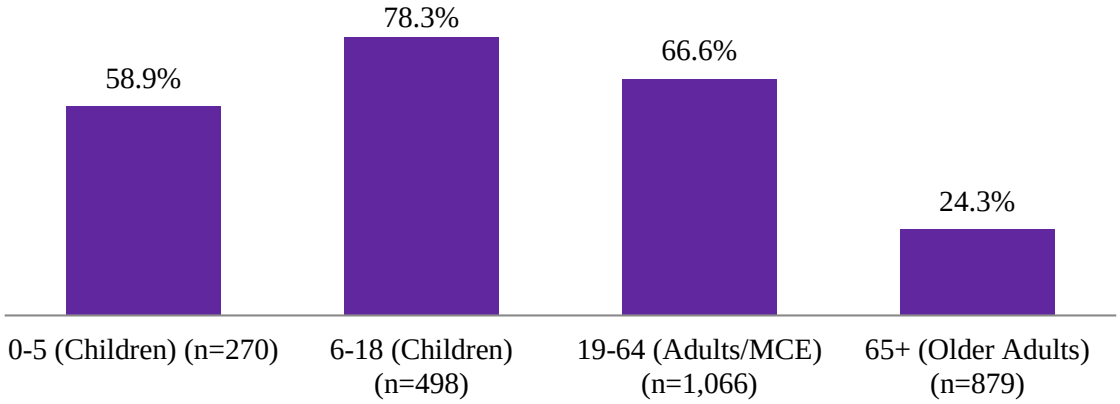
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

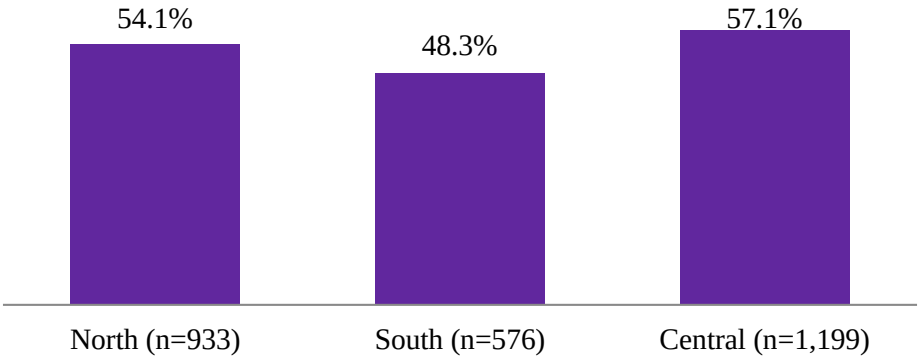
CalOptima language:



Age Category:



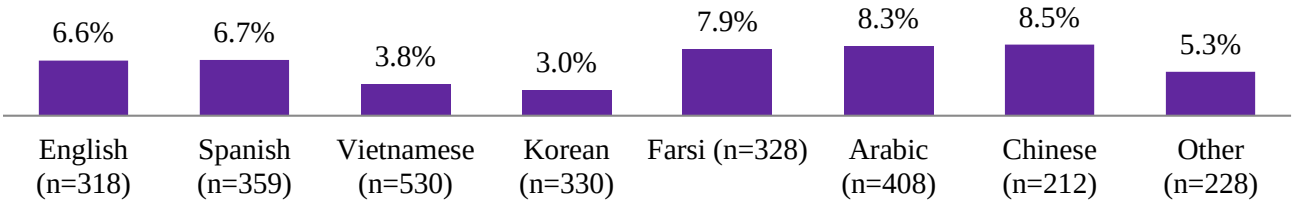
Region:



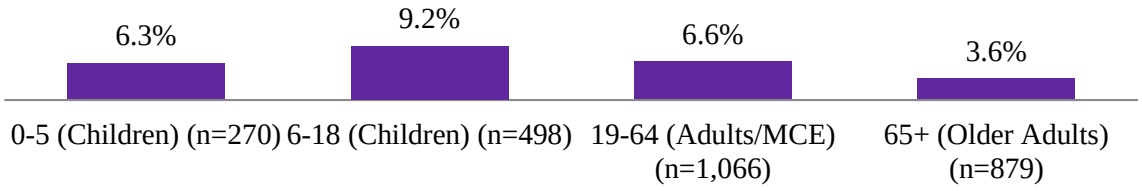
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

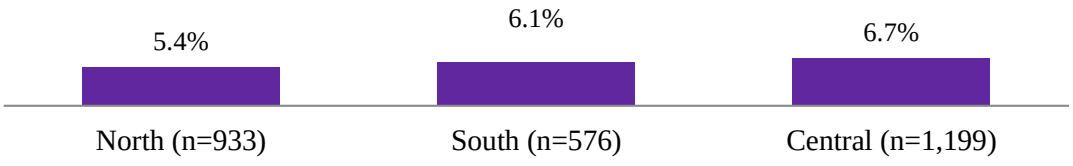
CalOptima language:



Age Category:

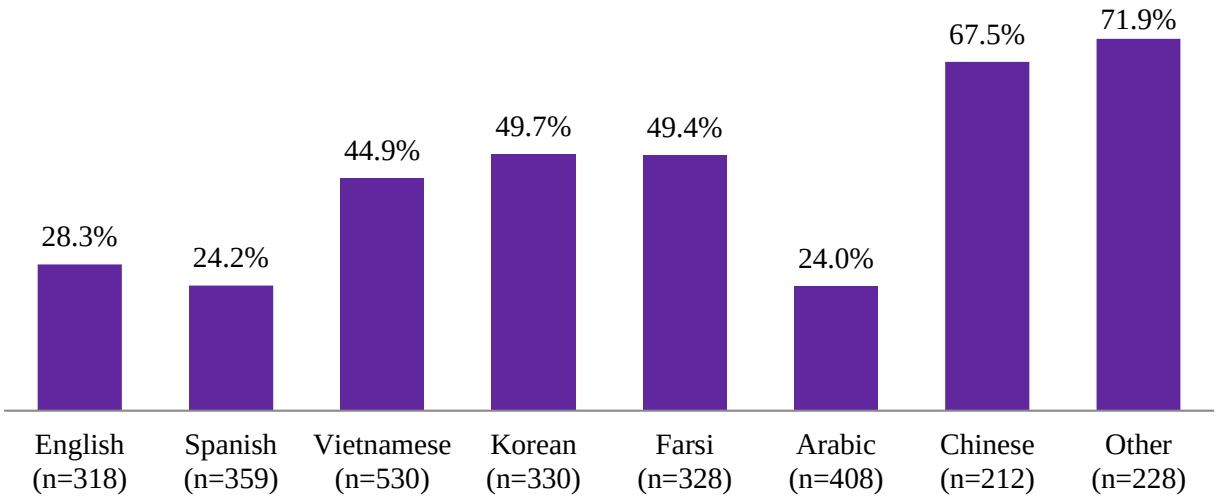


Region:

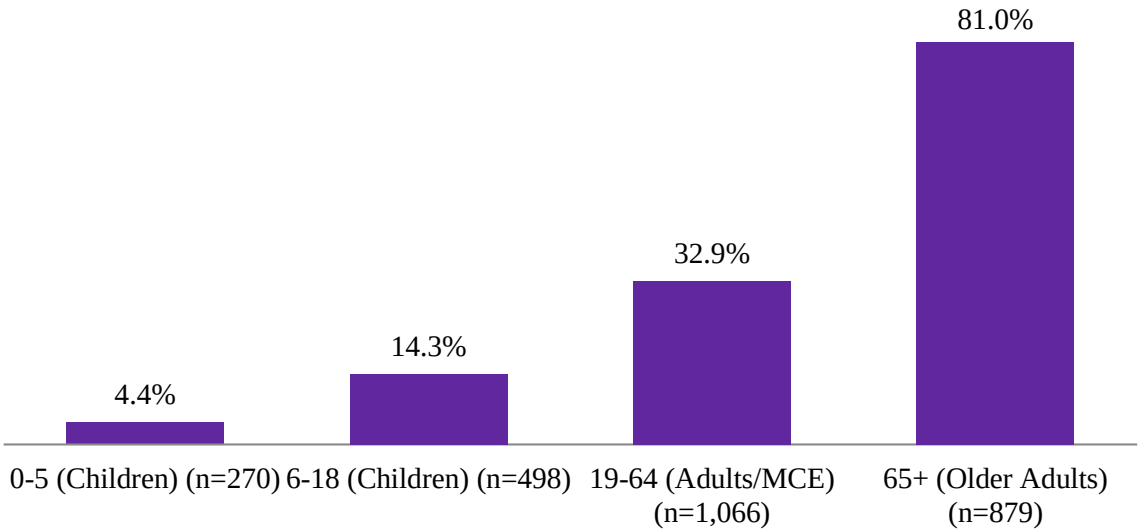


Receive SSI or SSDI as a public benefit:

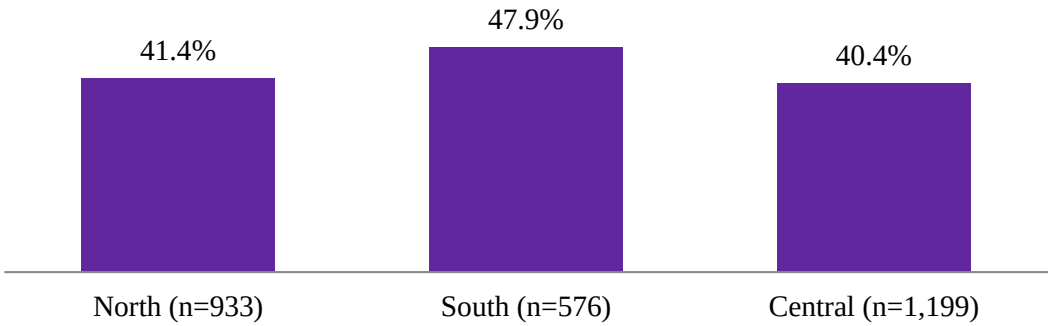
CalOptima language:



Age Category:

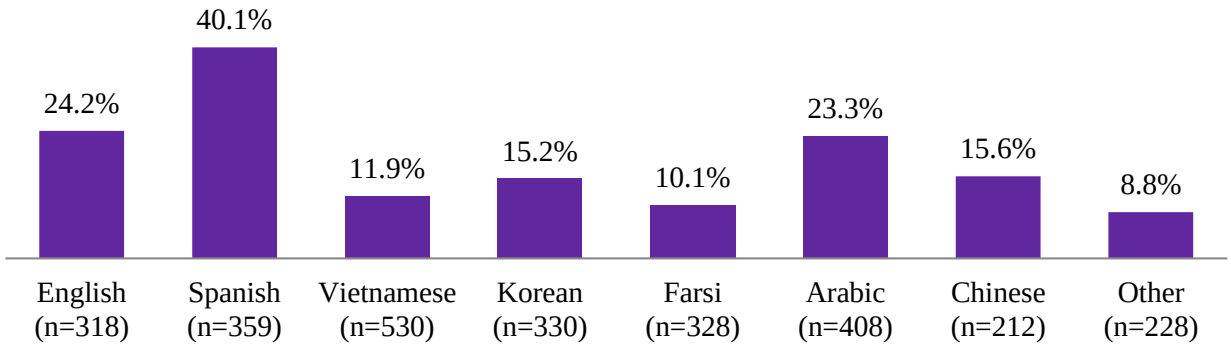


Region:

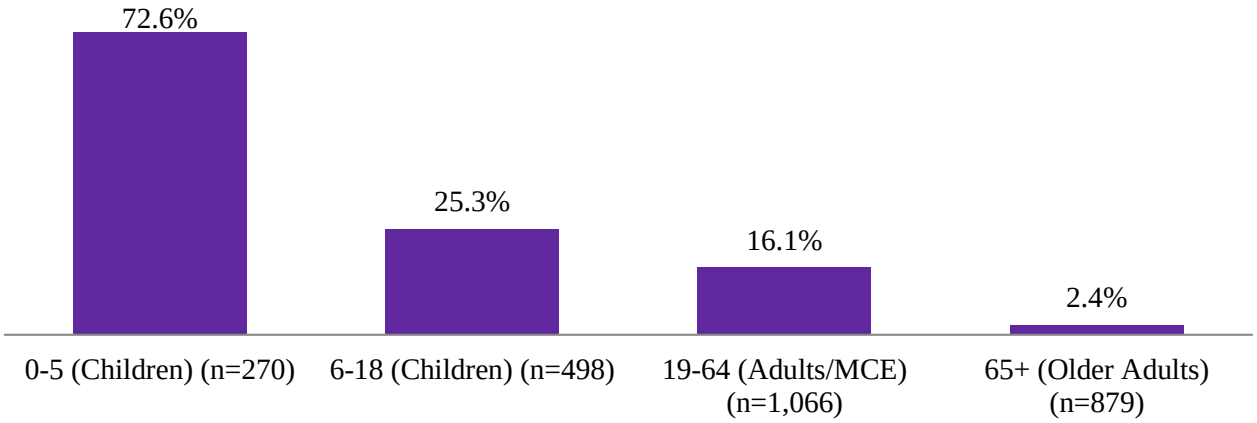


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

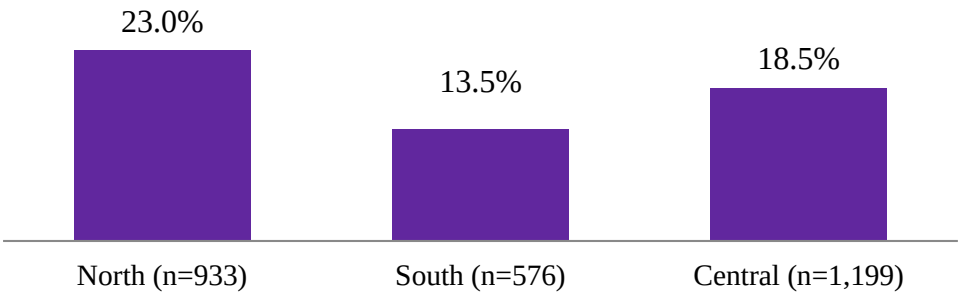


Exhibit 15. Personal activities participation:

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

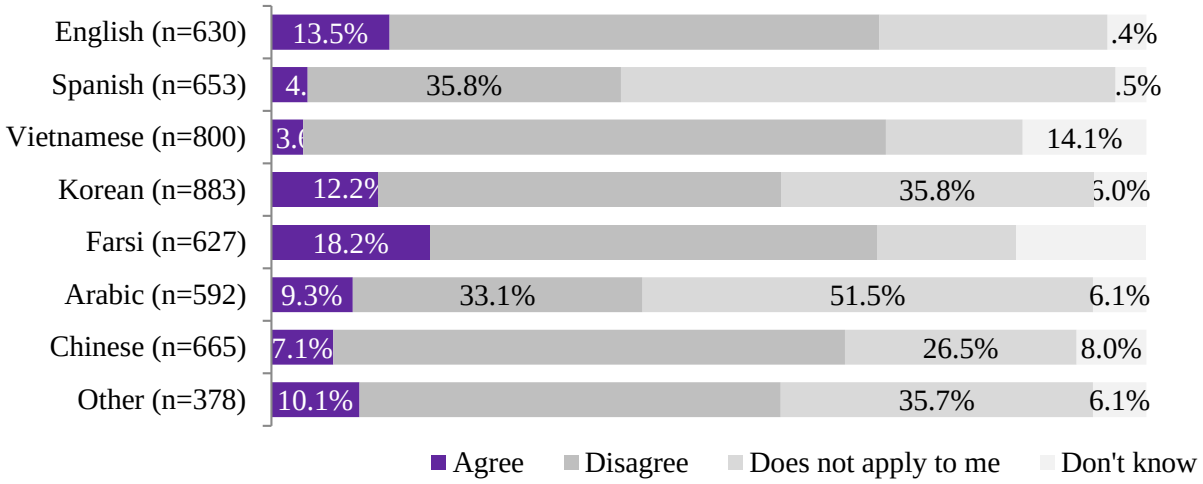
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

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

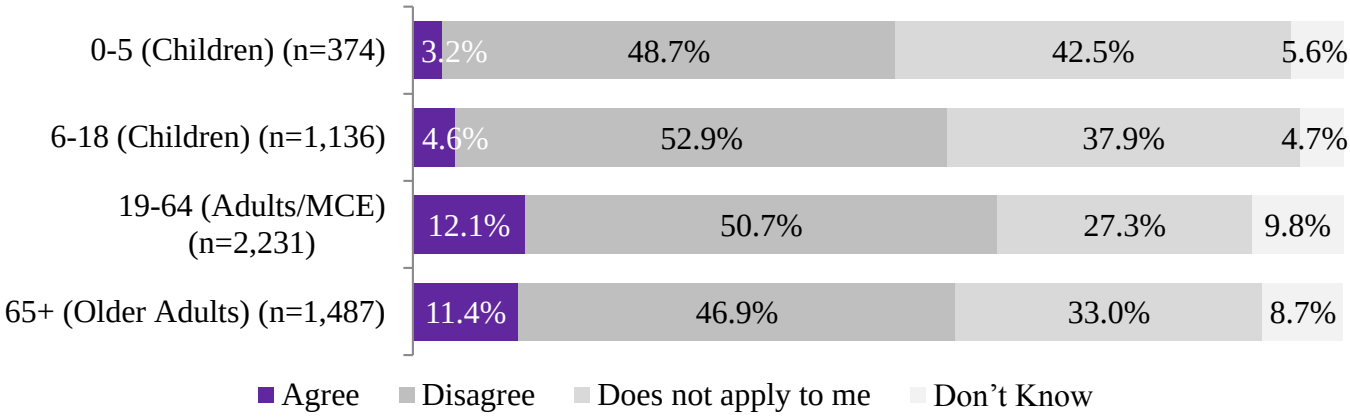
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

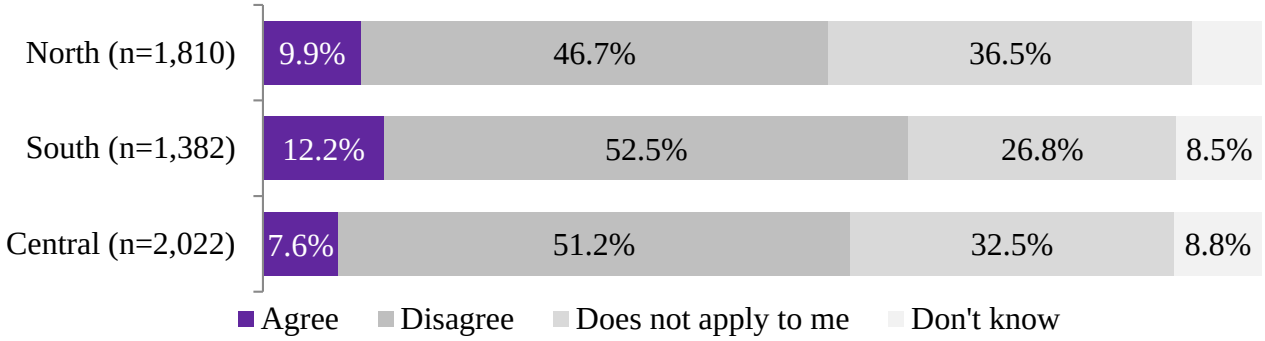
CalOptima language:



Age Category:

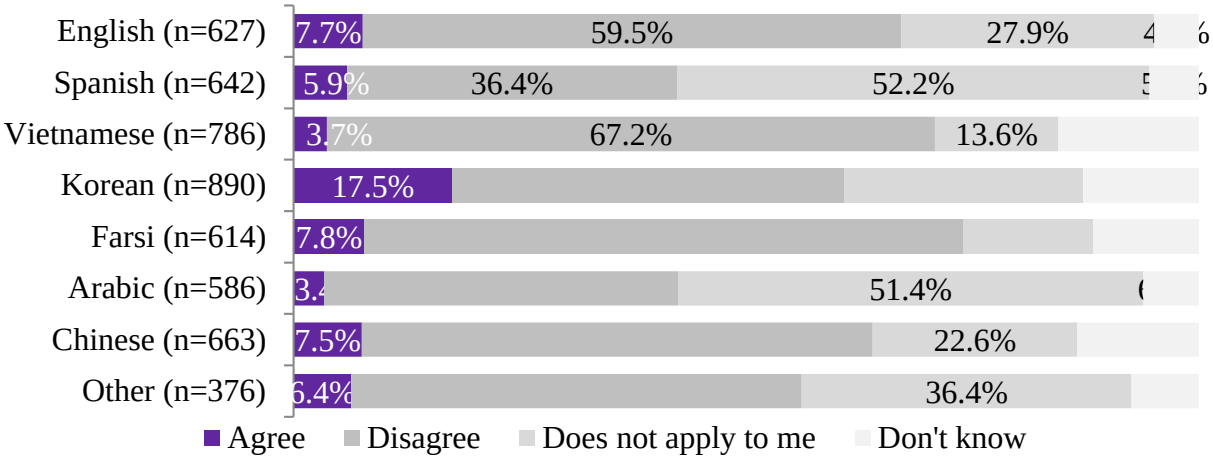


Region:

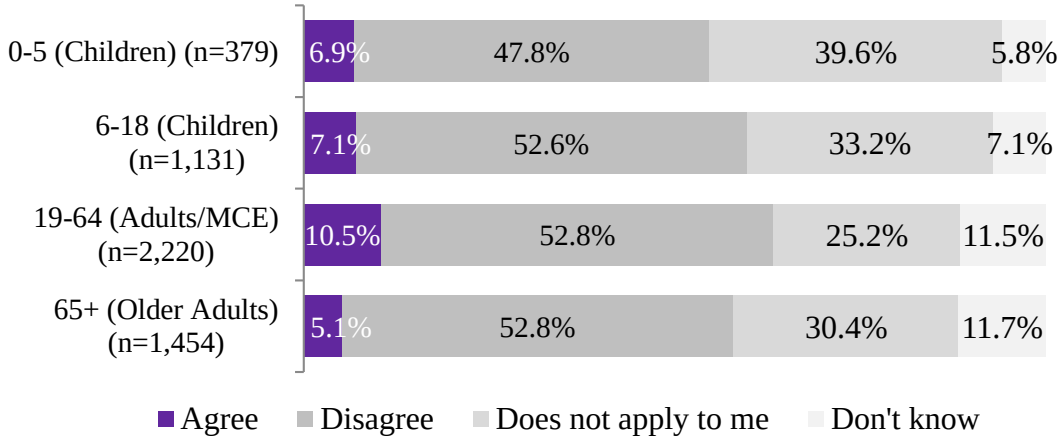


Feel not treated equally because of ethnic and culutral backgrounds:

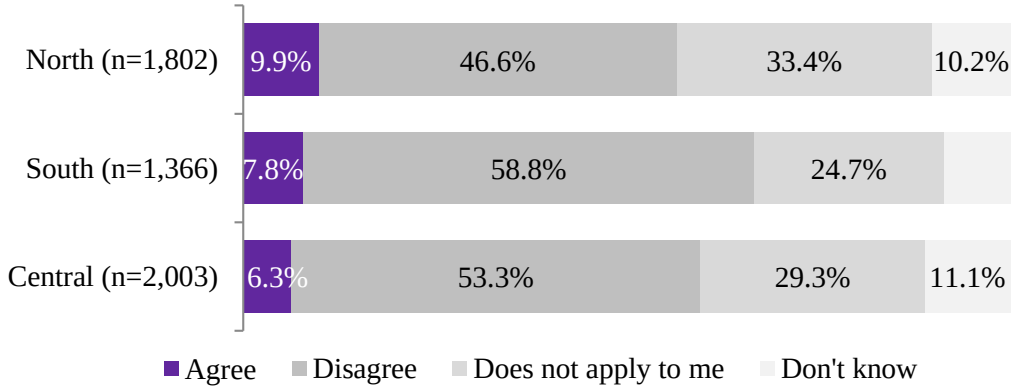
CalOptima language:



Age Category:

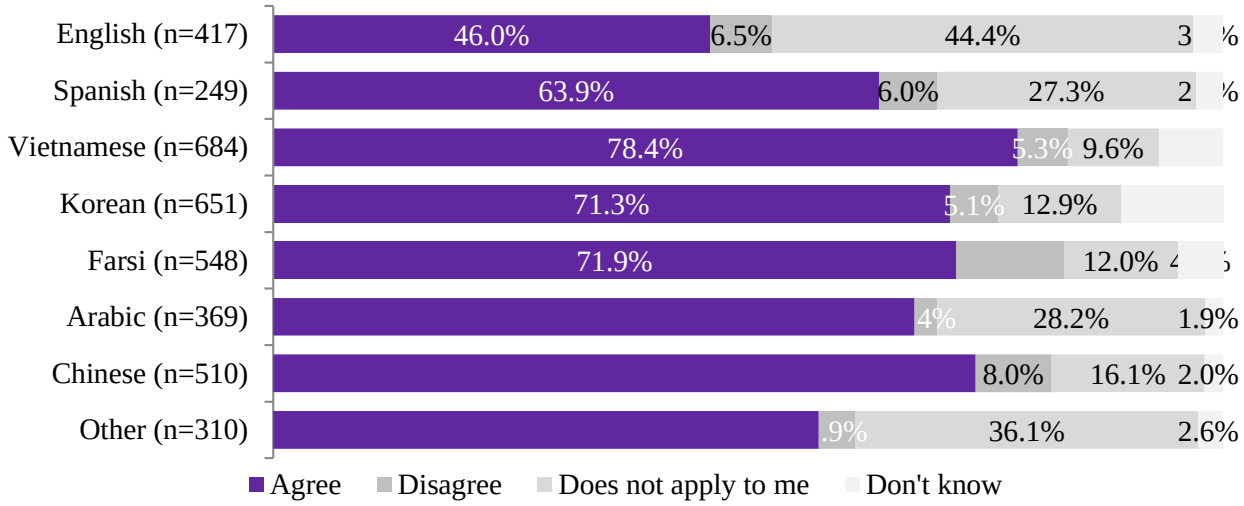


Region:

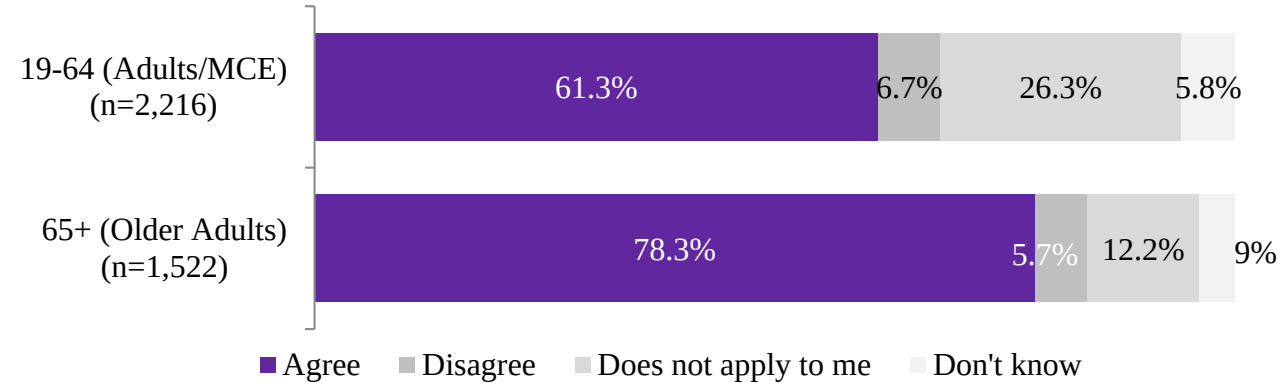


Feel child respects them as a parent[9]:

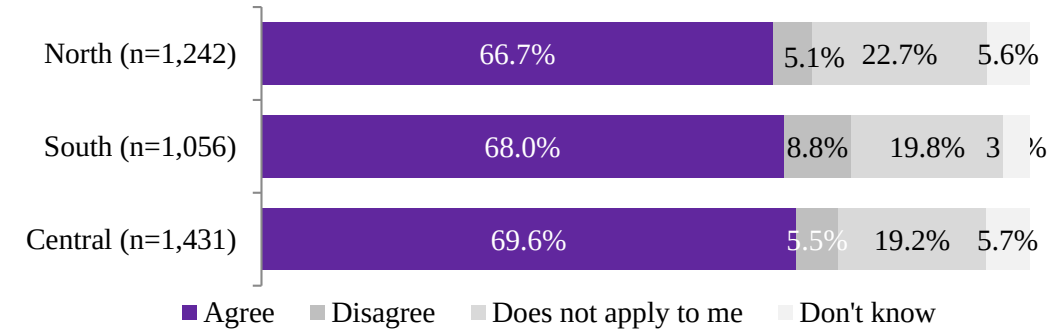
CalOptima language:



Age Category:



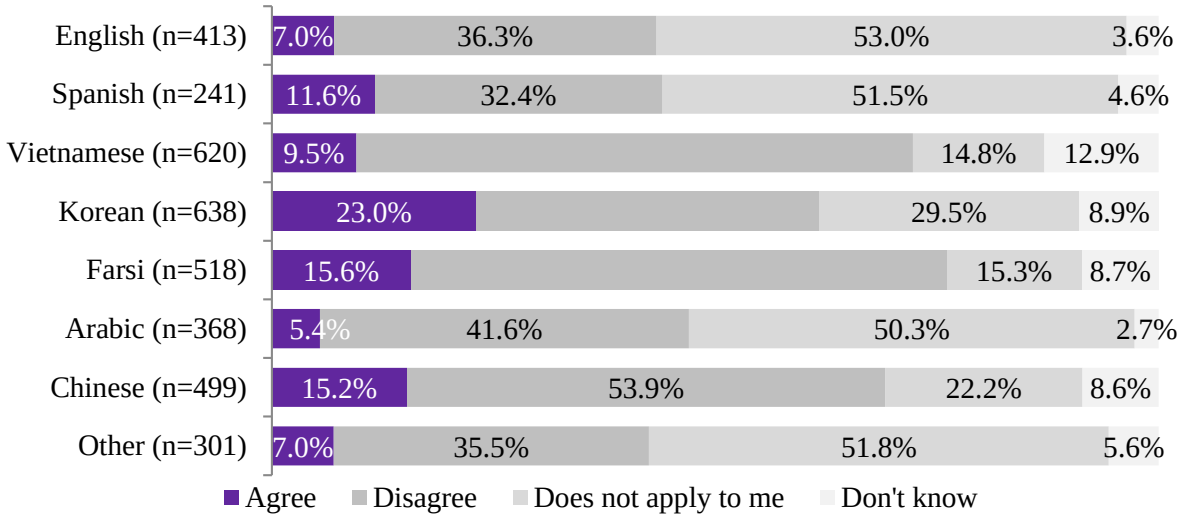
Region:



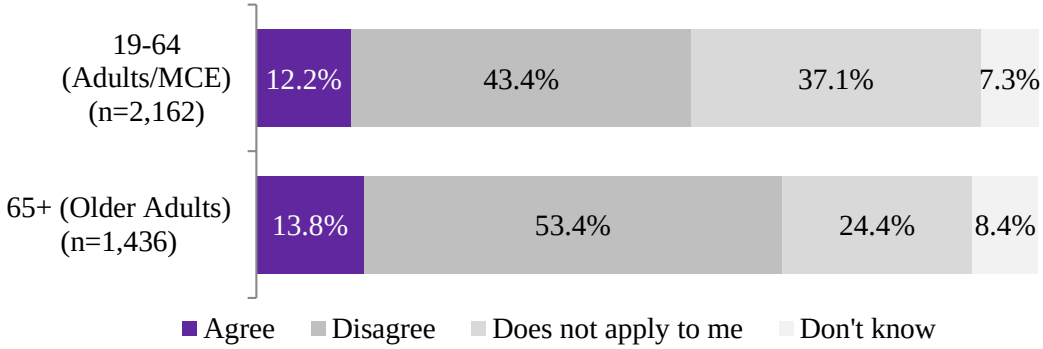
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

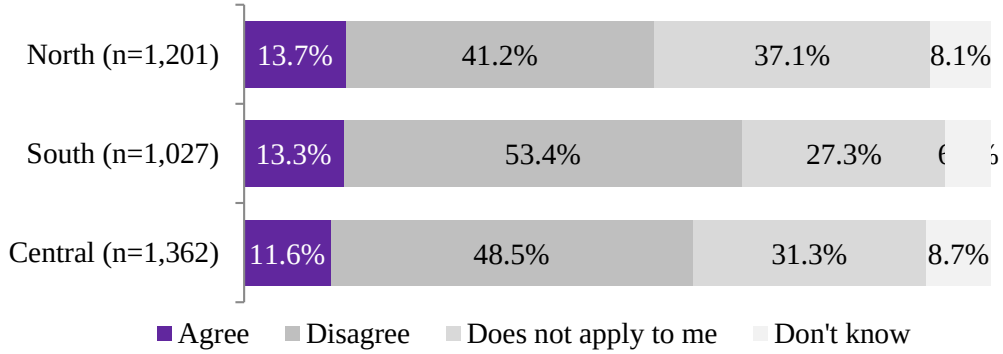
CalOptima language:



Age Category:



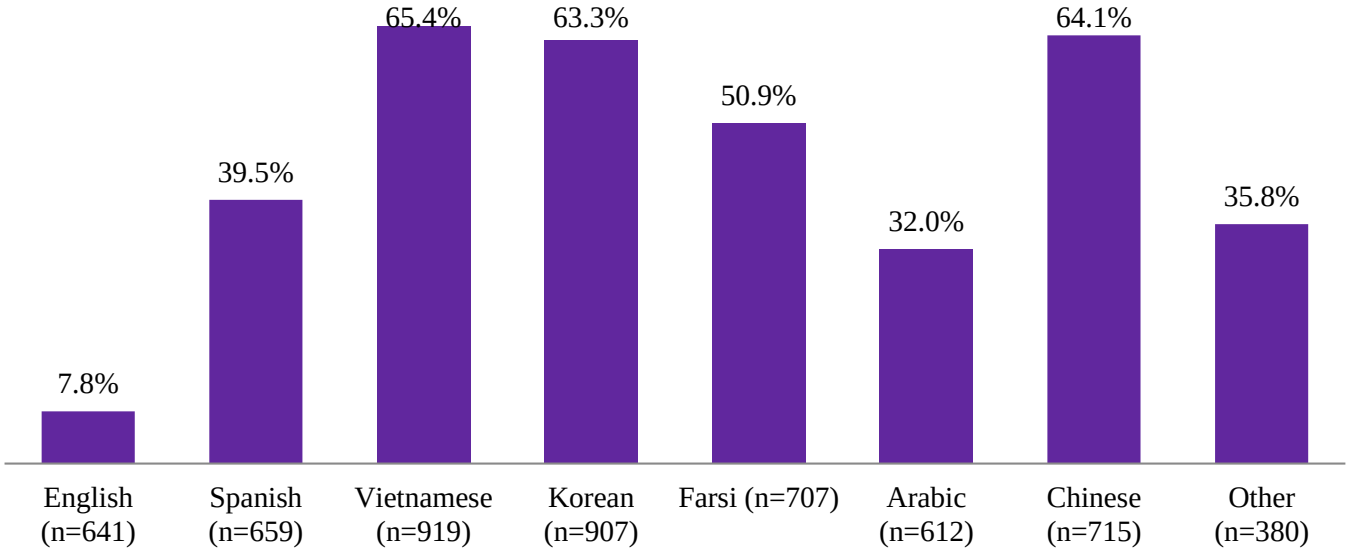
Region:



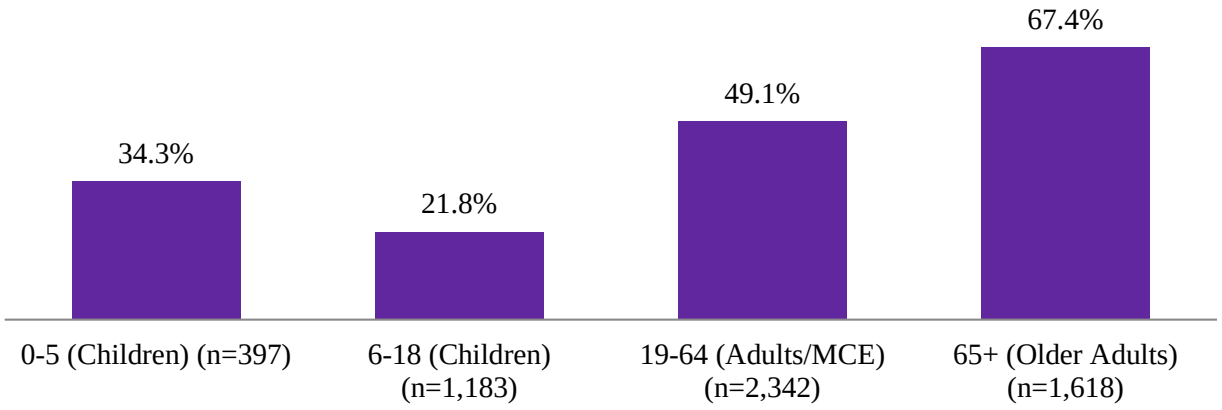
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

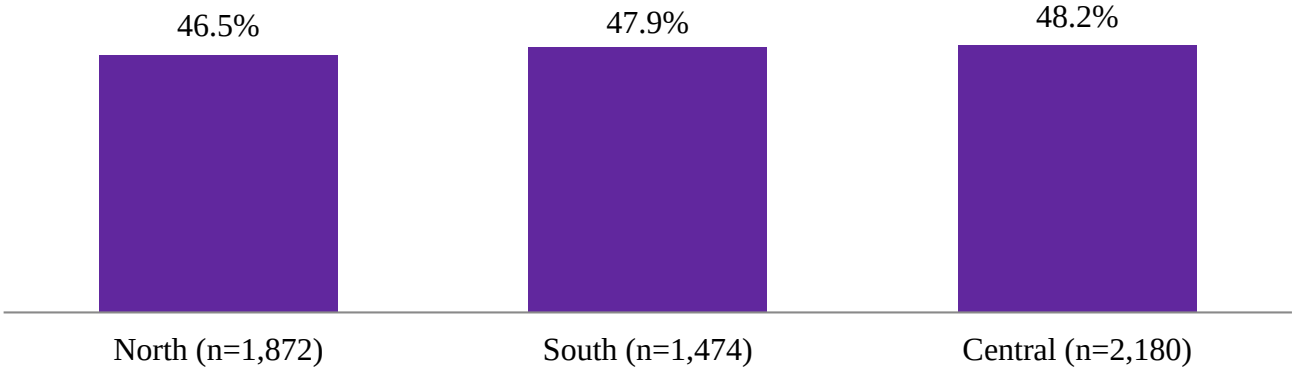


Exhibit 18. Employment status[11,12]

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

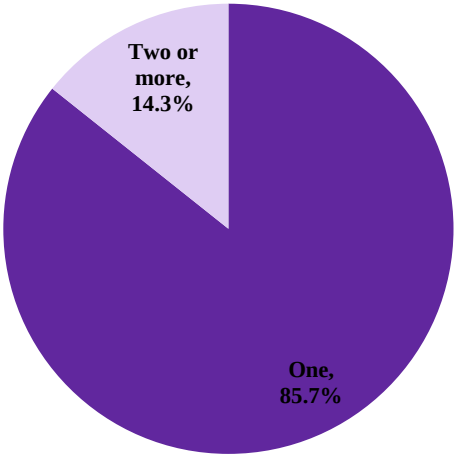
Region:

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

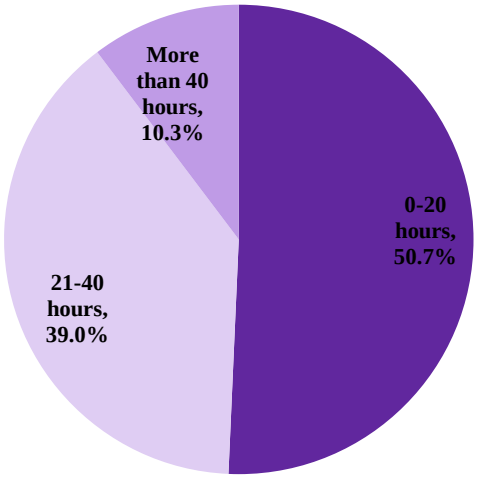
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

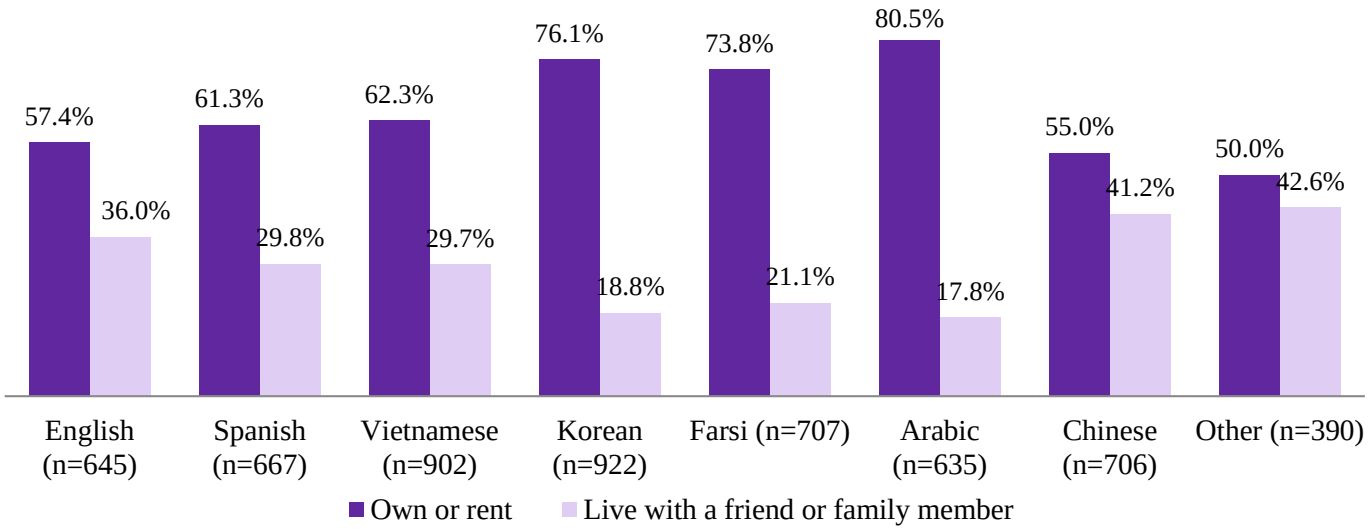


Number of hours that members work each week

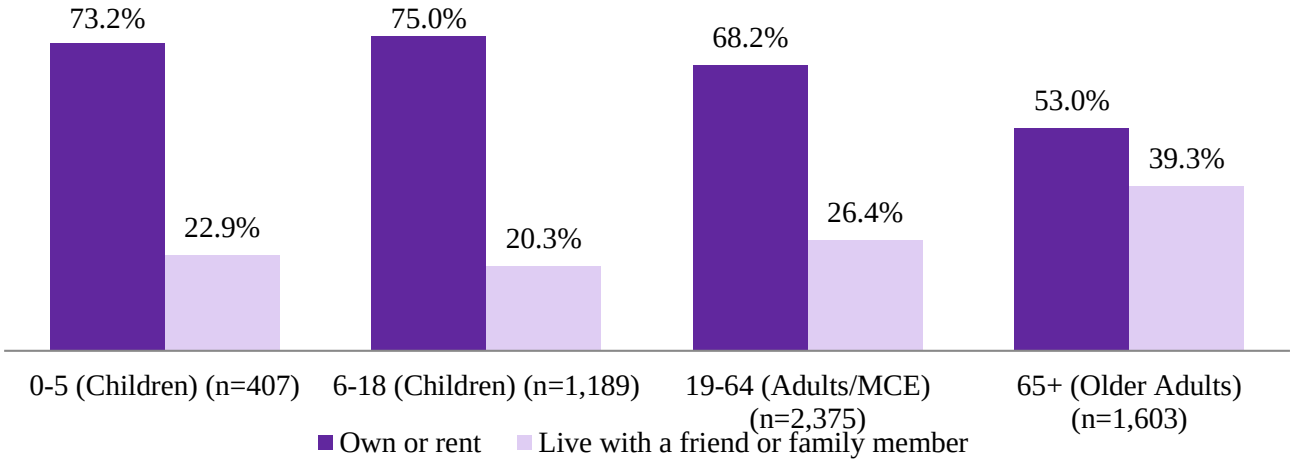


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

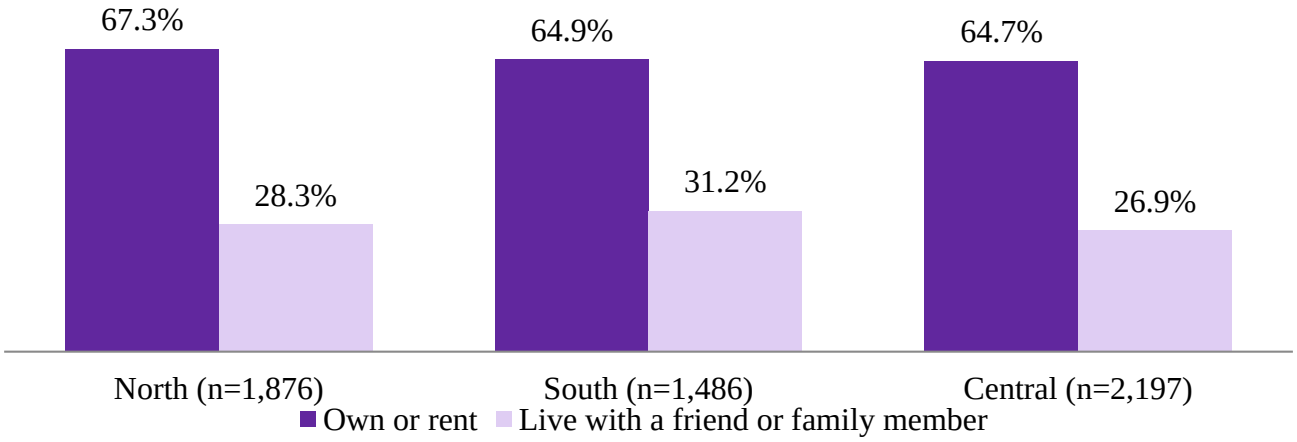
Exhibit 20. Members' living situation[14]



Age Category:



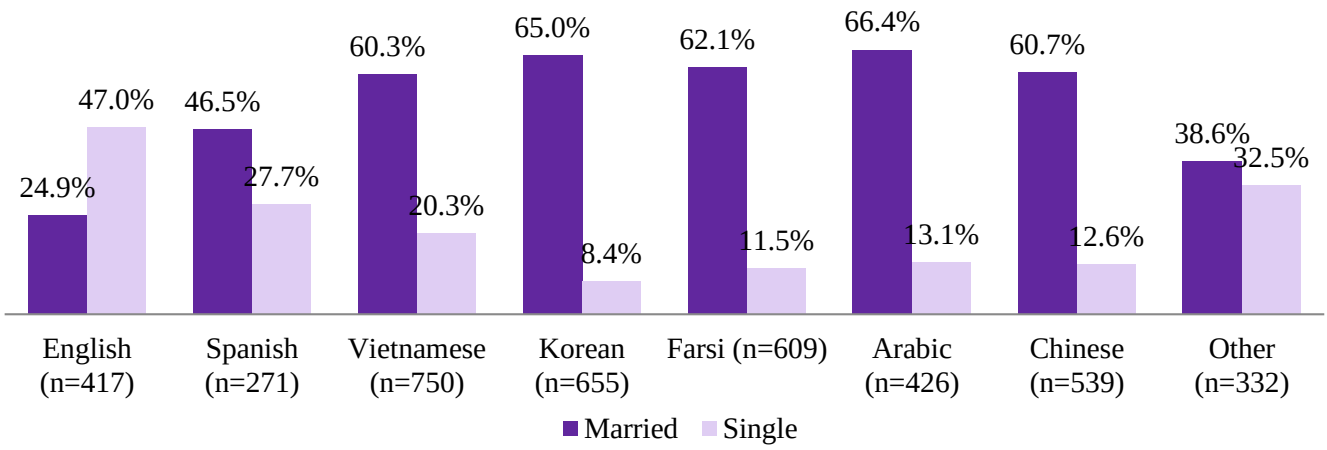
Region:



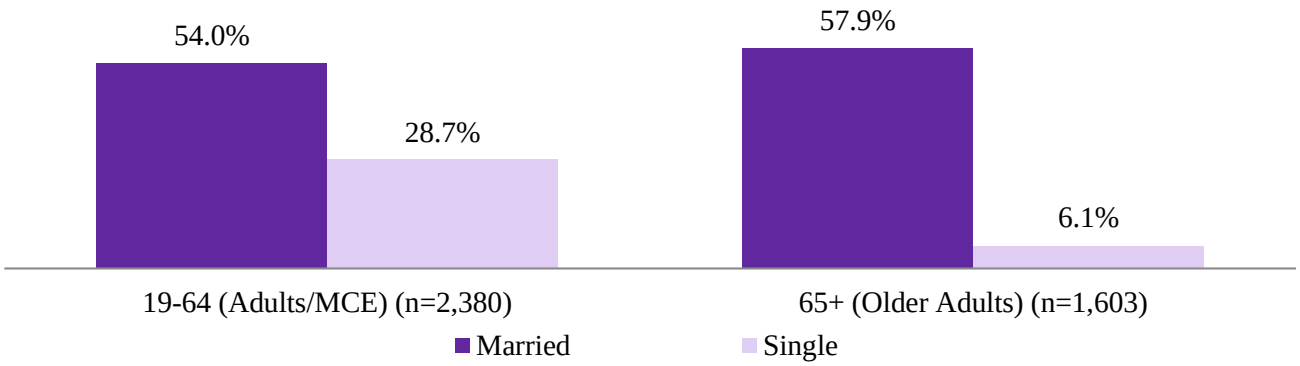
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

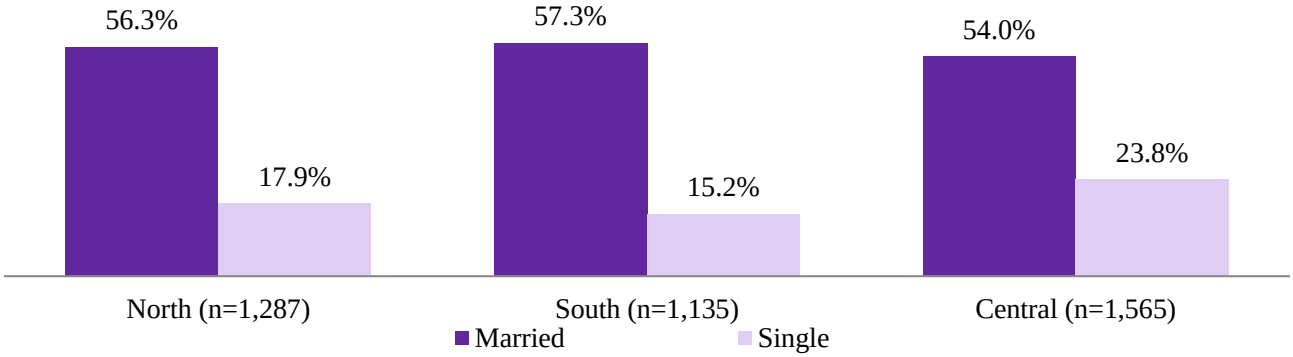
CalOptima language:



Age Category:



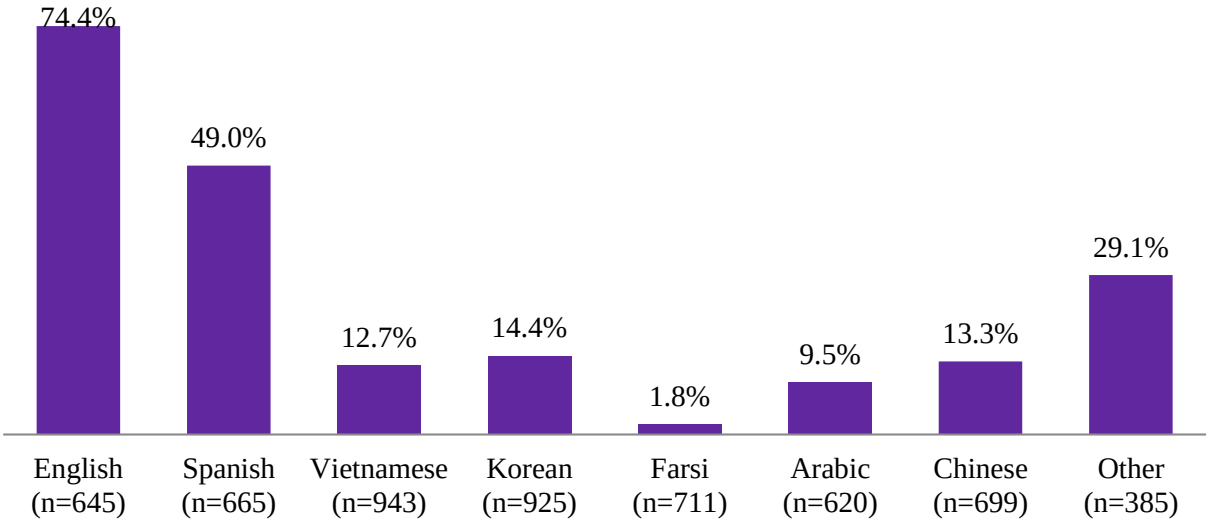
Region:



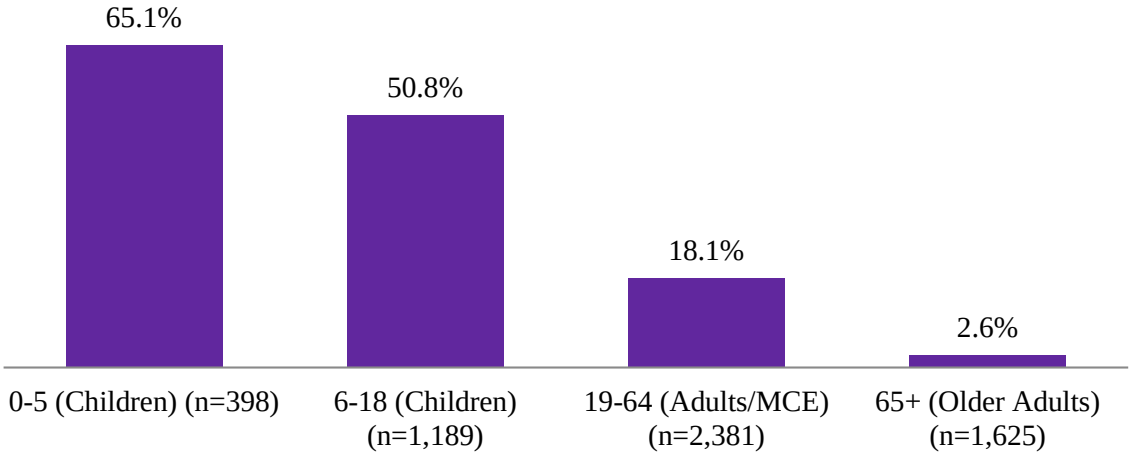
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

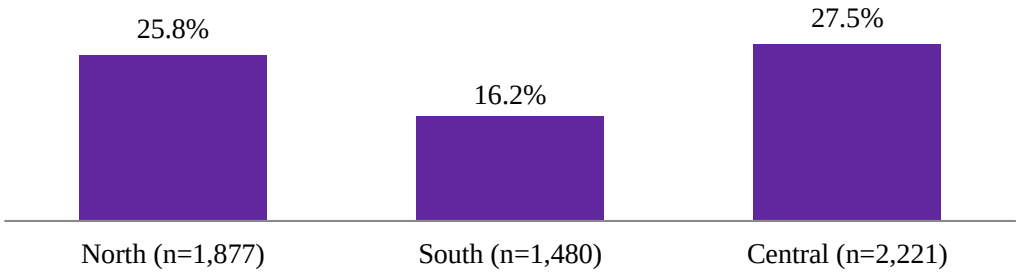
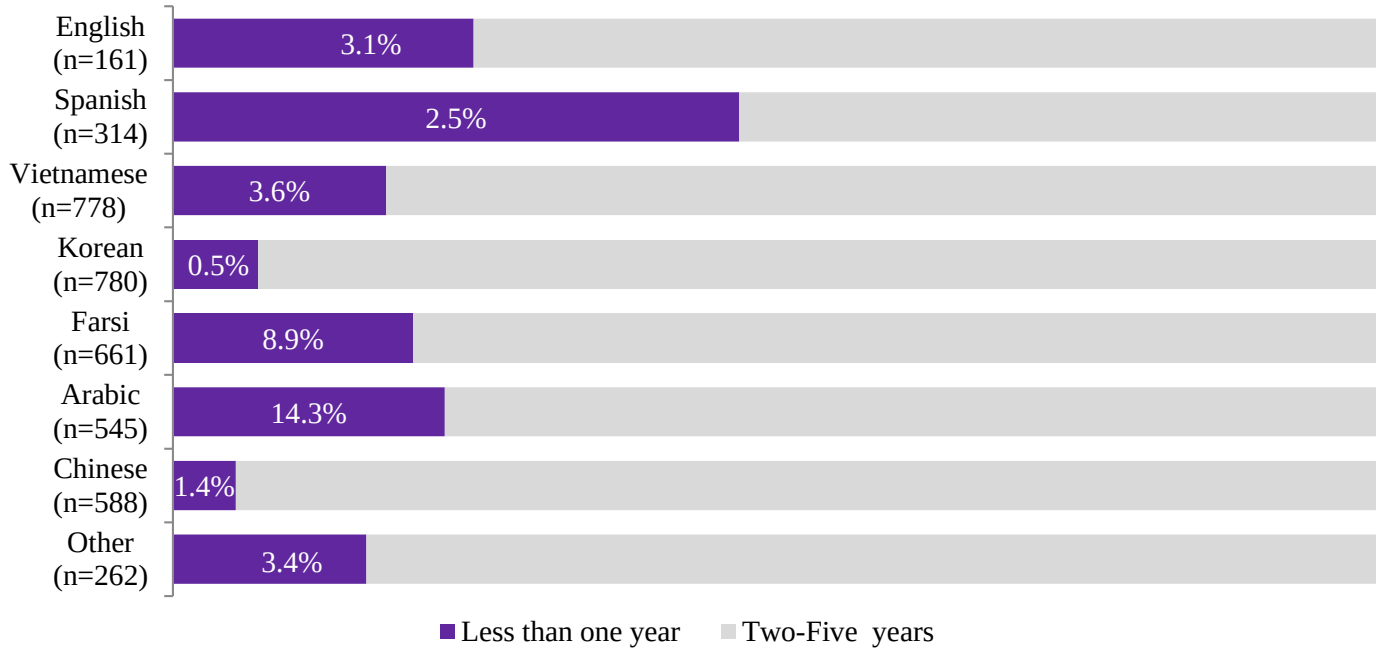
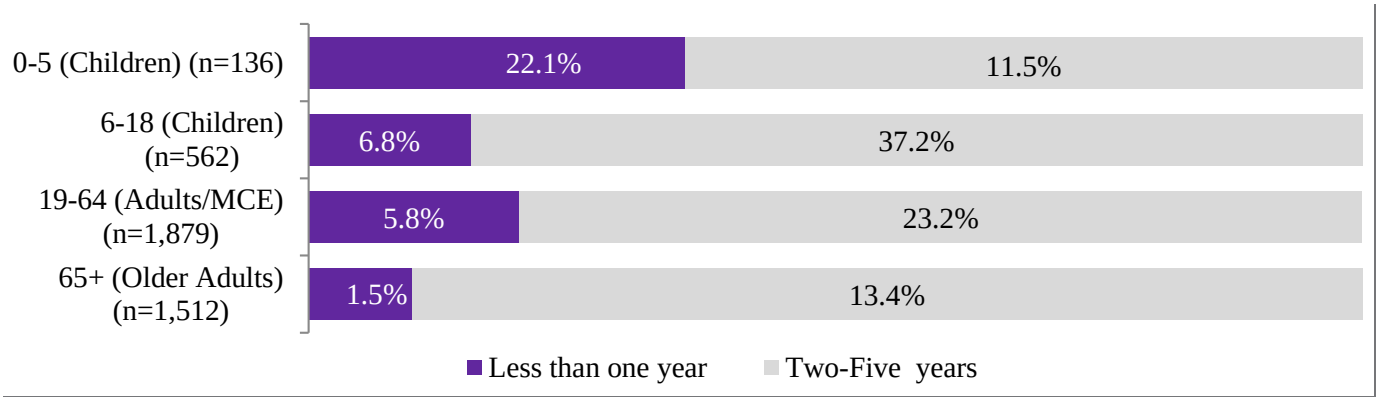


Exhibit 23. Length of time lived in the United States of those not born in the United States

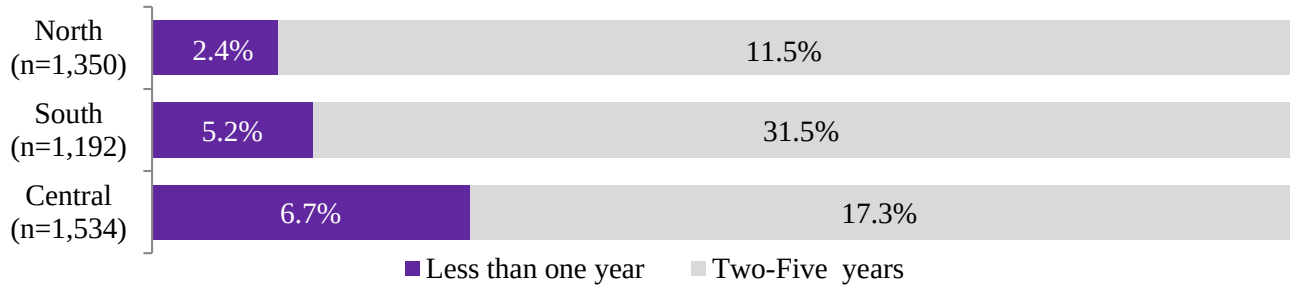
CalOptima language:



Age Category:



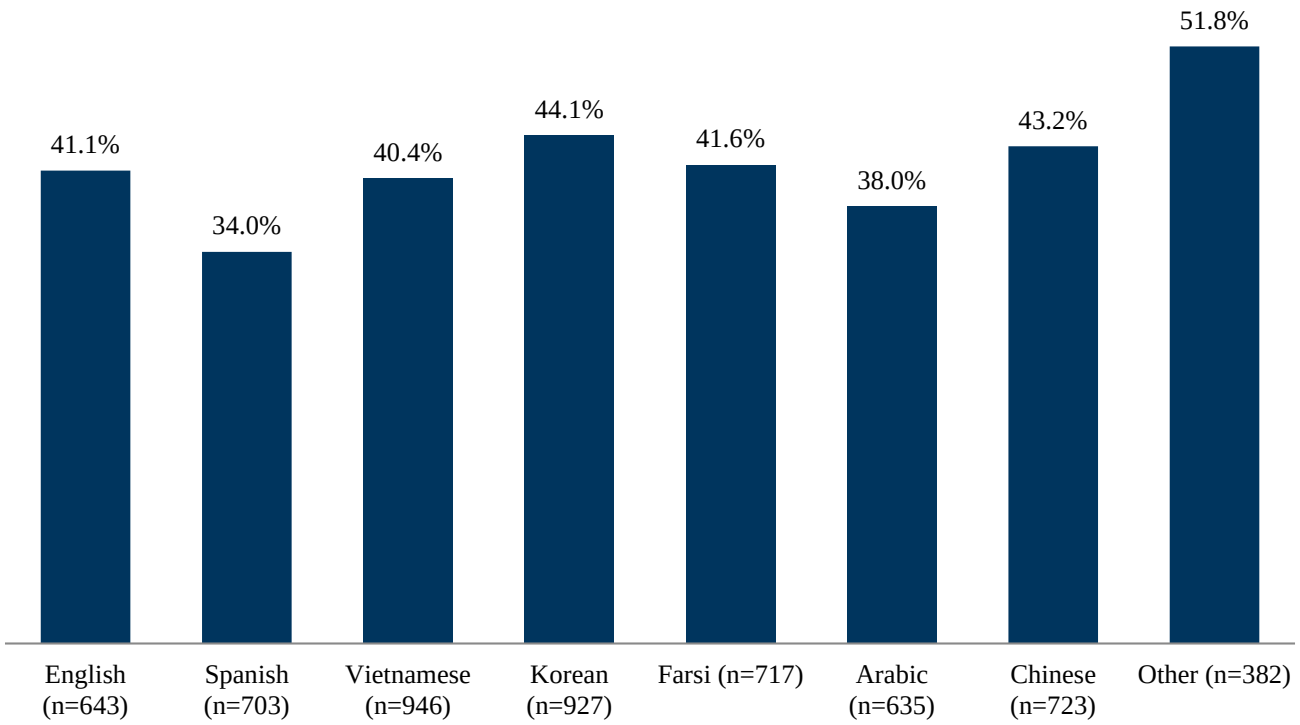
Region:



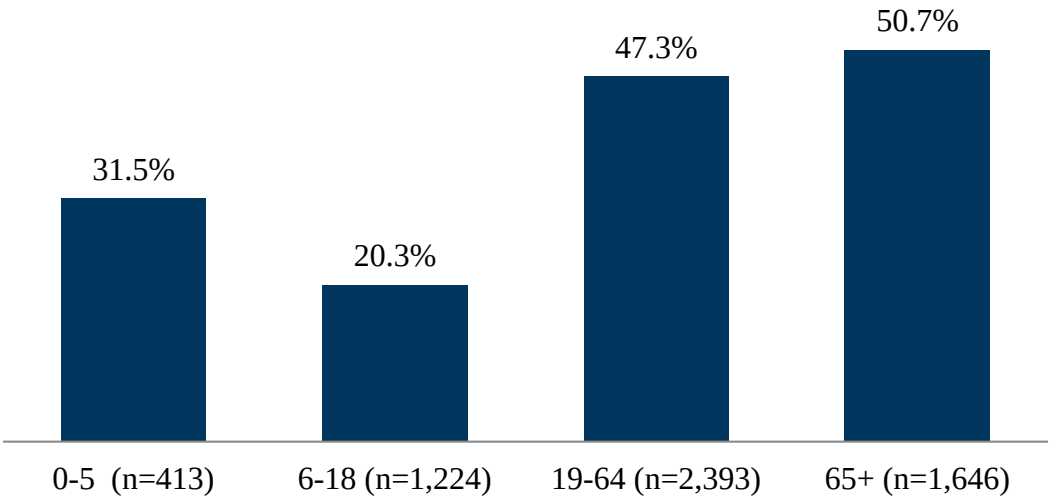
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

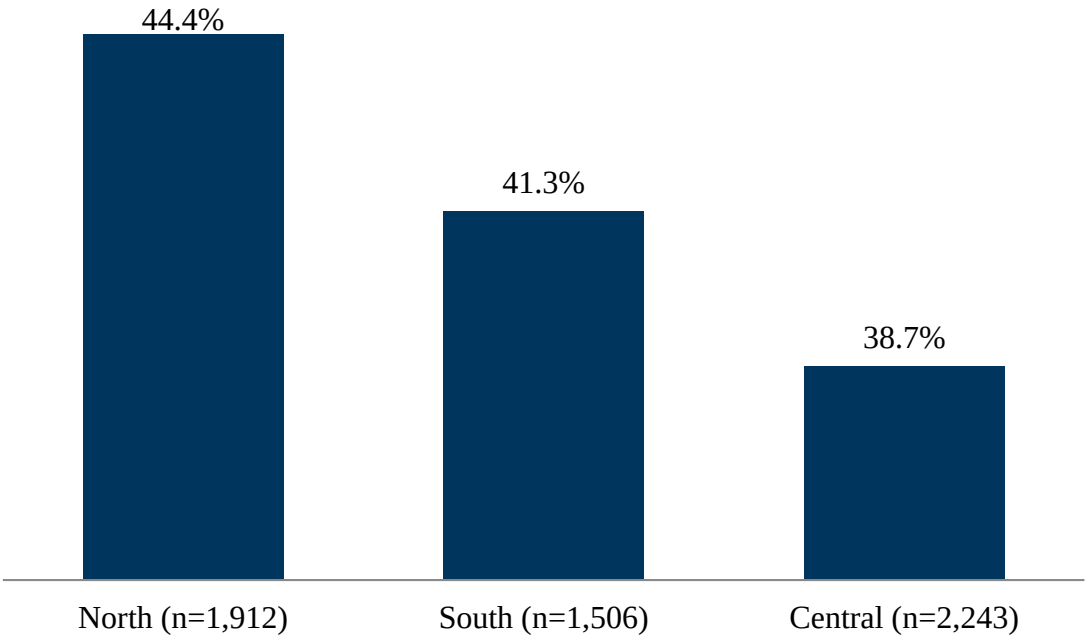


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

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

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

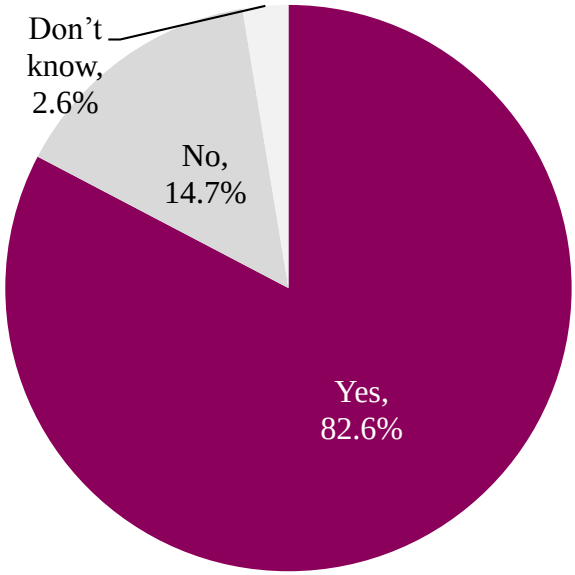


Exhibit 28. Where respondents go to see their doctor (n=5,743)

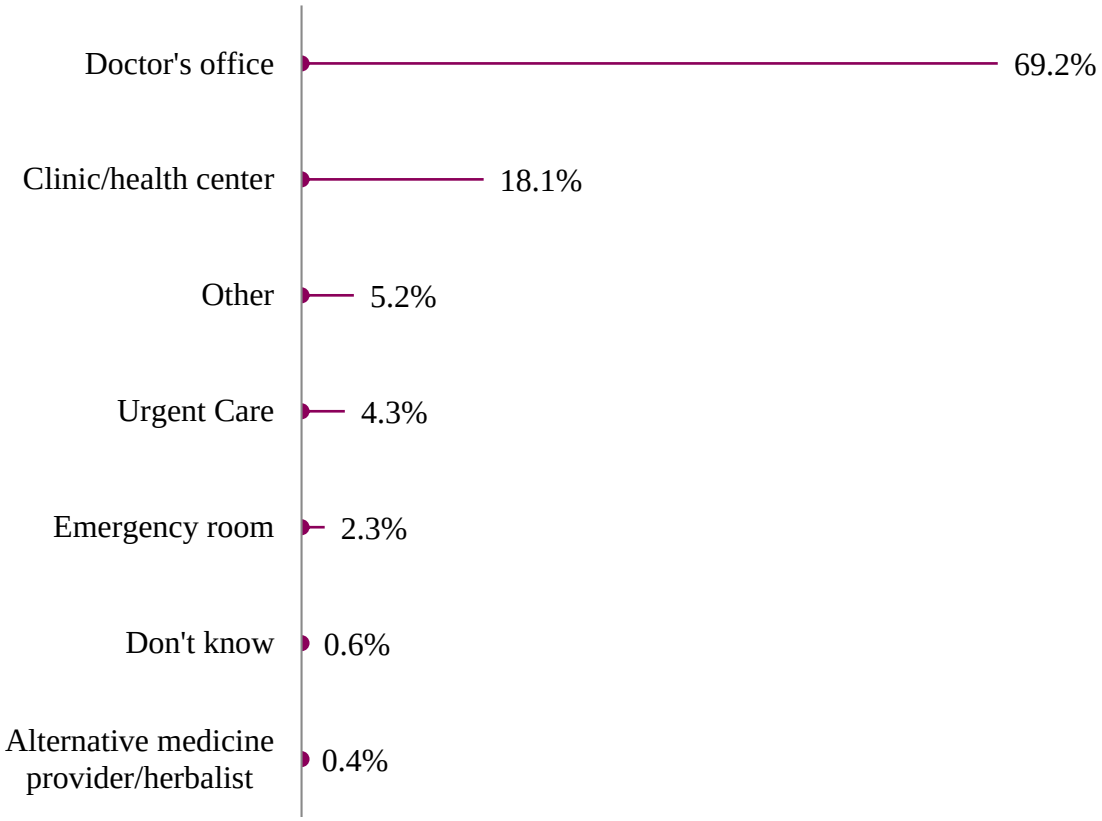


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

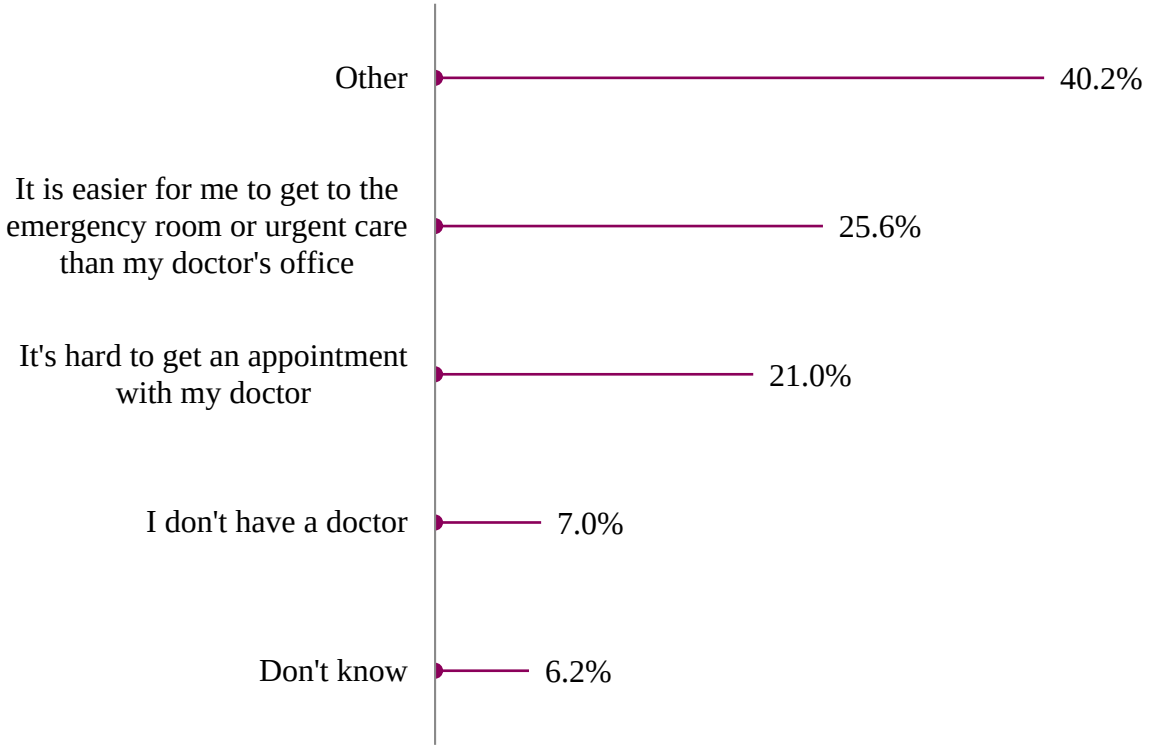


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

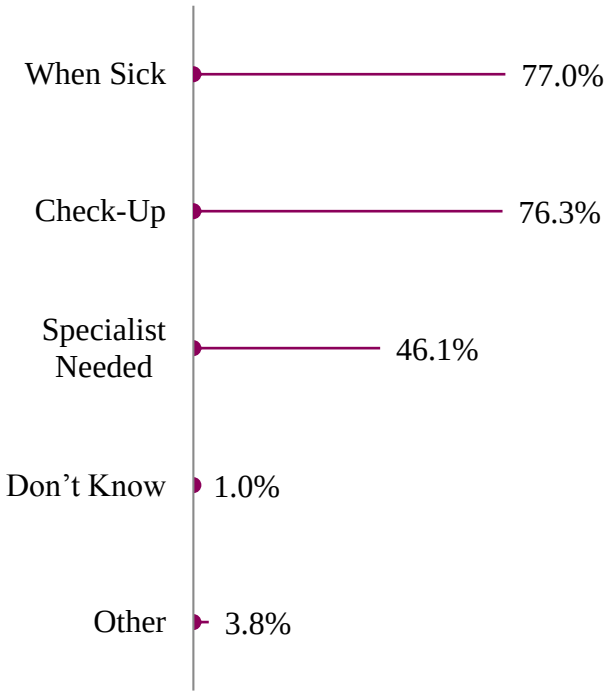
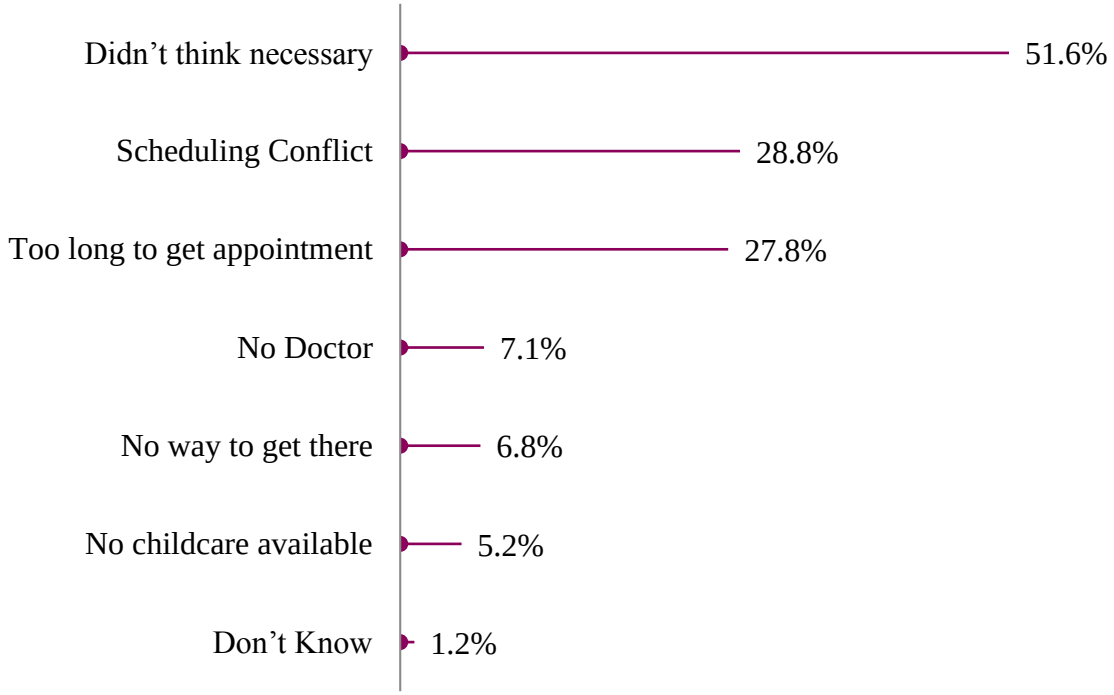


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[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]

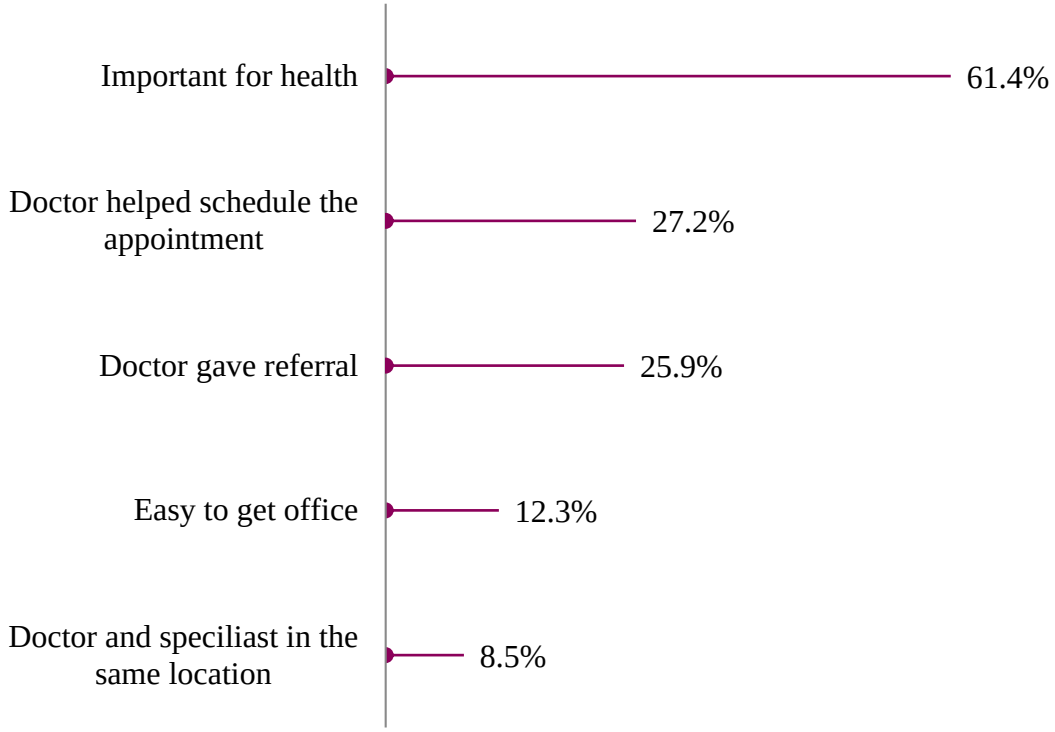
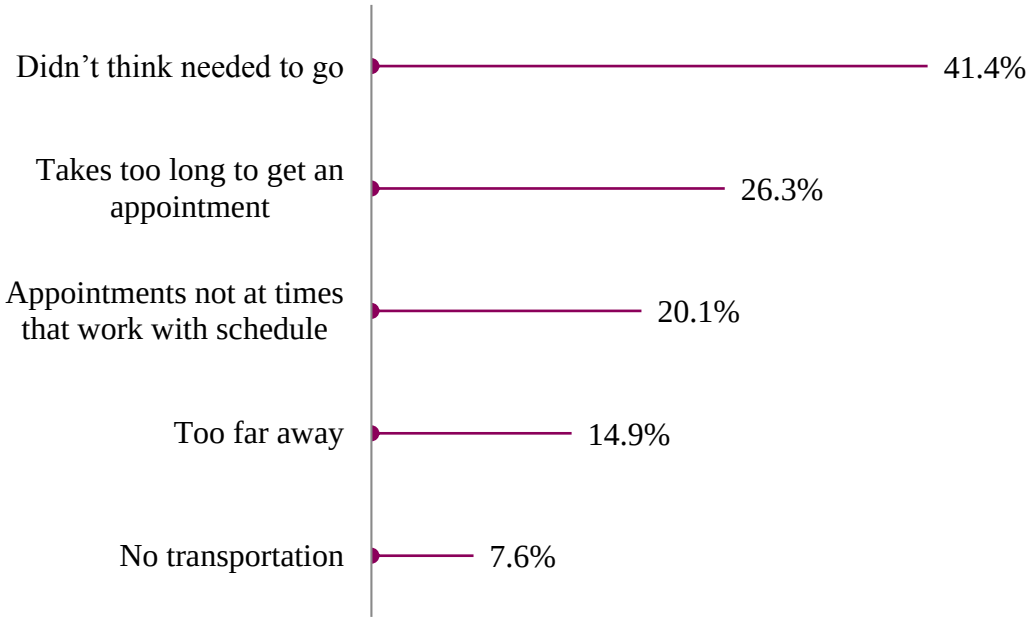
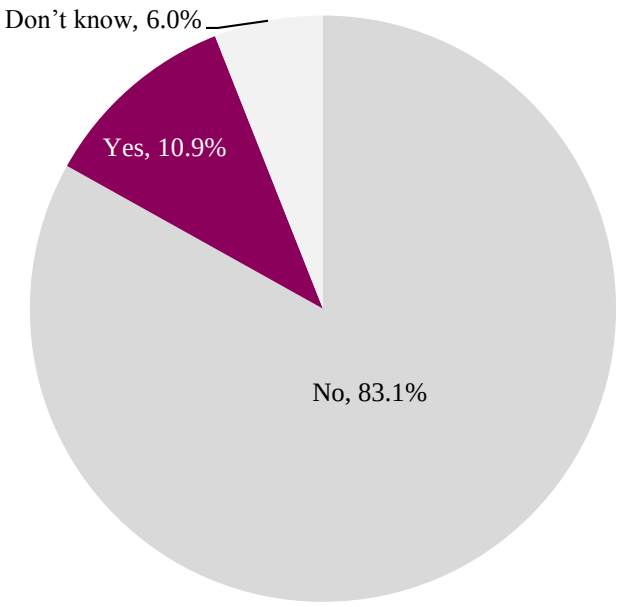


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[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)

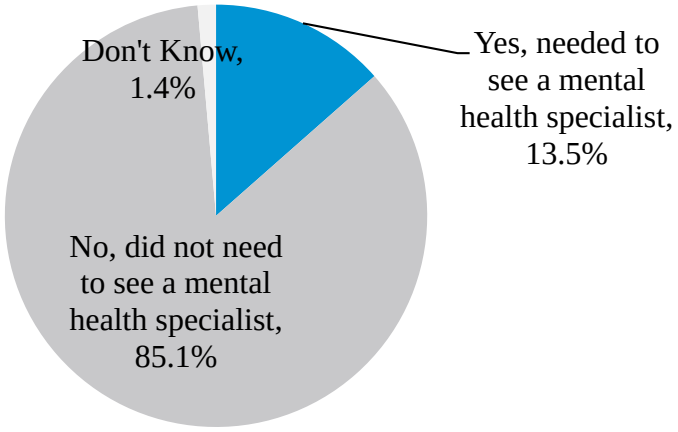


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

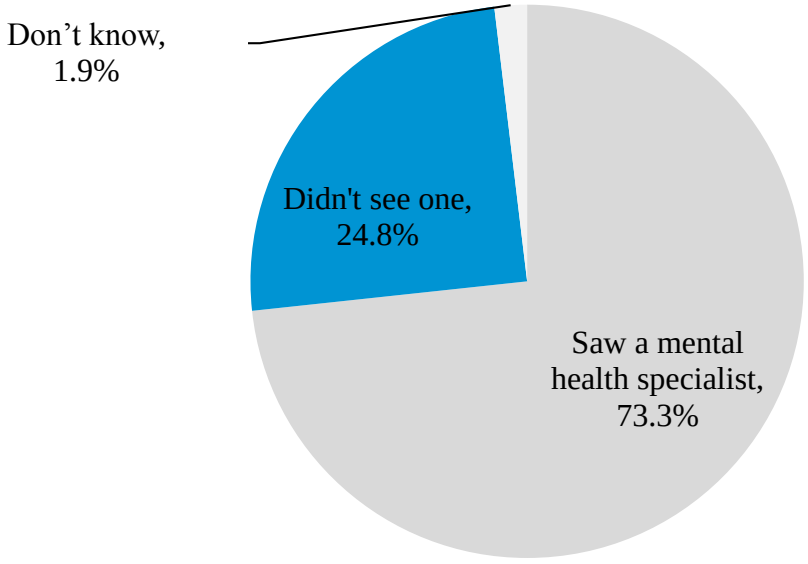


Exhibit 37. Reasons why members didn't see mental health specialist[24]

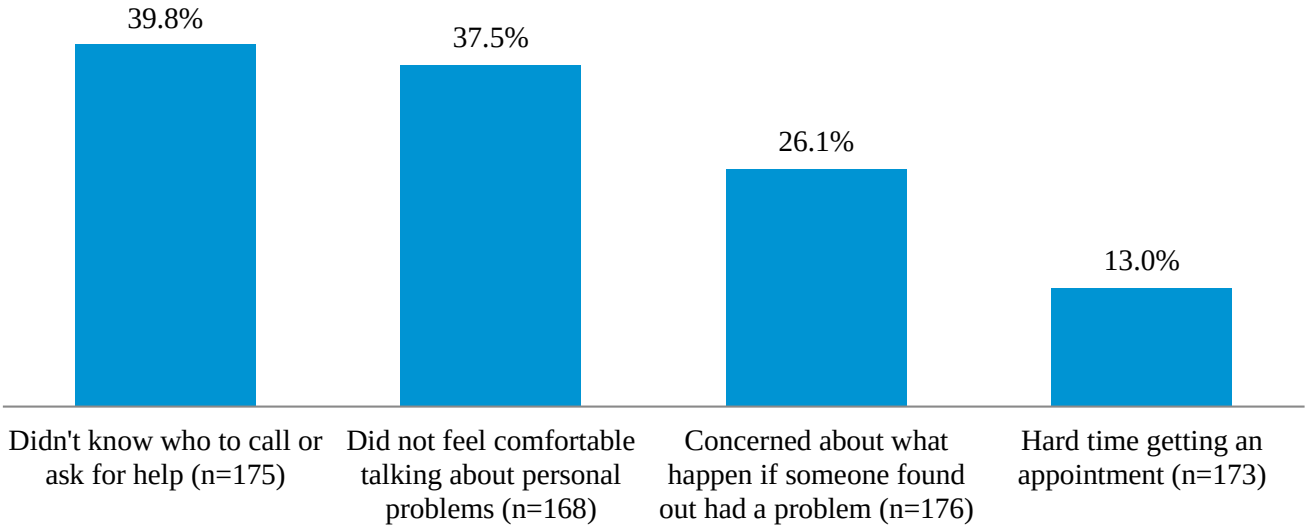
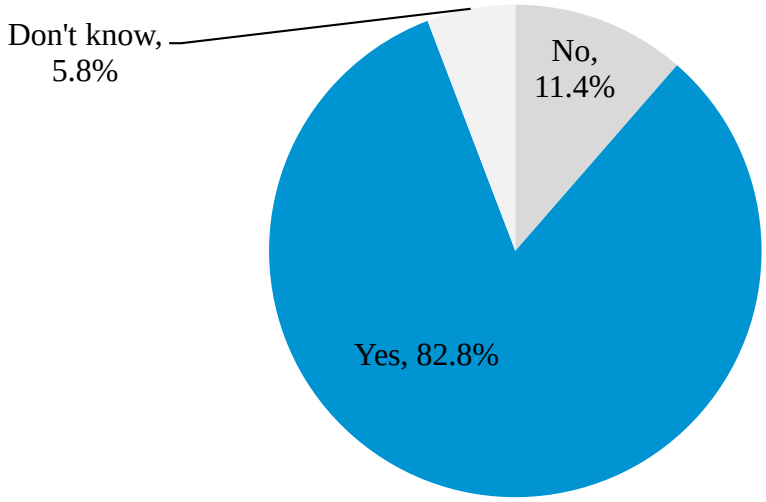


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[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:

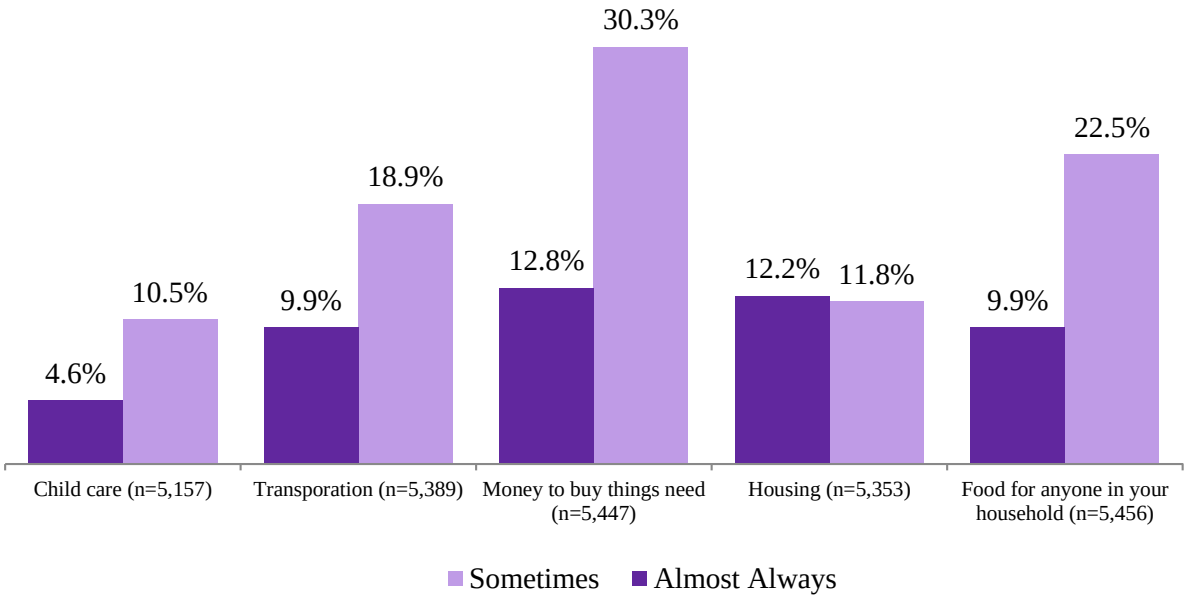


Exhibit 41. Percent of members who receive public benefits (n=5,117):

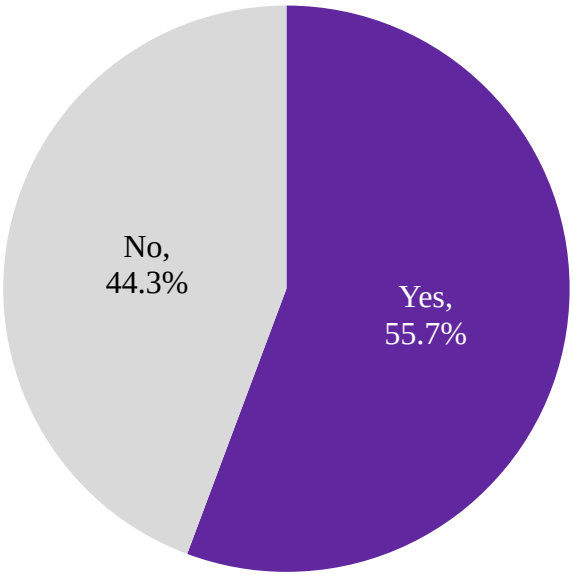
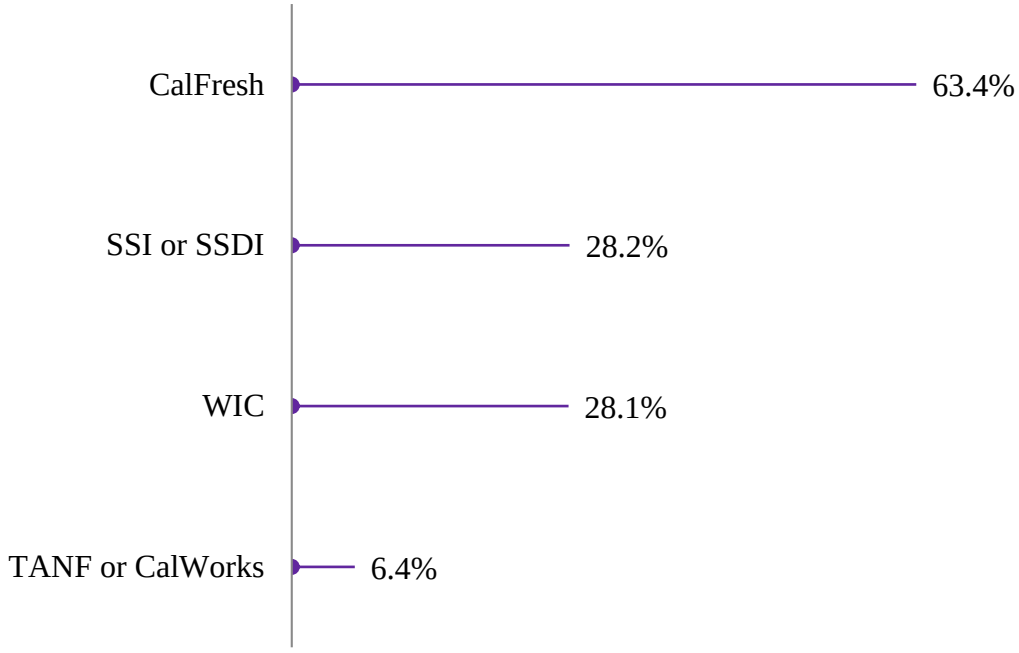


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

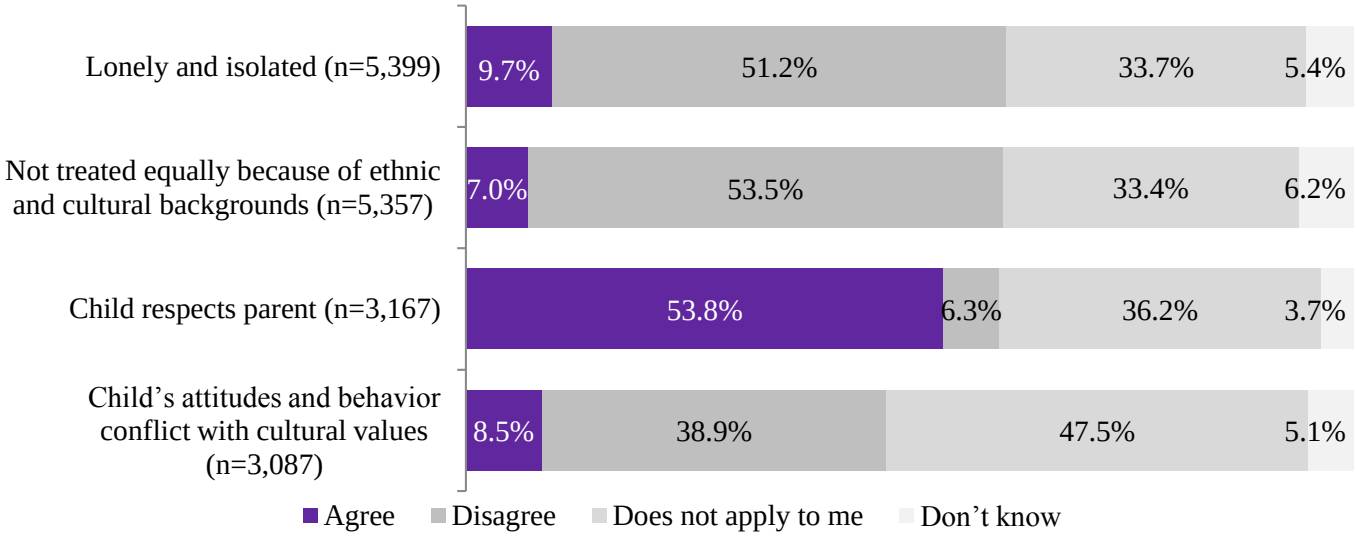


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

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)

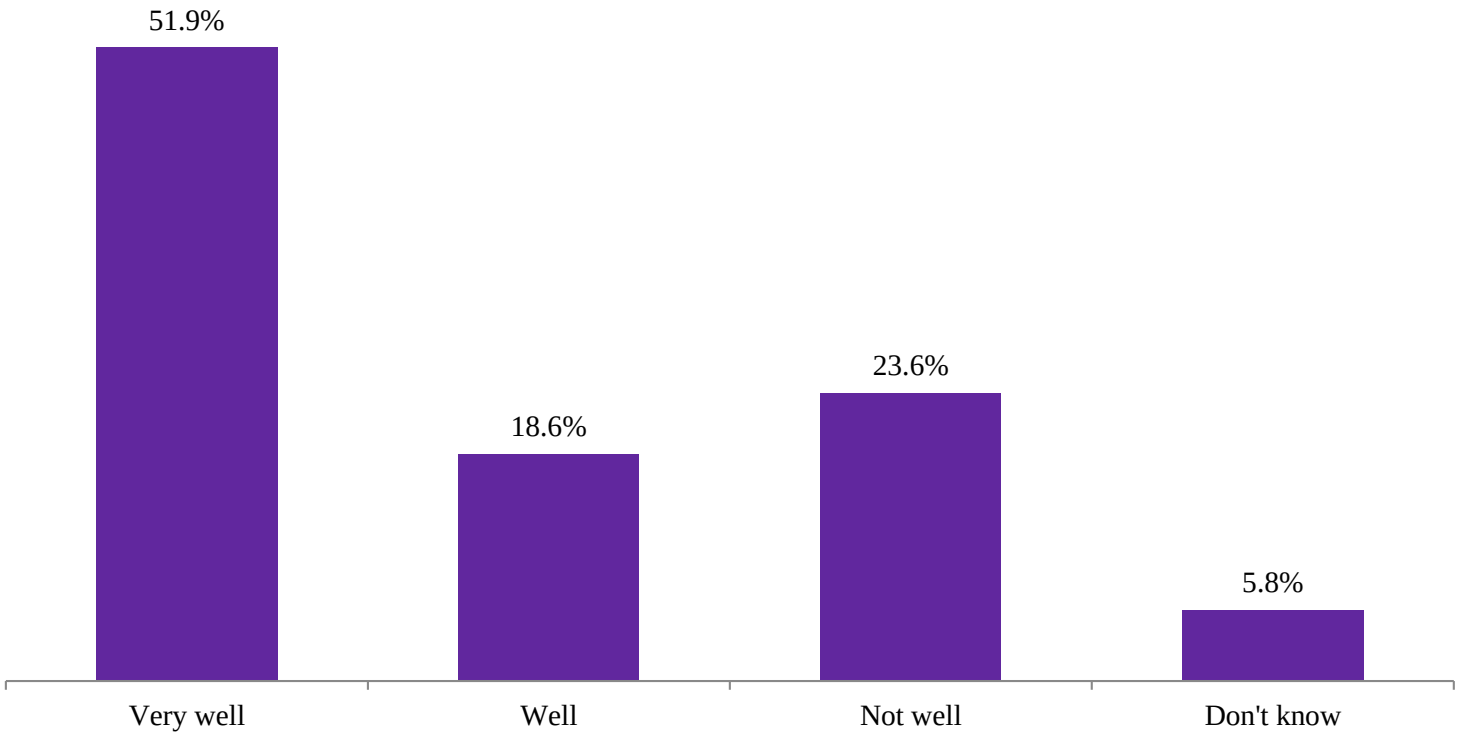


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

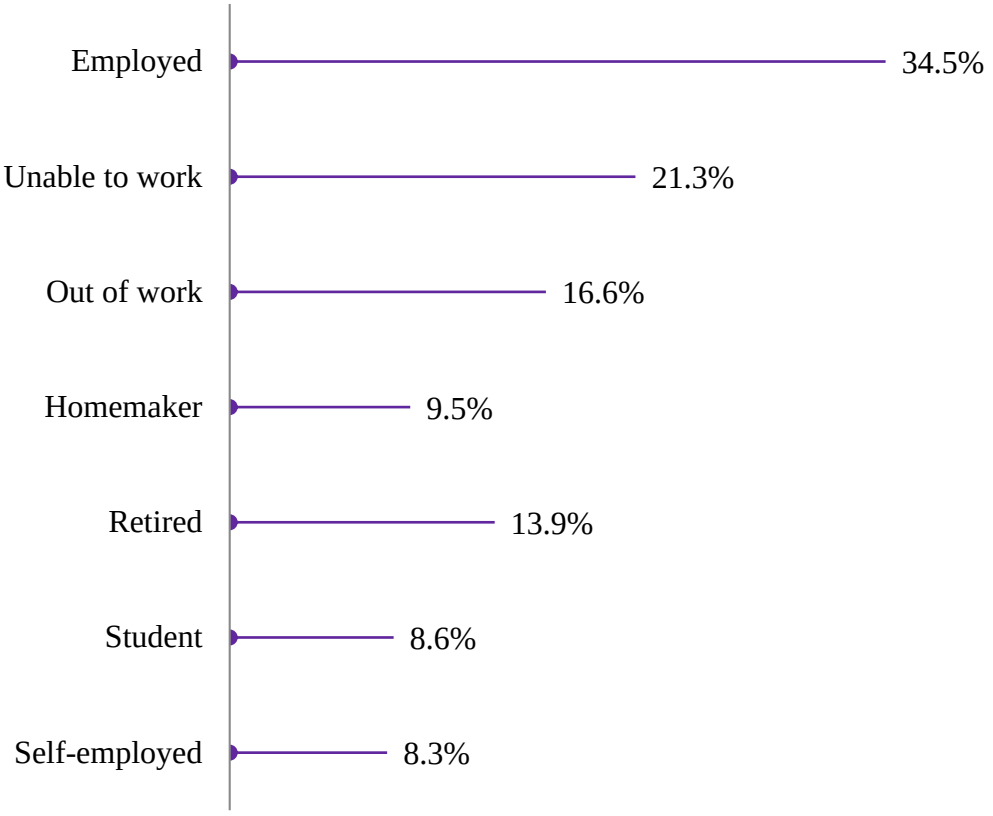
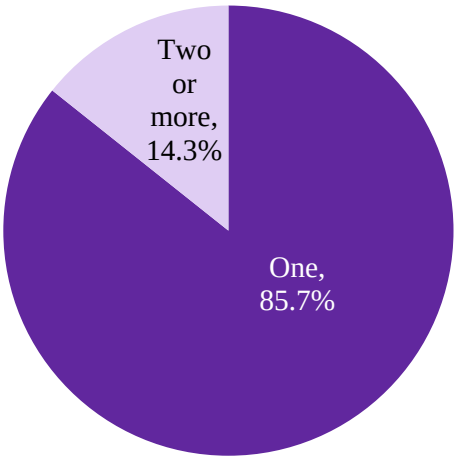
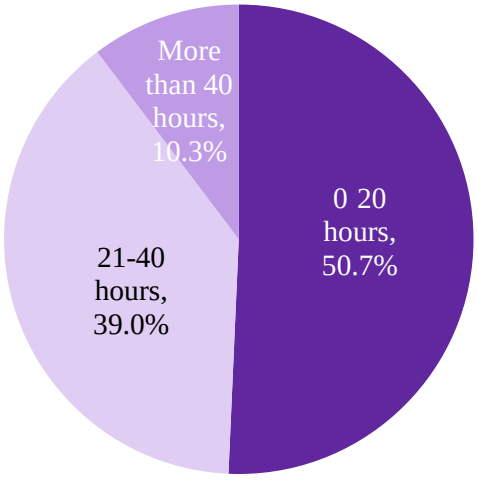


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

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)

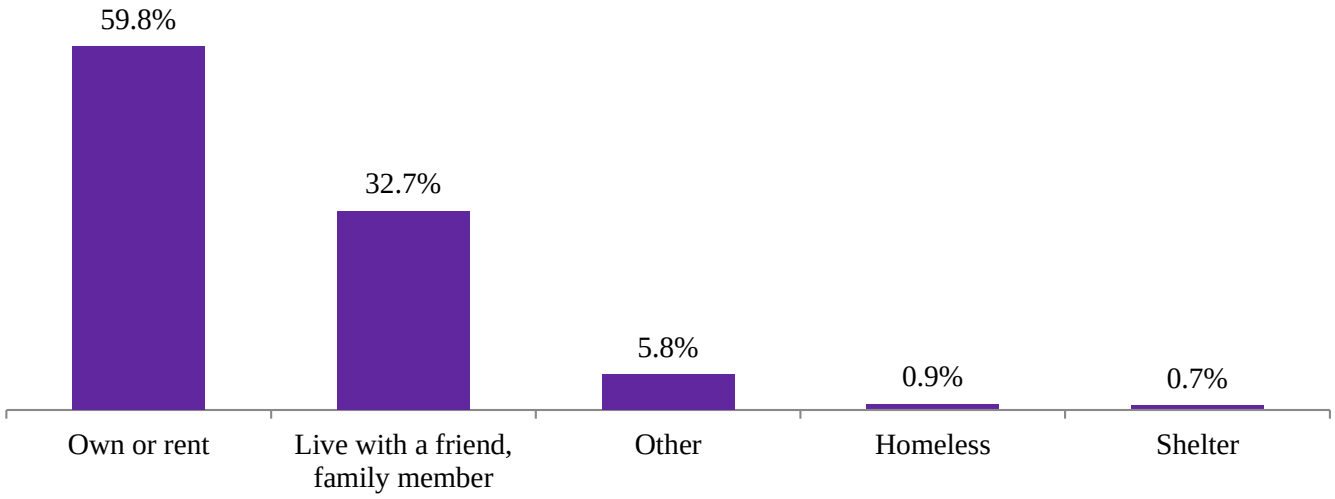
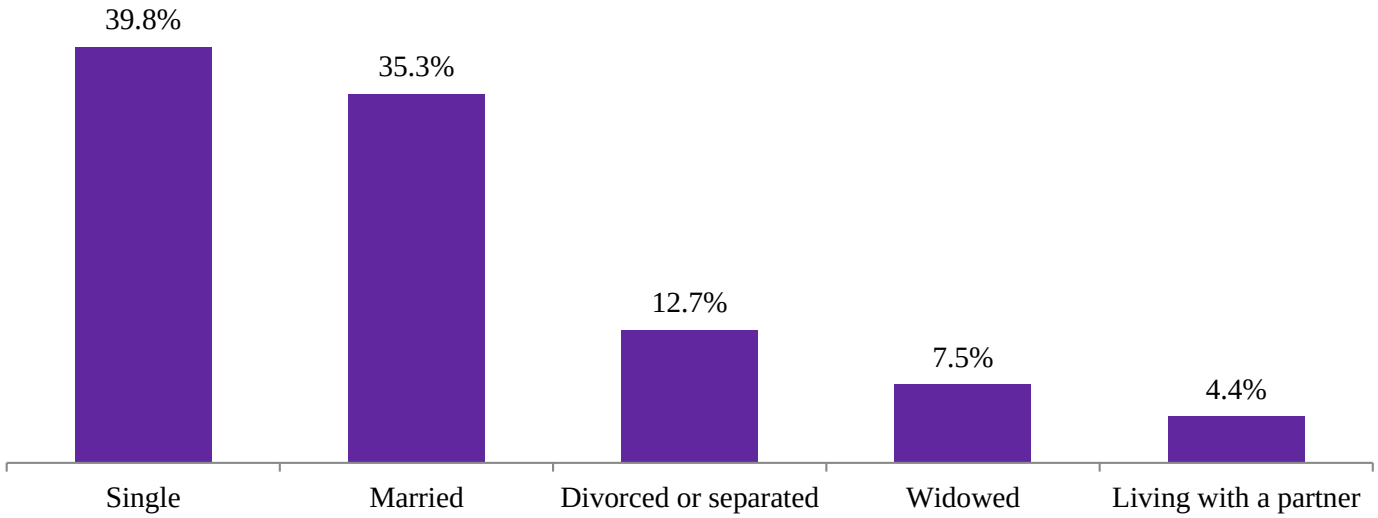


Exhibit 49. Marital status of members (n=3,271)[30]



[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)

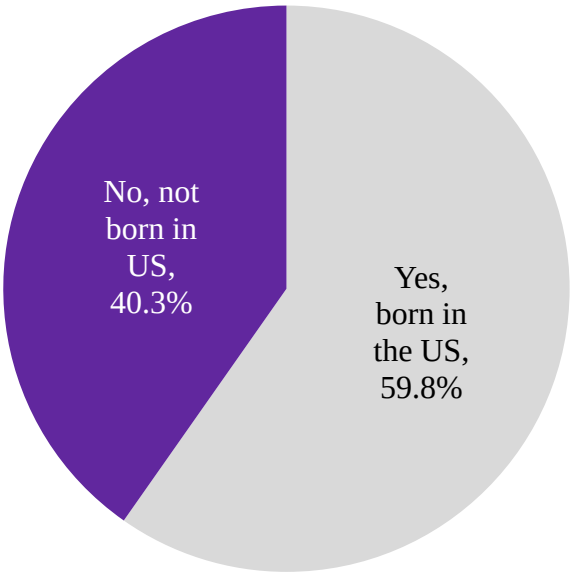
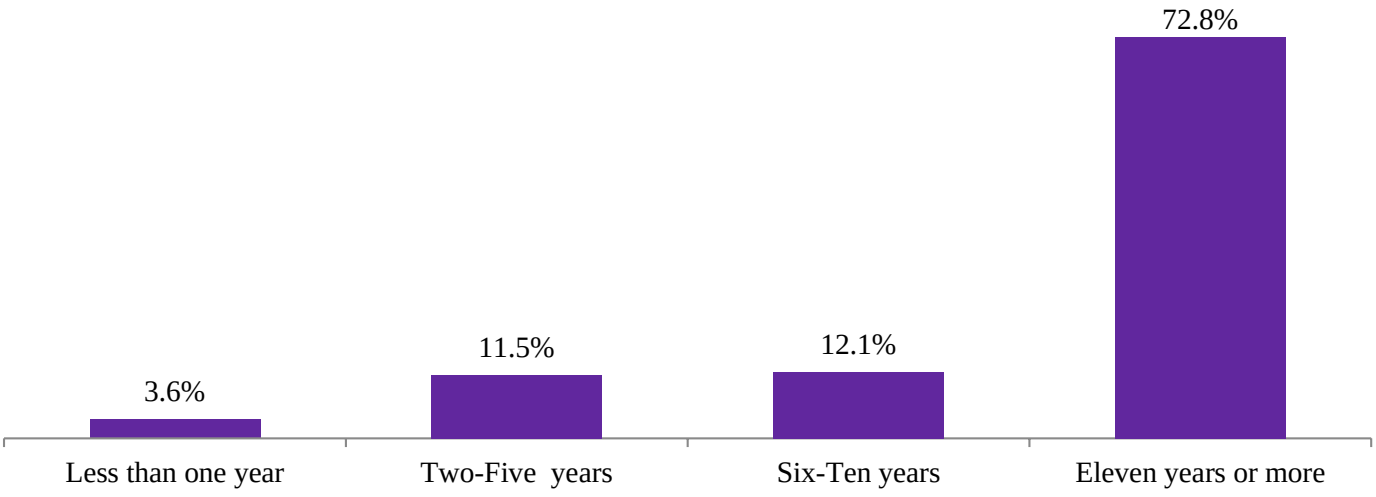


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

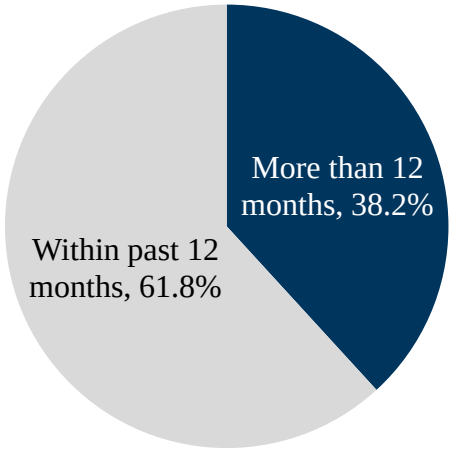
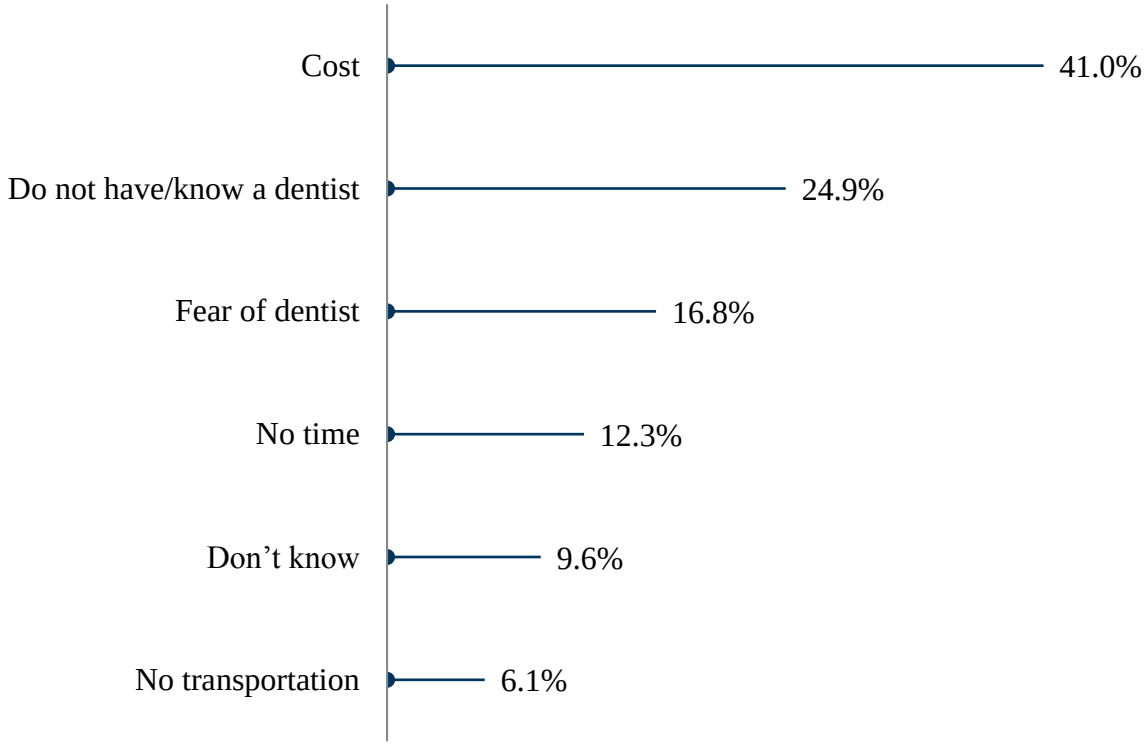
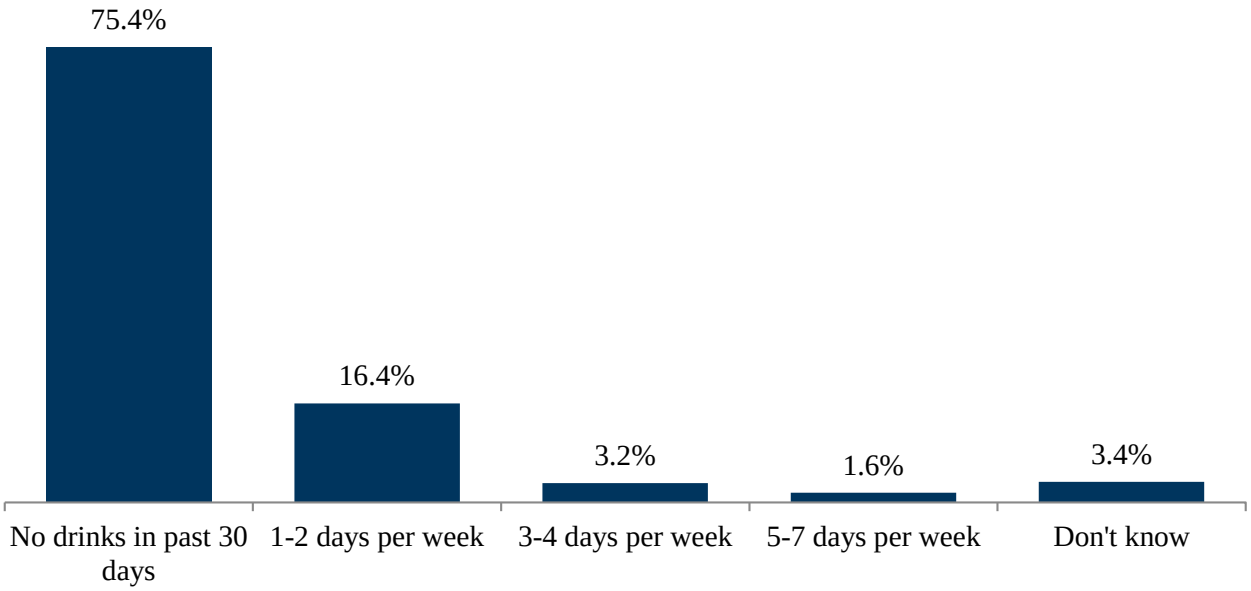


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[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

CalOptima A Public Agency Better. Together.

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

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**

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

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

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

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 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 recommended allocations of IGT 5 funds in the total amount of $3.4 million 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.

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.

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:

- 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.

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 *7/24/19*

Authorized Signature **Date**

IGT 5 Community Grant Award Consideration

Board of Directors Meeting

August 1 2019

Candice Gomez

Executive Director, Program Implementation

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

CalOptima
A Public Agency
Better. Together.

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

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

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**

CalOptima A Public Agency Better. Together.

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**

CalOptima
A Public Agency
Better. Together.

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**

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**

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

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.

#	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

A Public Agency

CalOptima

Better. Together.

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

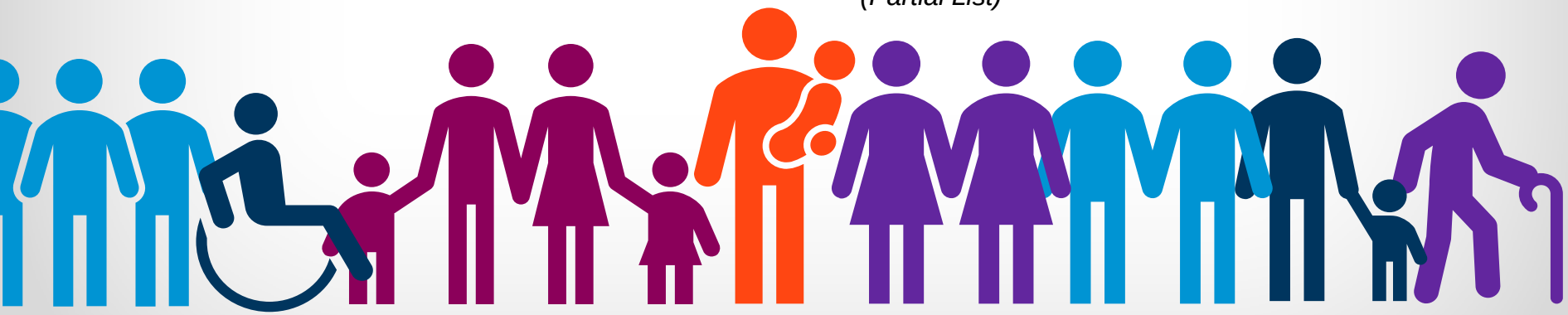
Back to Agenda

CalOptima
Better Together

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.)

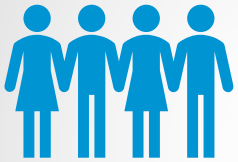
- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In 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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Back to Agenda

CalOptima
Better Together

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

CalOptima
A Public Agency
Better. Together.

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)

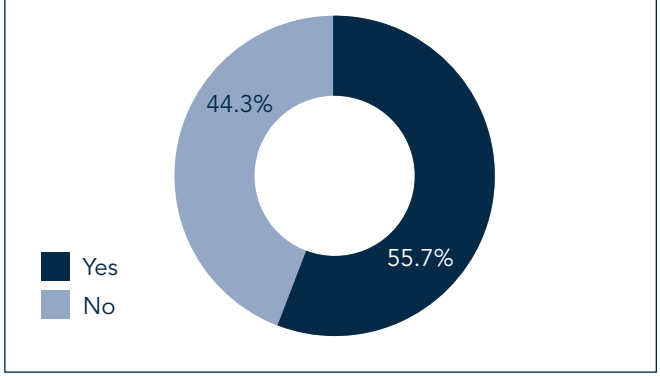
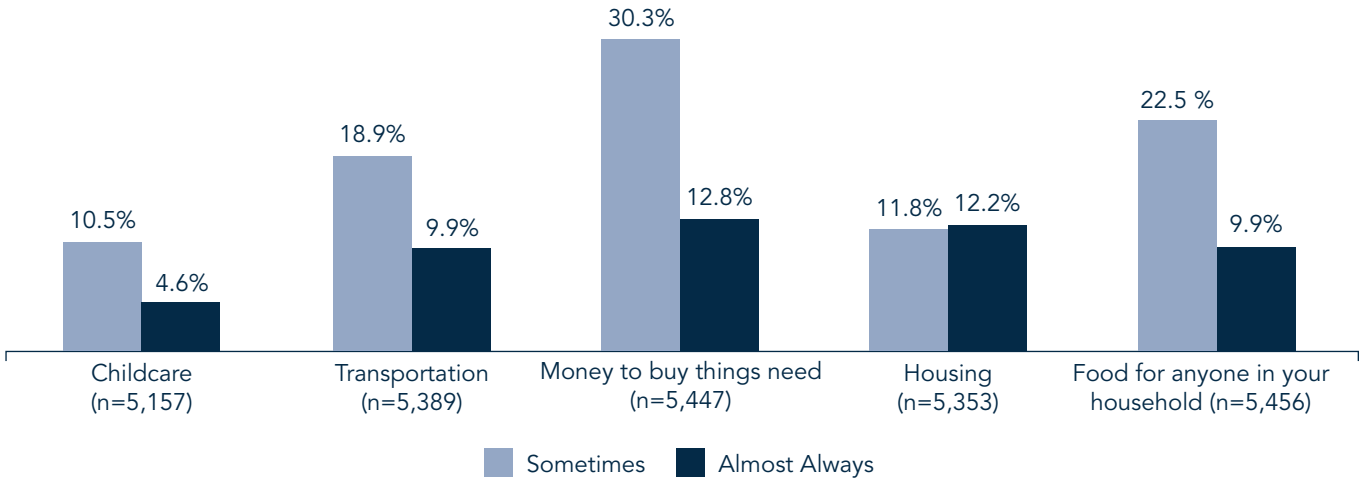


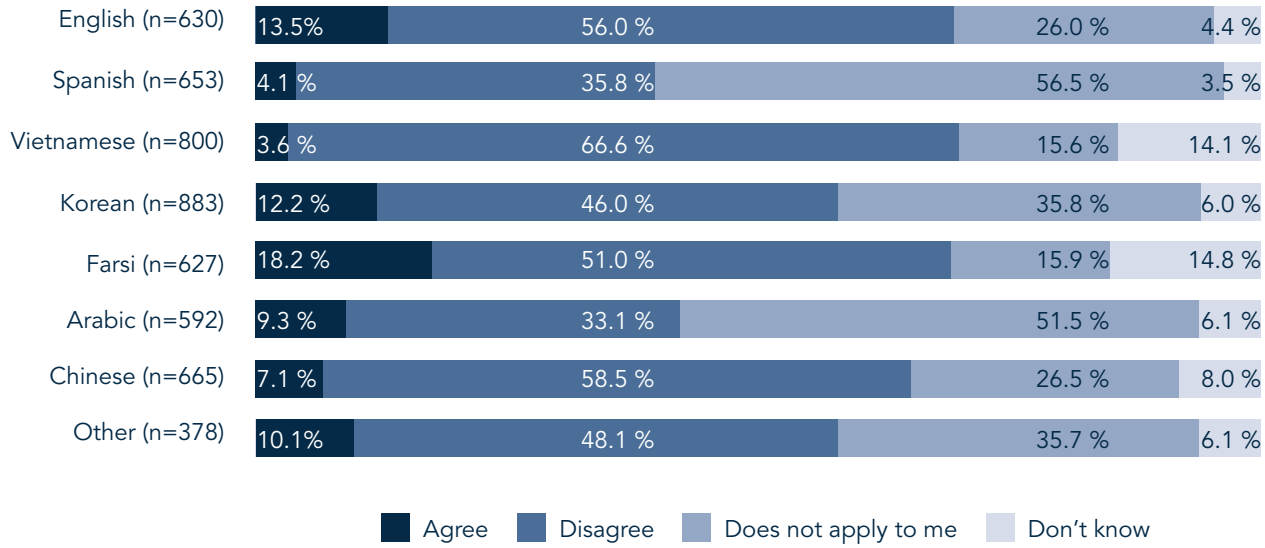
Exhibit 3: Percent of members who needed help with basic needs in the past six months



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)

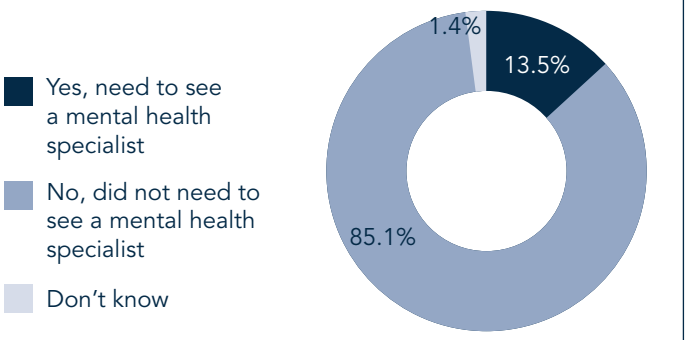
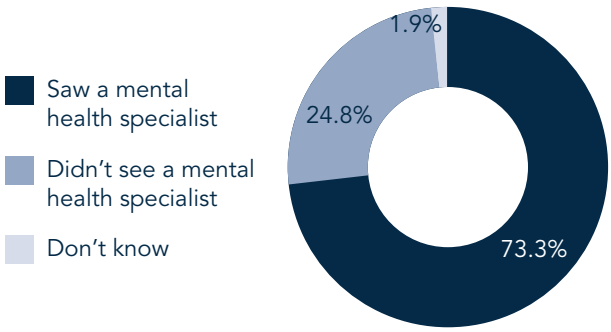
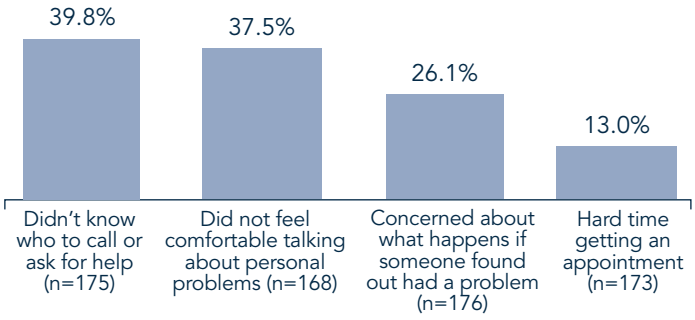


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



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)

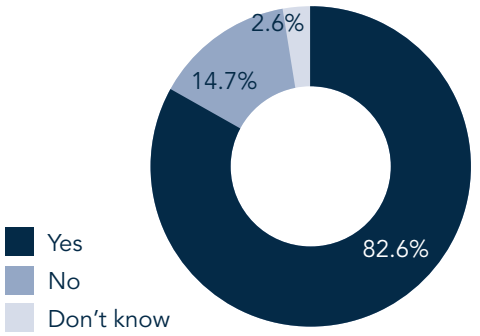
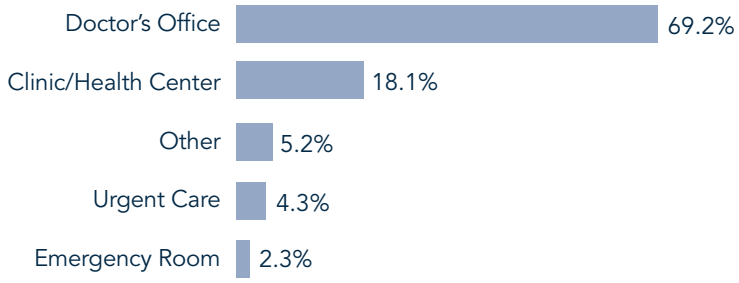


Exhibit 9: Where respondents go to see their doctor (n=5,743)

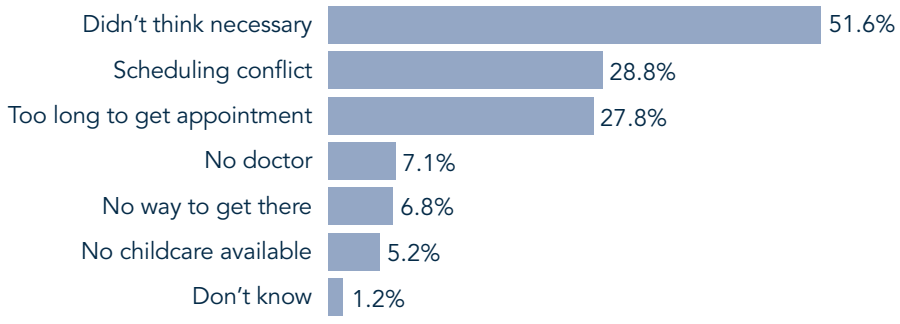


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited 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)

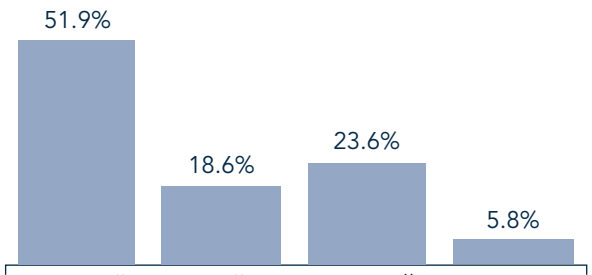
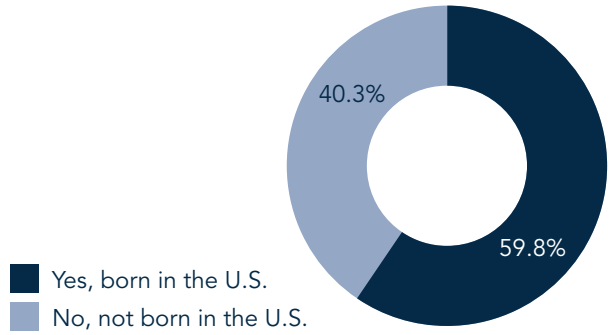


Exhibit 12: Percent of members who were born in the United States (n=5,599)



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)

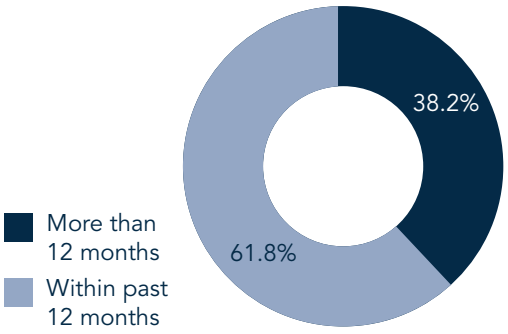
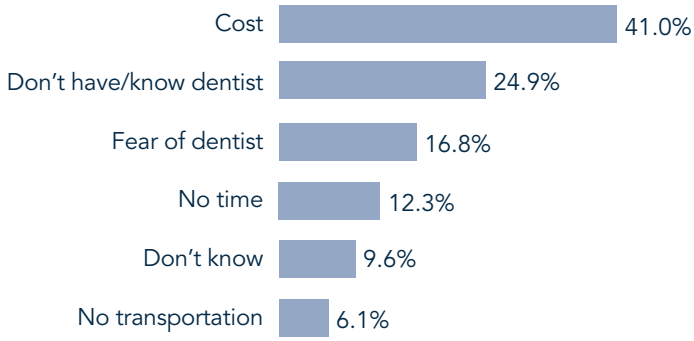


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3] [4]



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

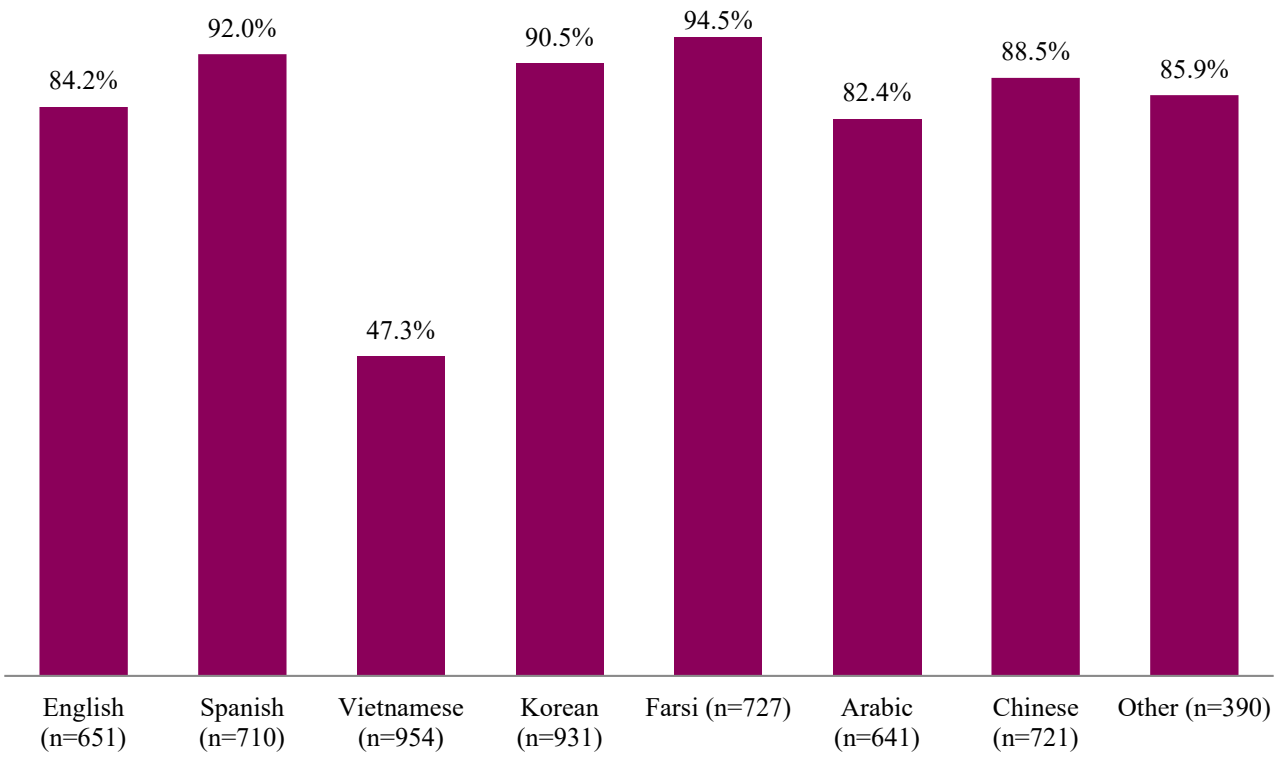
CalOptima A Public Agency Better. Together.

Back to Agenda

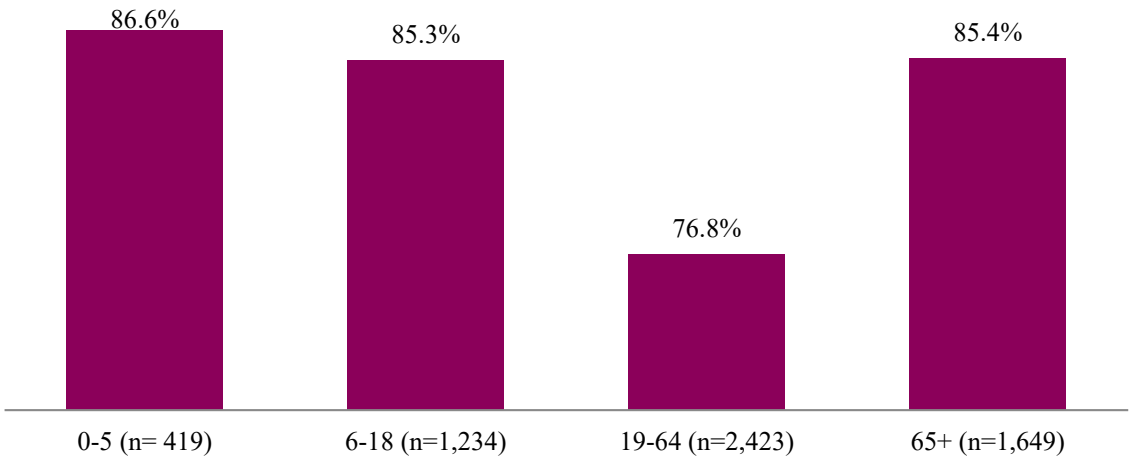
Navigating the Healthcare System

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:

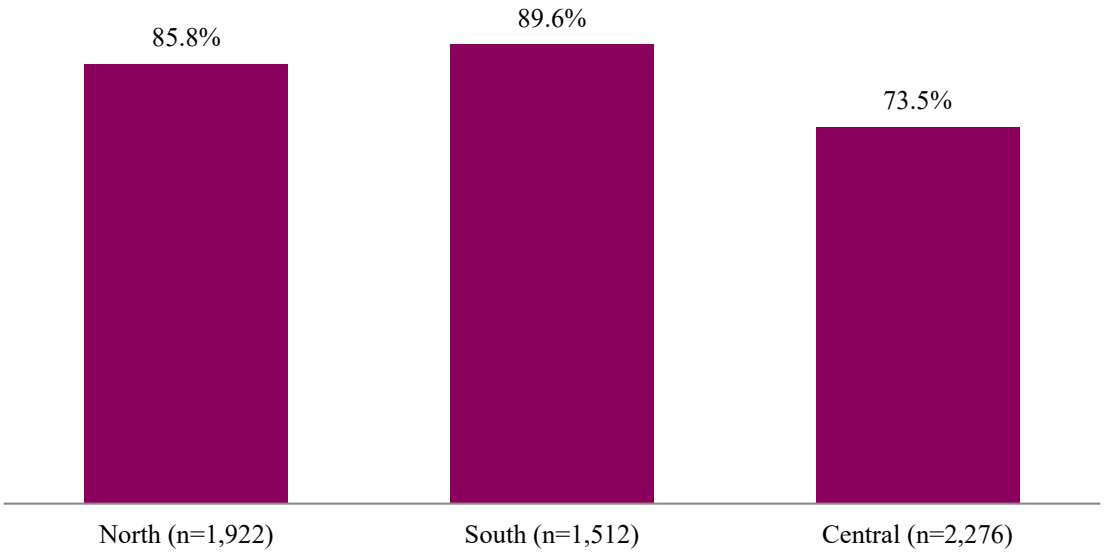


Exhibit 2. Where respondents go to see their doctor

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%.

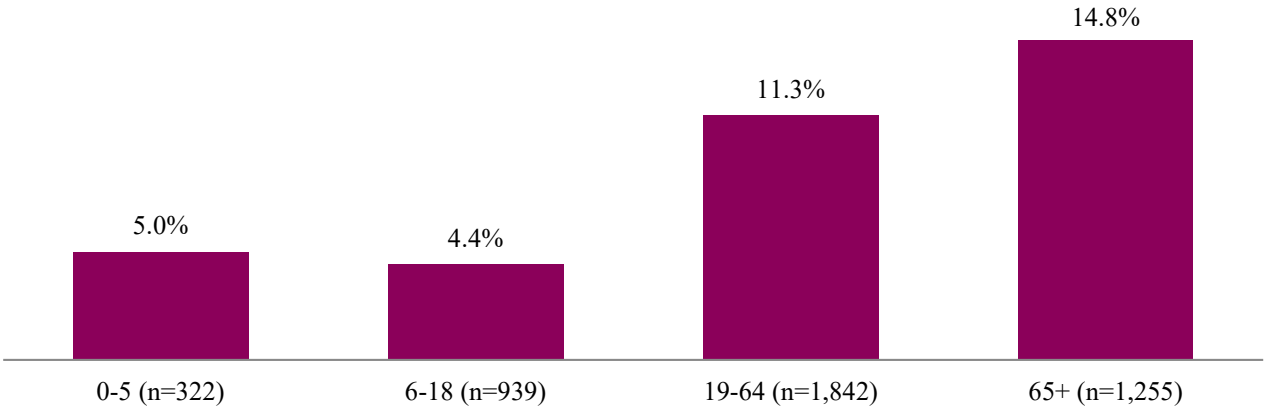
Region:

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

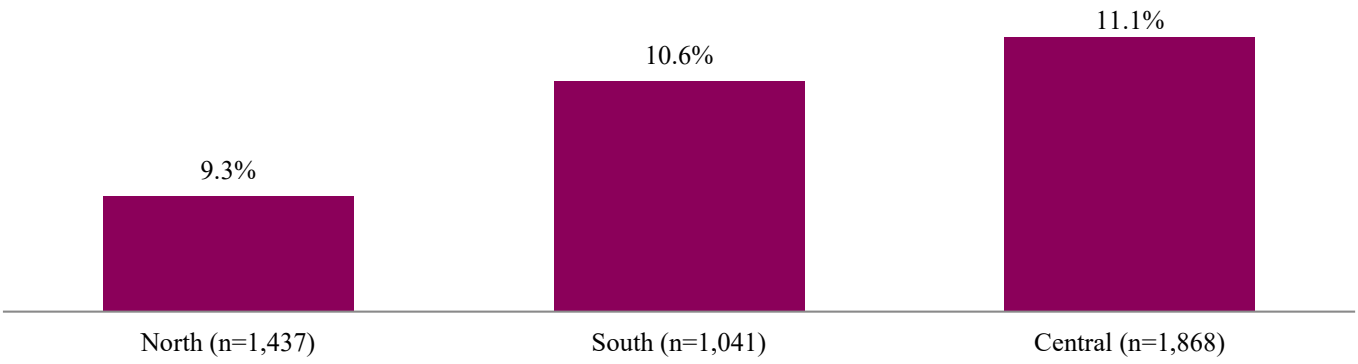
Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

CalOptima language:

Age Category:



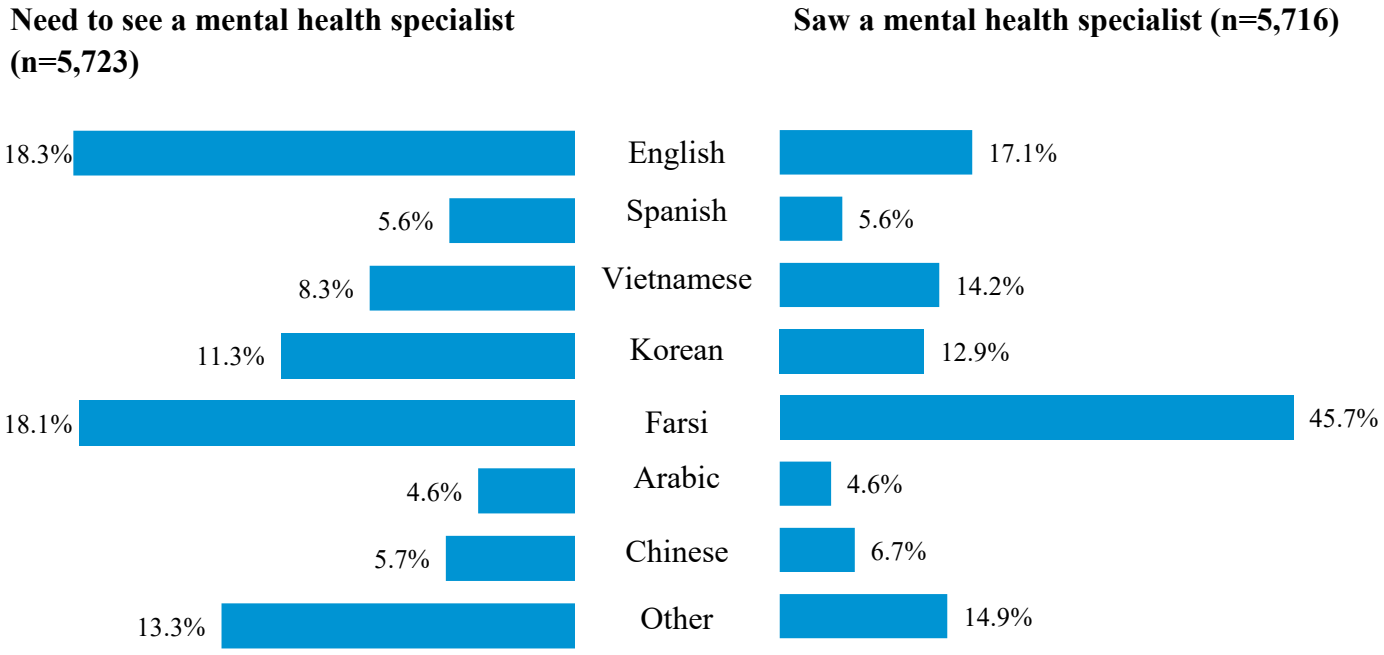
Region:



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:

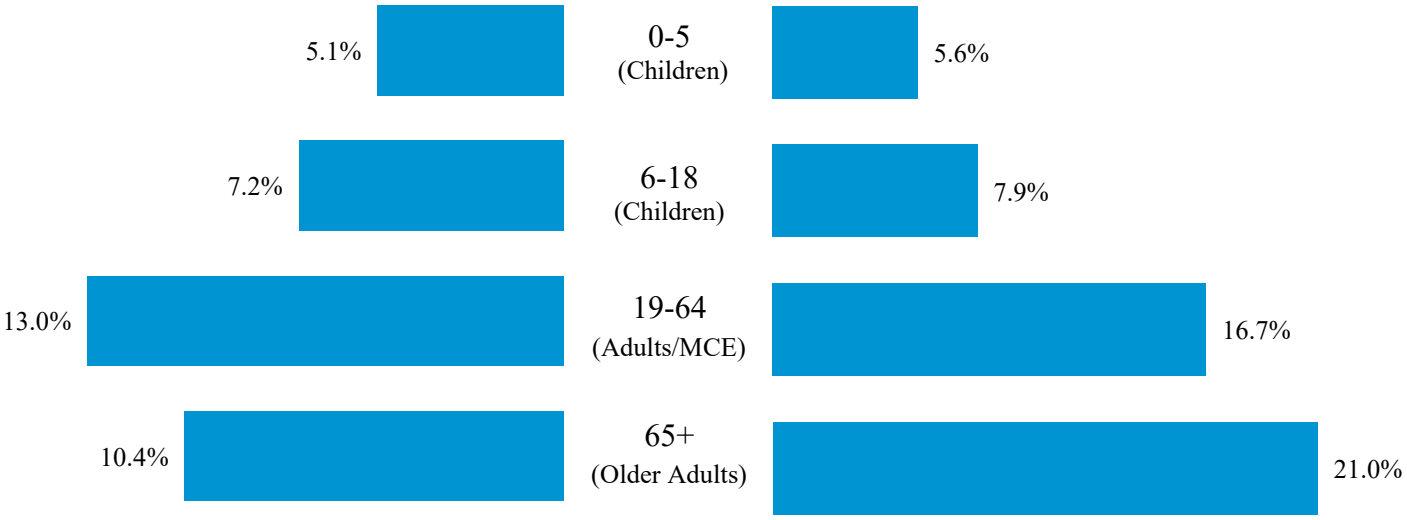


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

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)

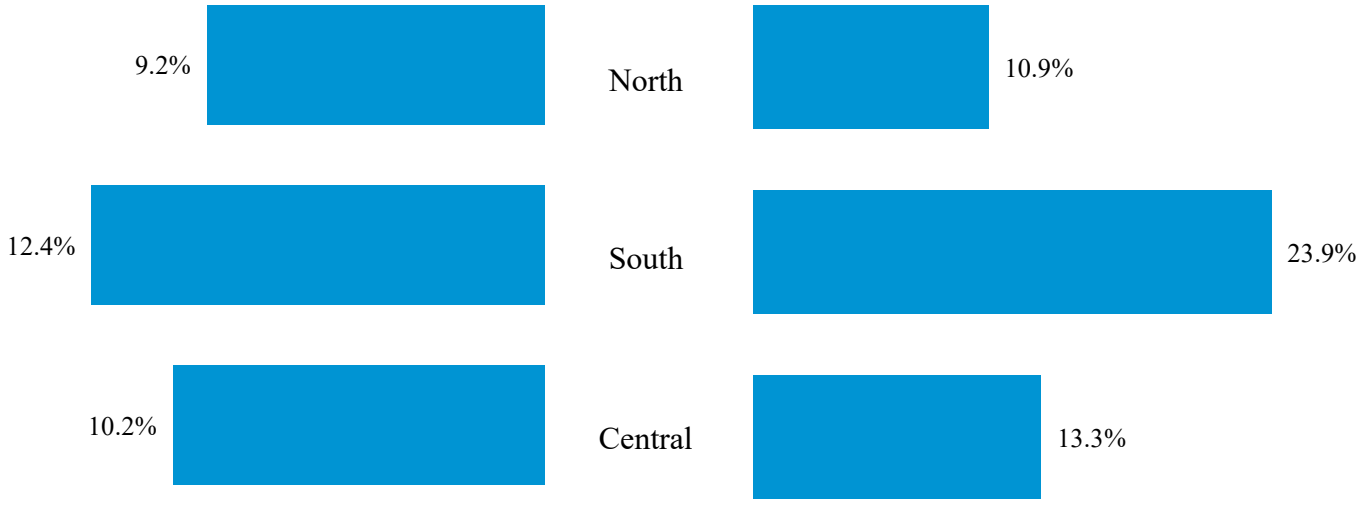
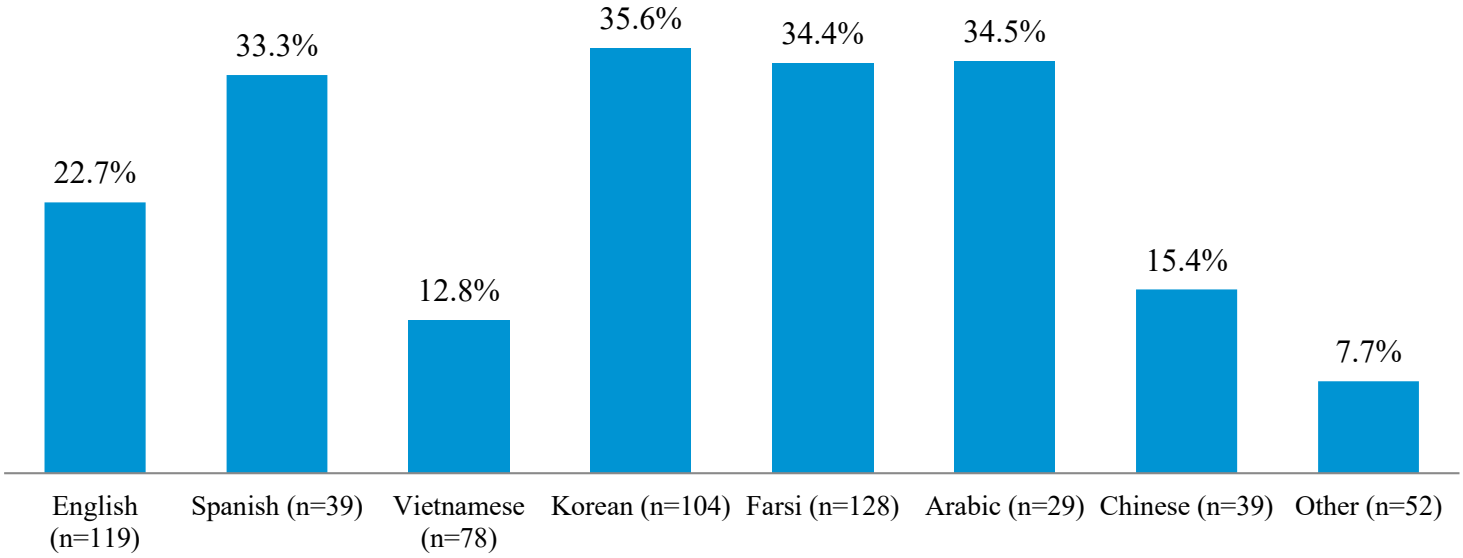
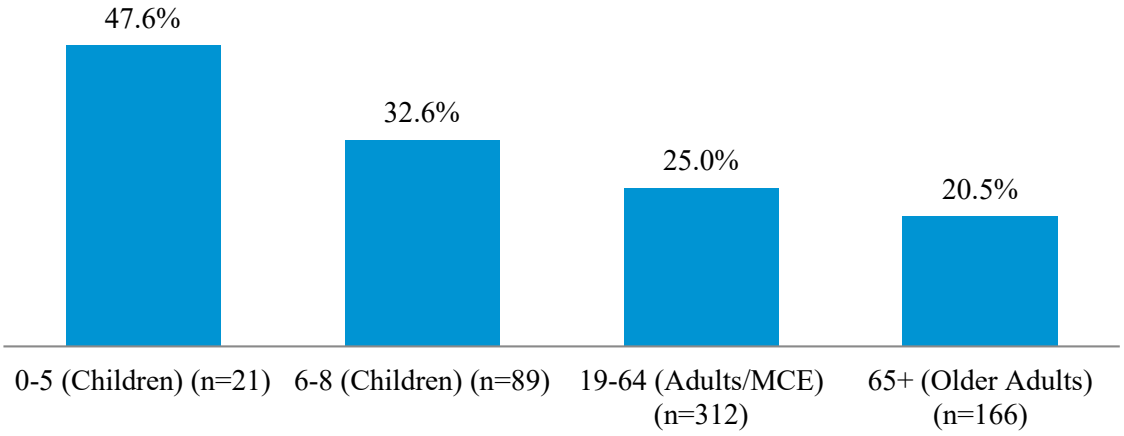


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

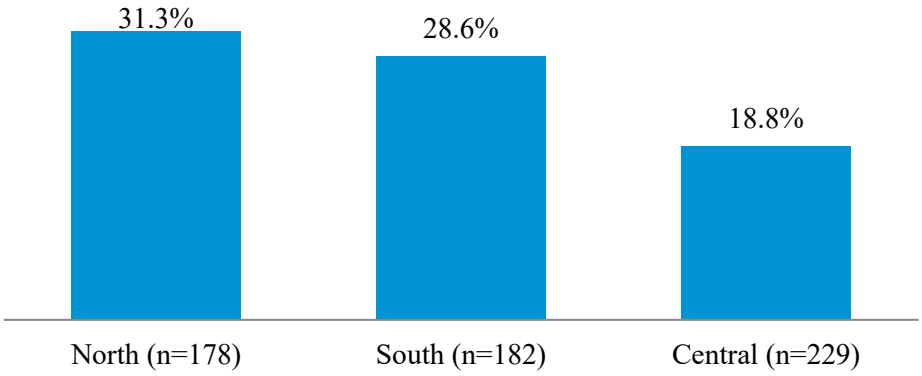
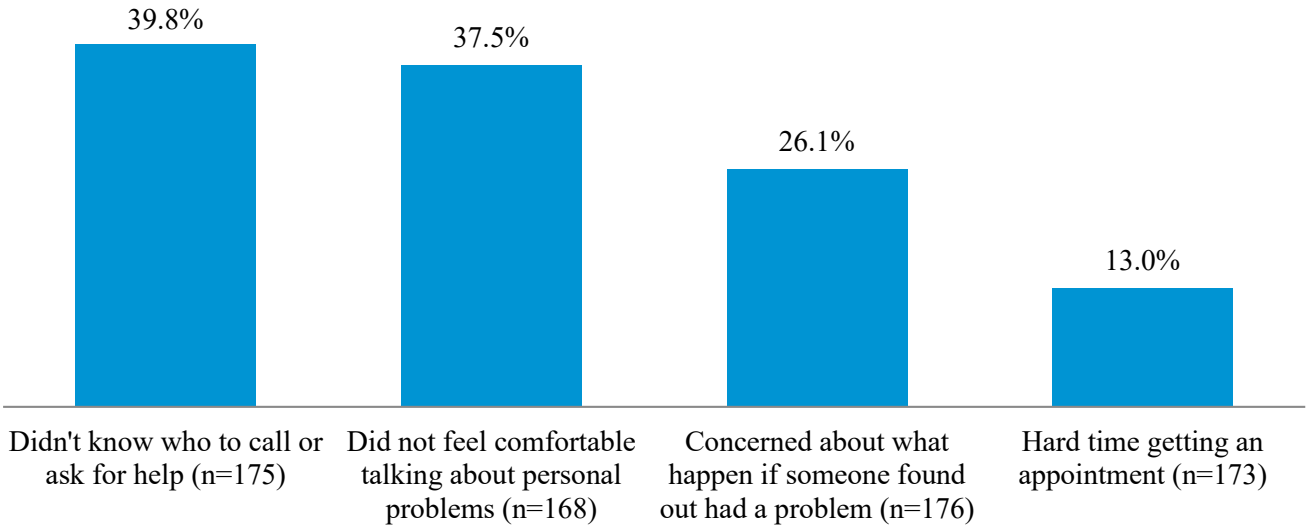


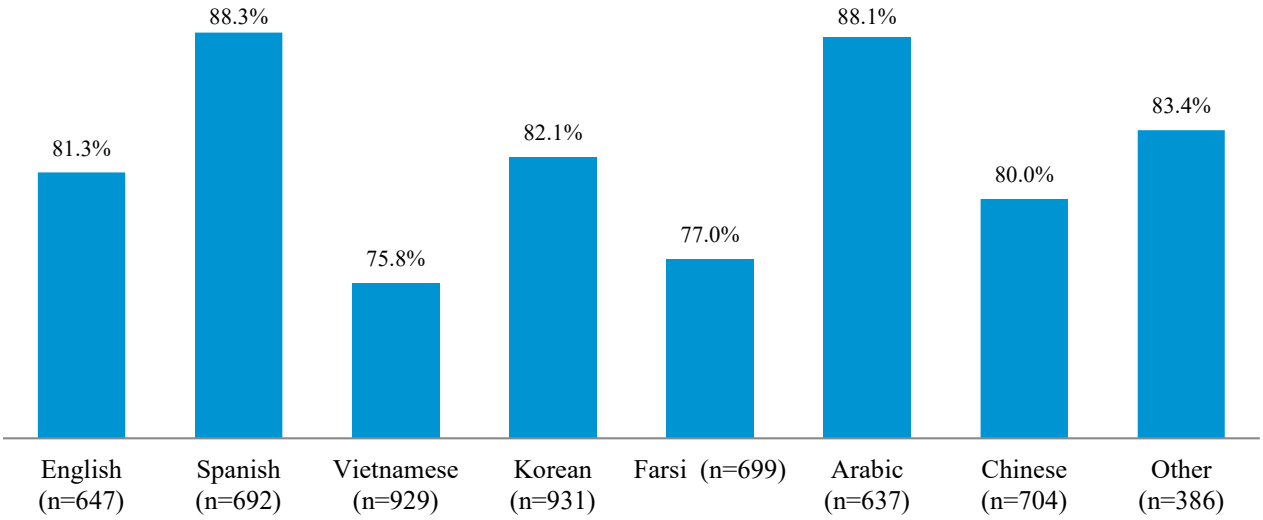
Exhibit 11. Reasons why members didn't see mental health specialist[7]



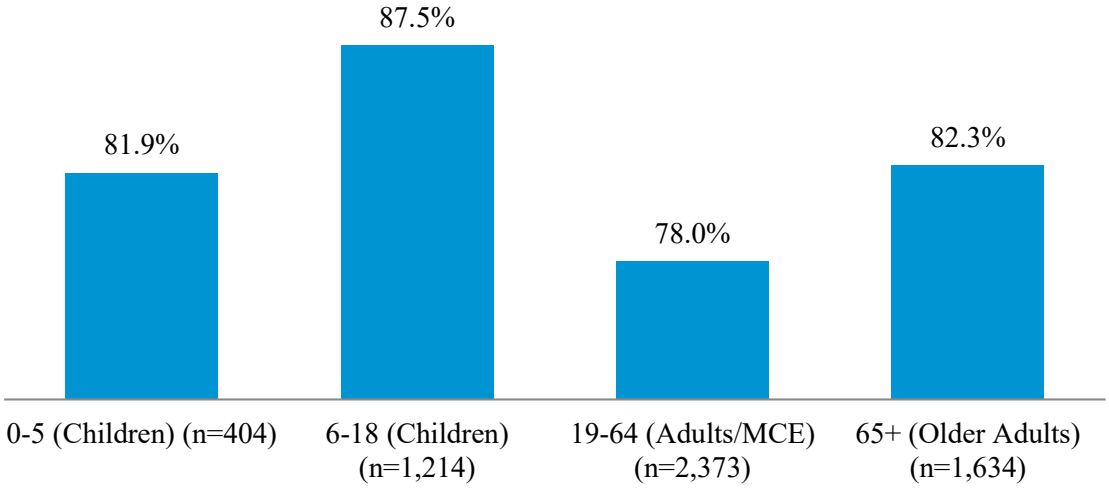
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

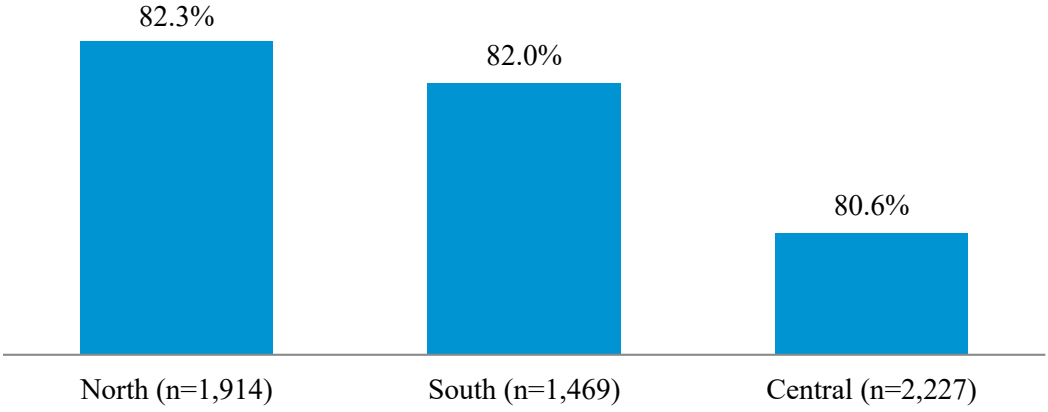
CalOptima language:



Age Category:



Region:

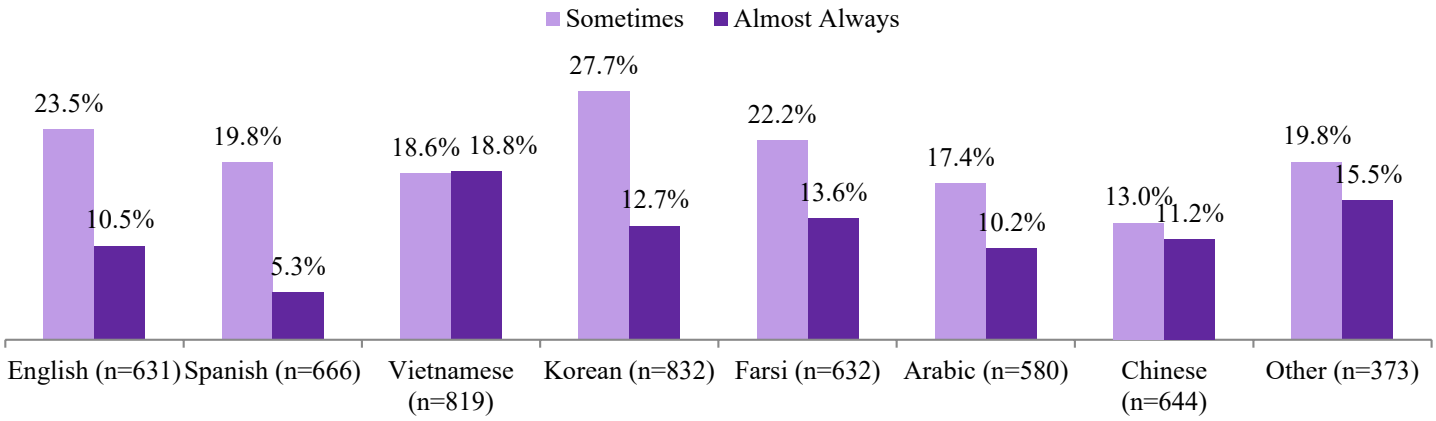


Social Determinants of Health

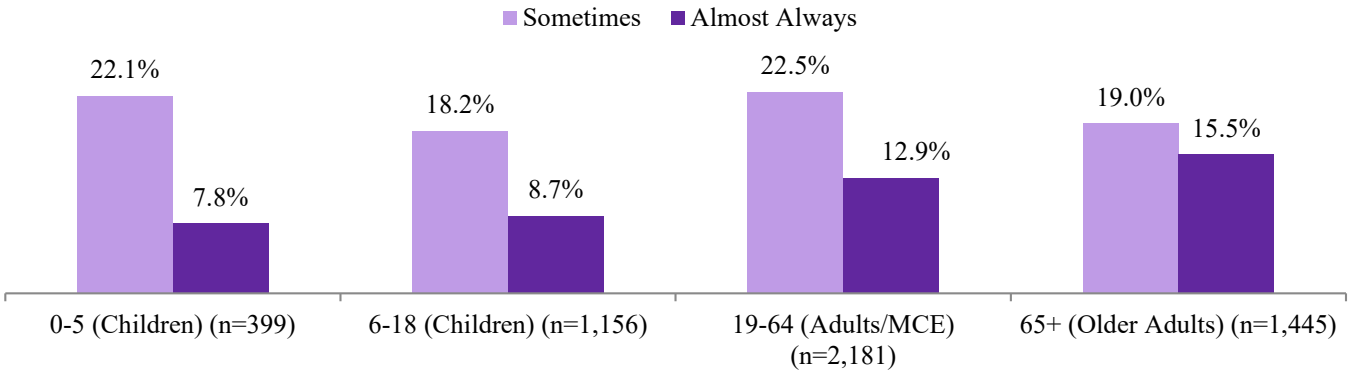
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

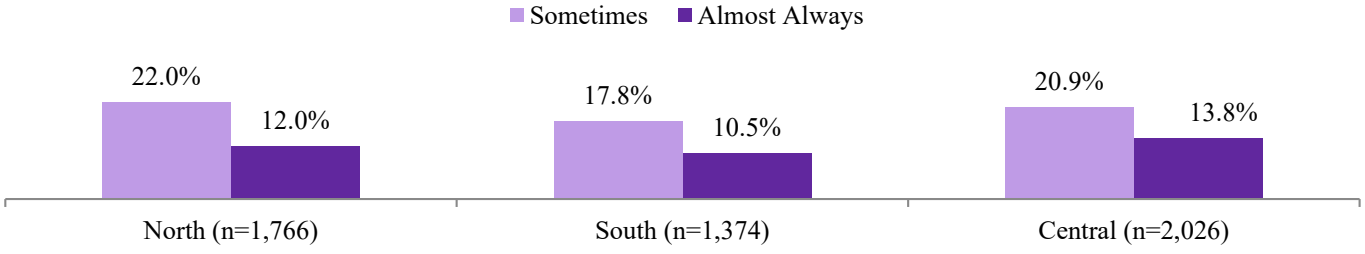
CalOptima language:



Age Category:

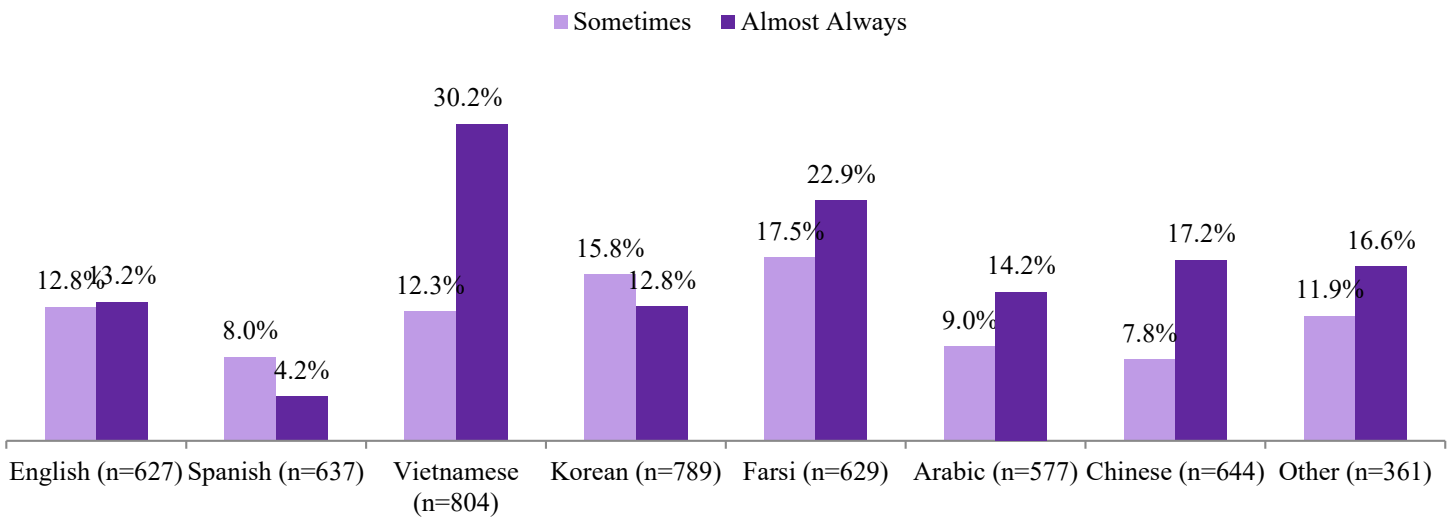


Region:

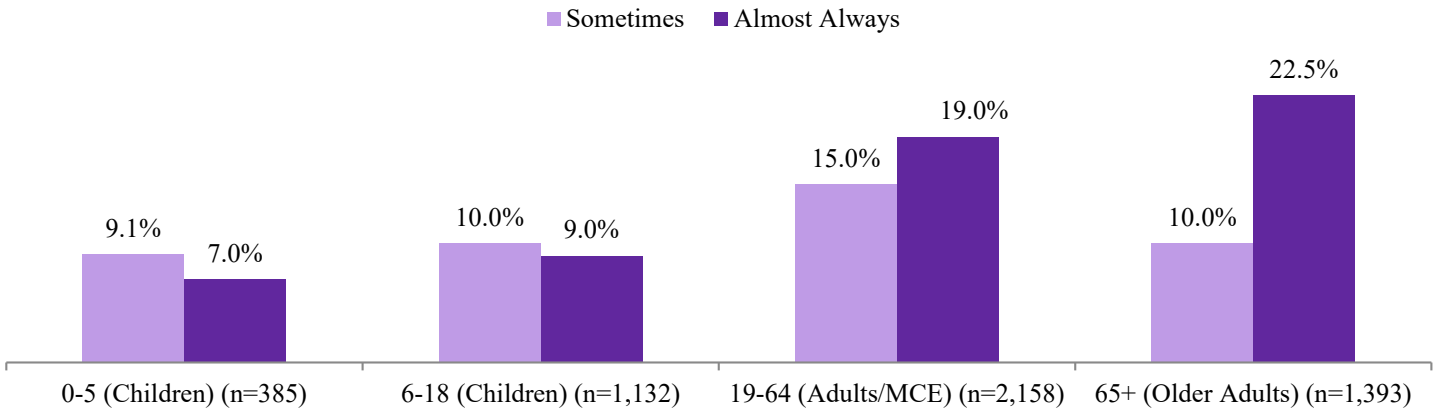


Housing:

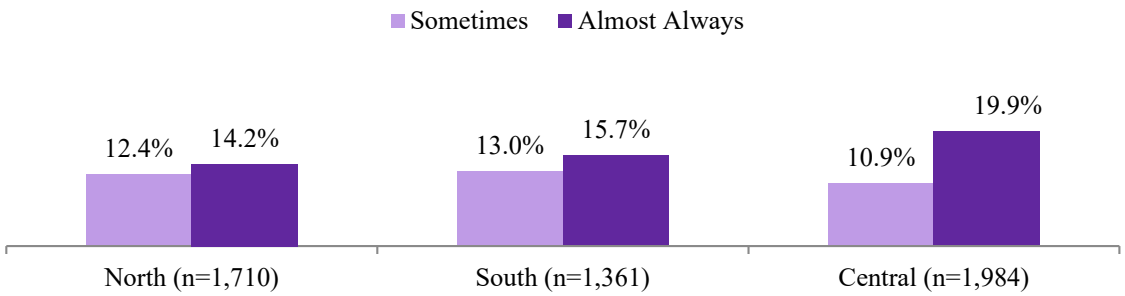
CalOptima language:



Age Category:

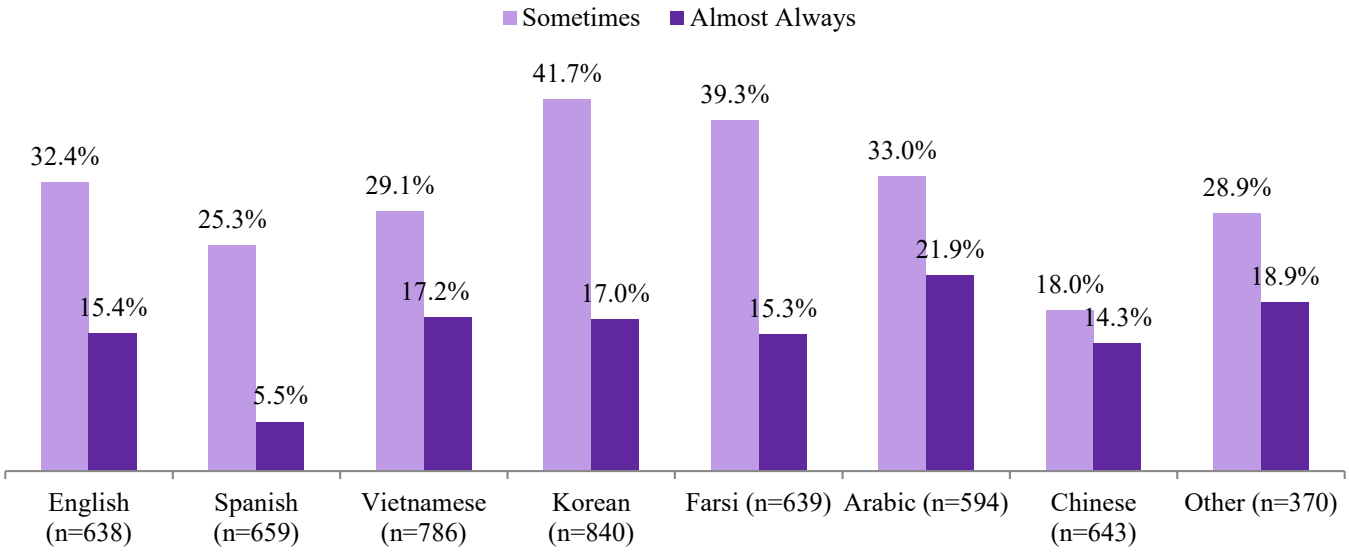


Region:

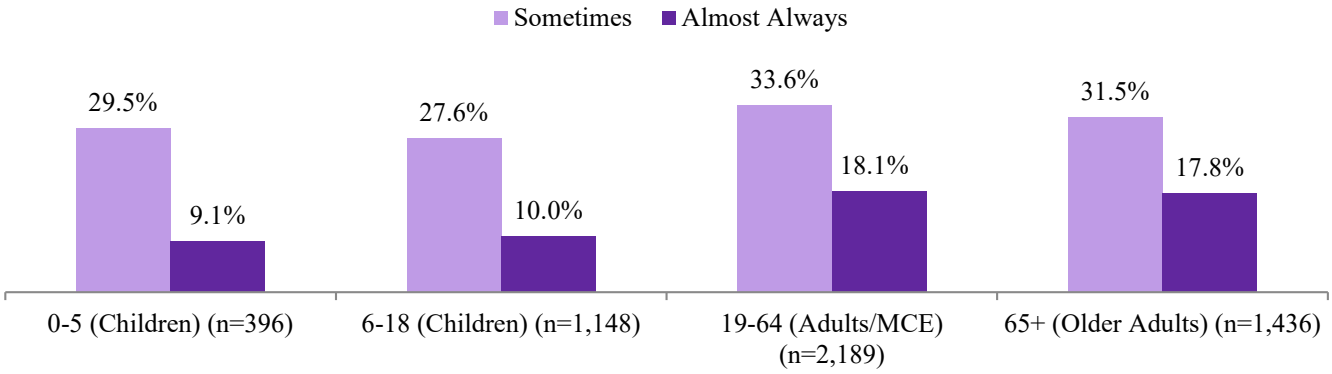


Money to buy things need:

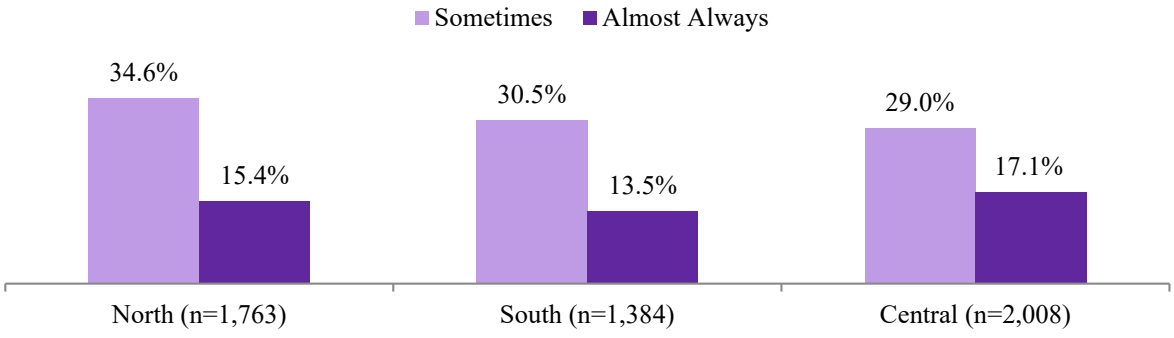
CalOptima language:



Age Category:

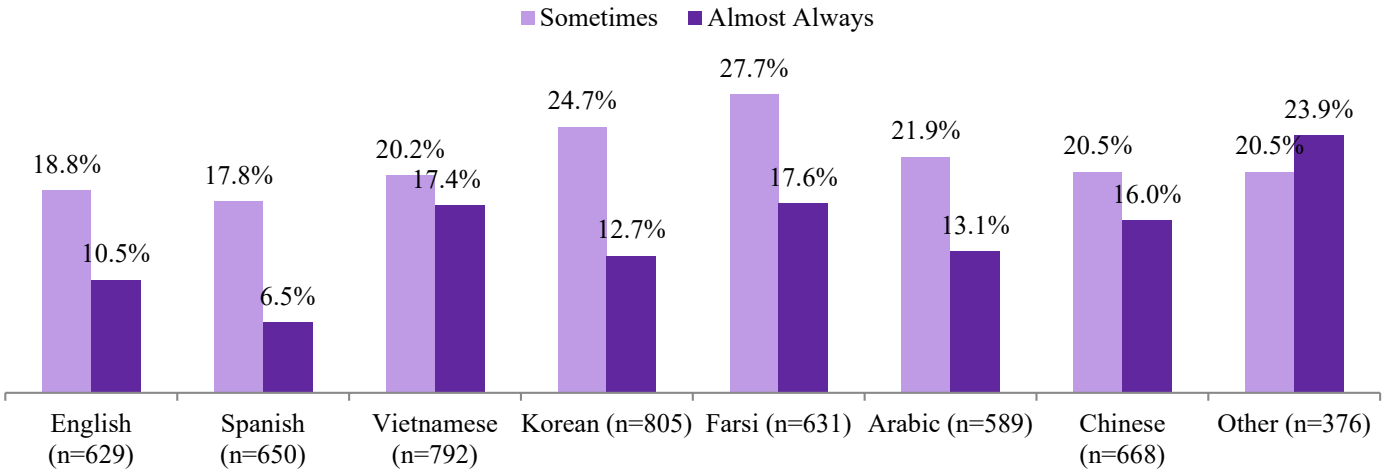


Region:

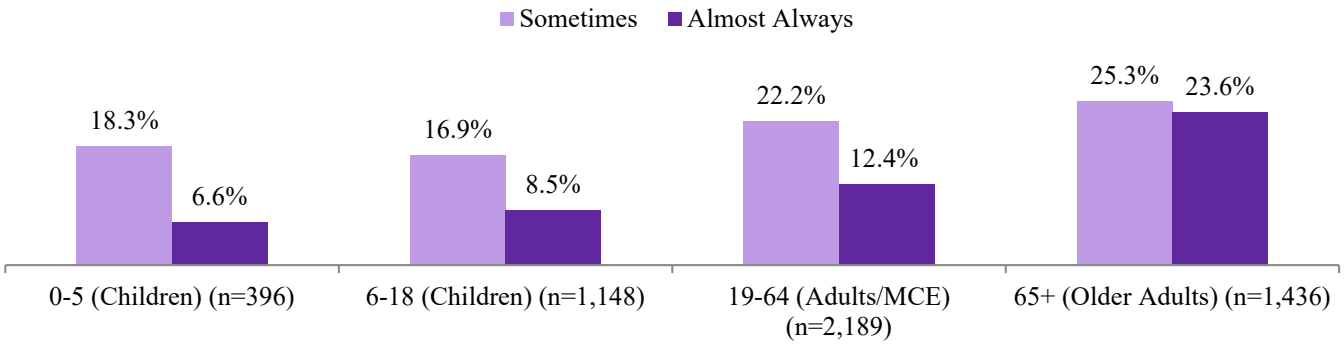


Transportation:

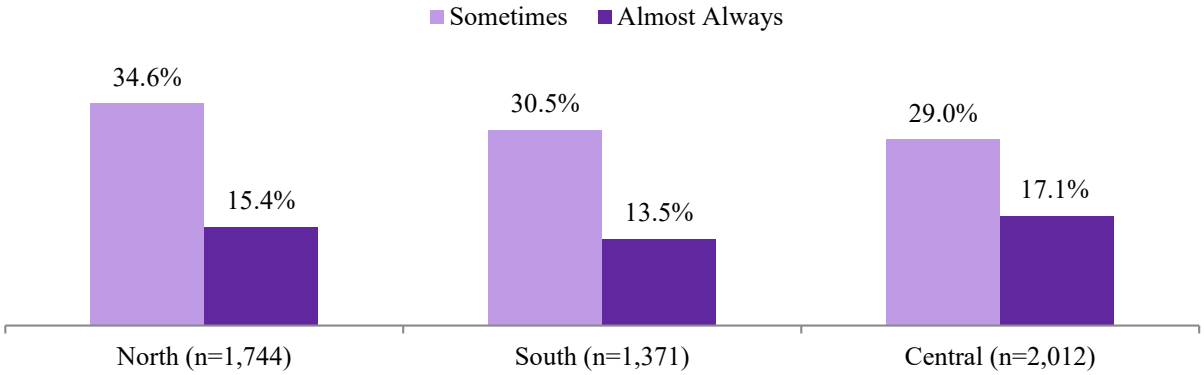
CalOptima language:



Age Category:

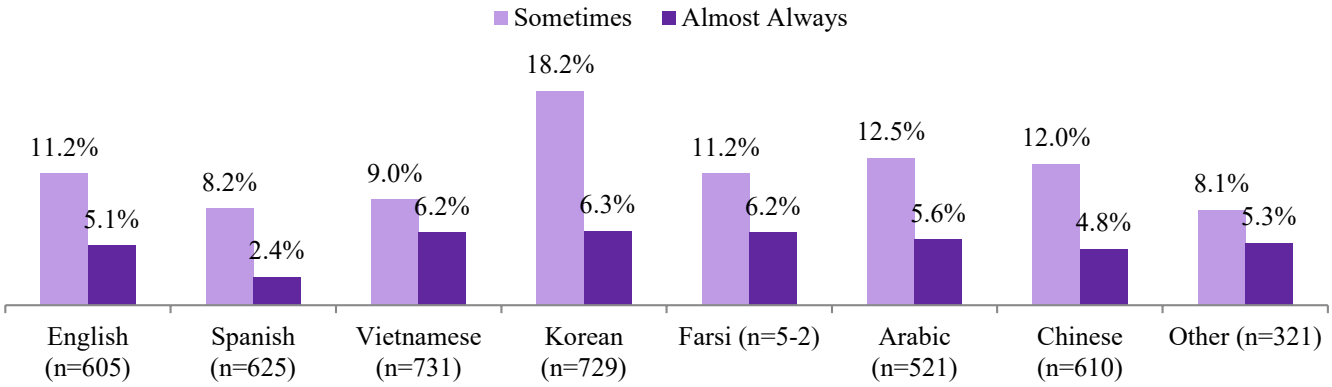


Region:

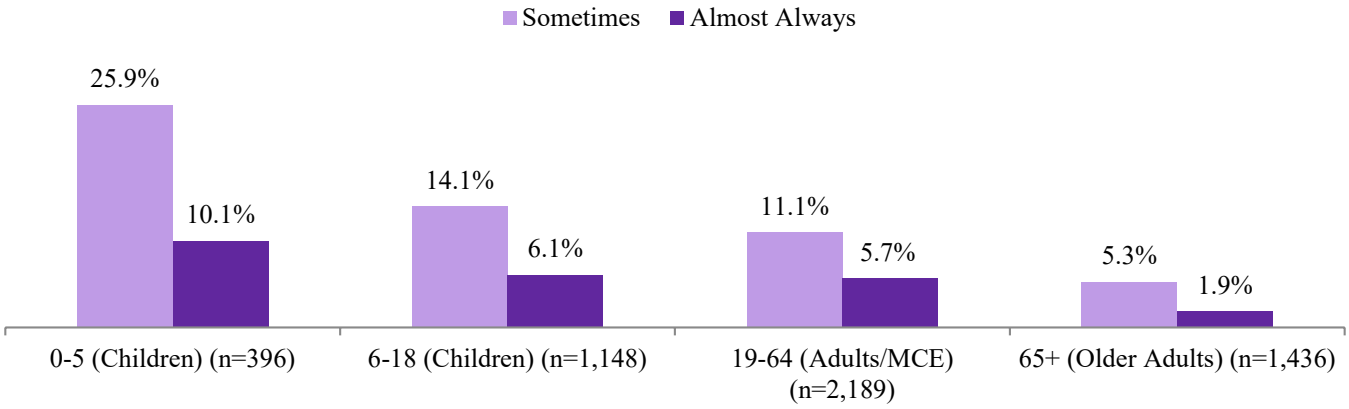


Child care:

CalOptima language:



Age Category:



Region:

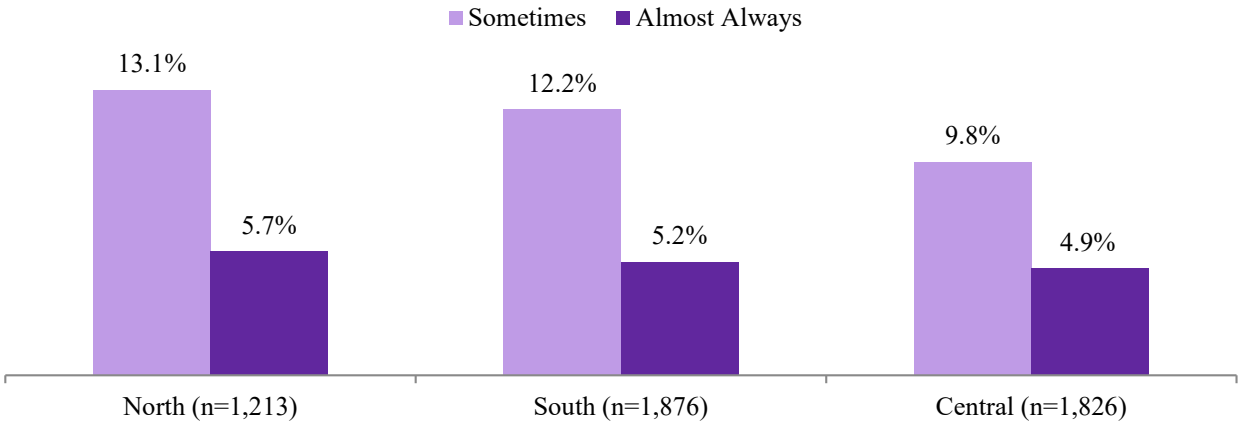
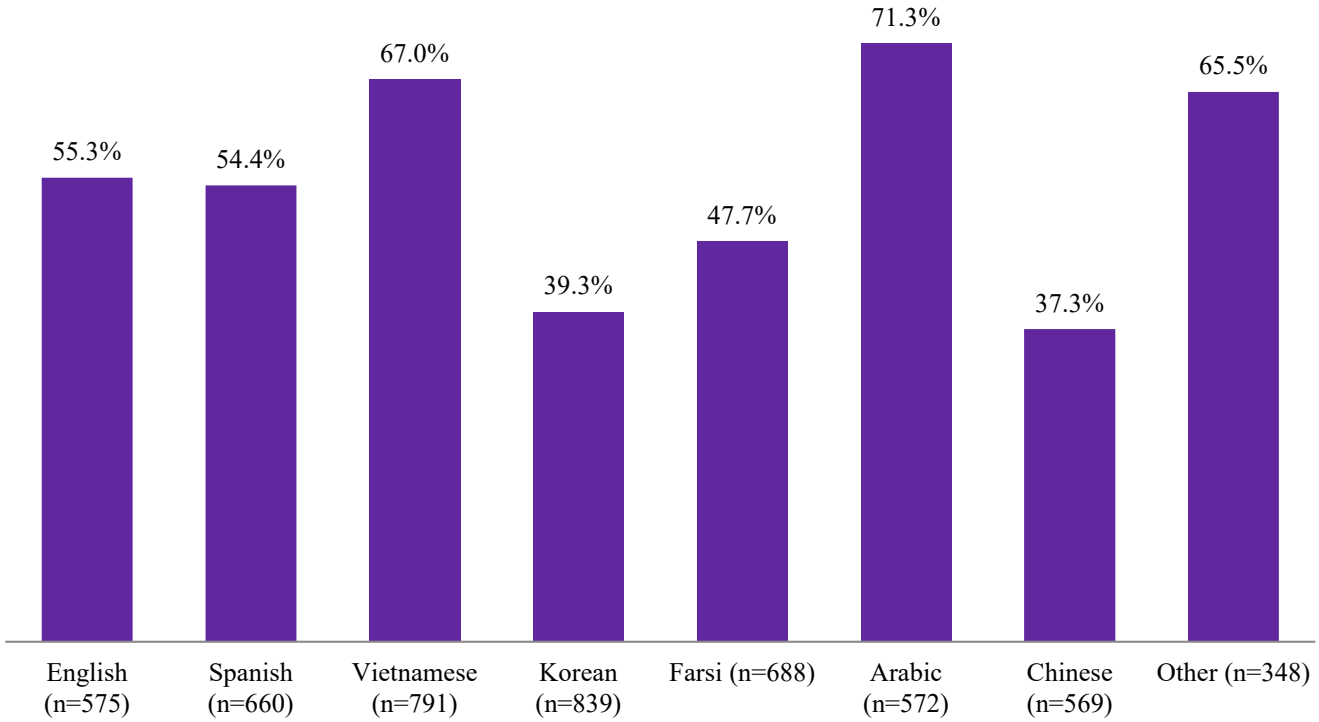


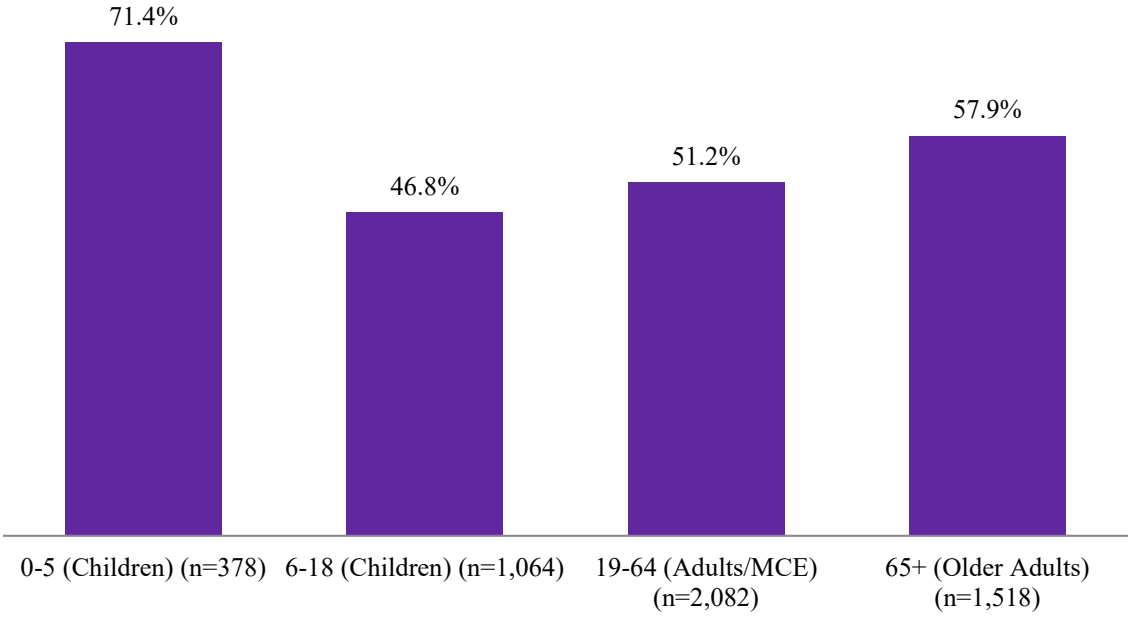
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

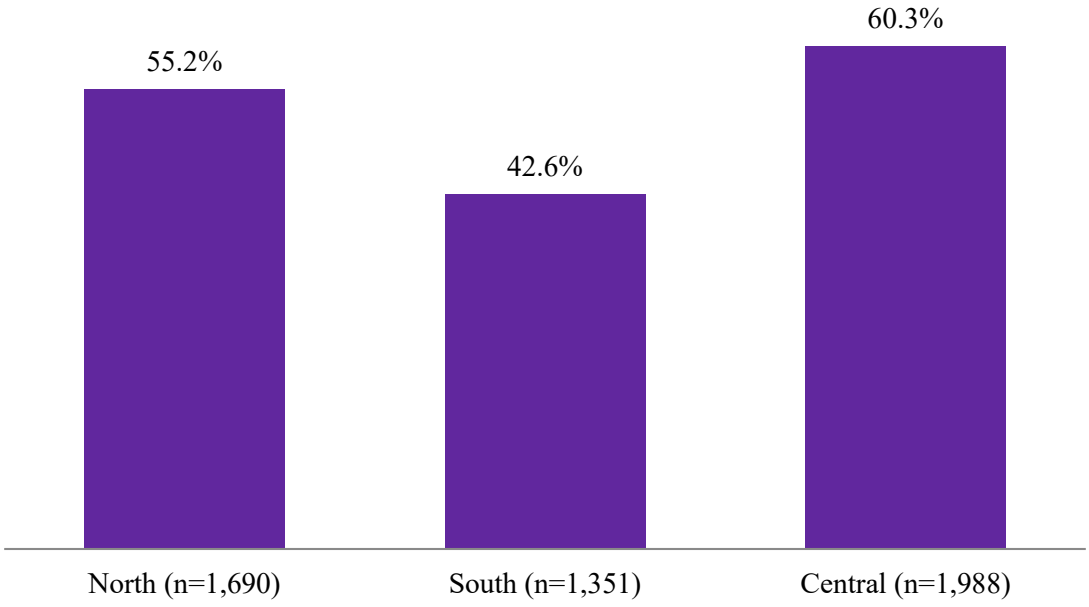
CalOptima language:



Age Category:



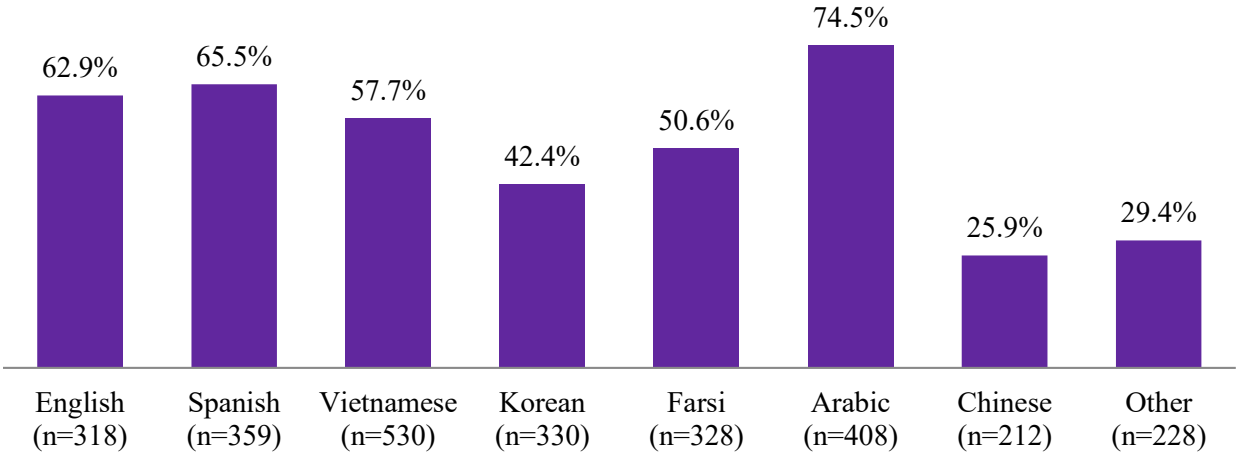
Region:



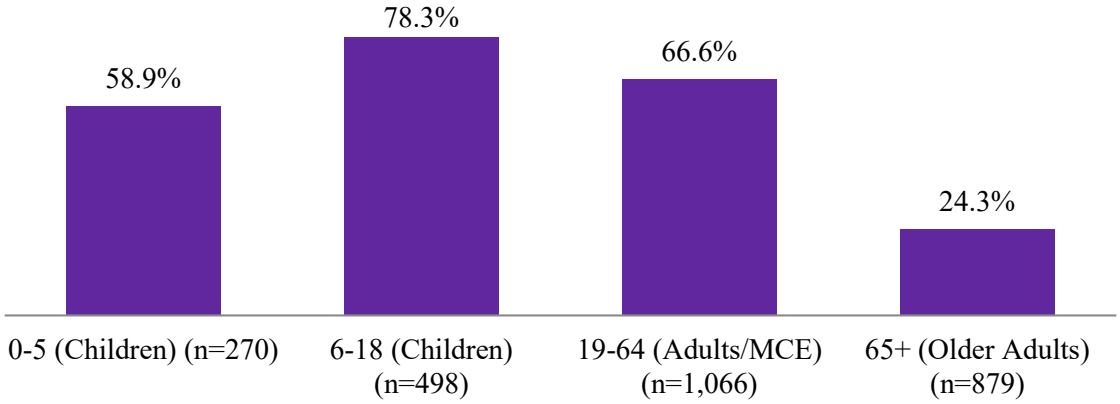
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

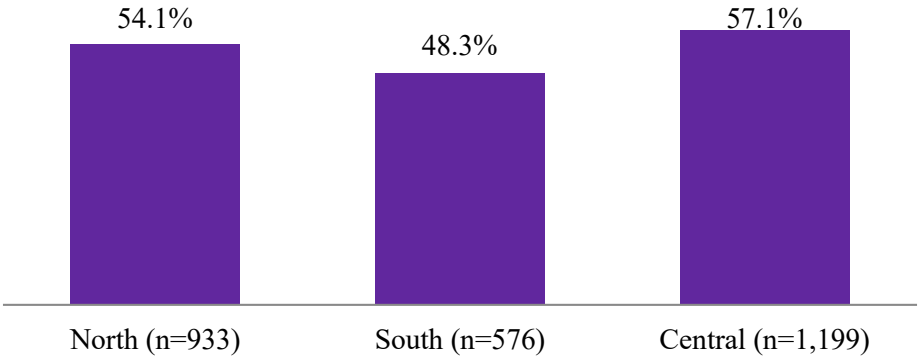
CalOptima language:



Age Category:



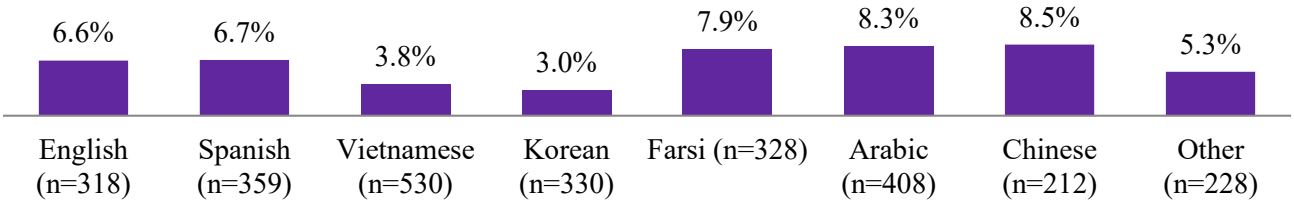
Region:



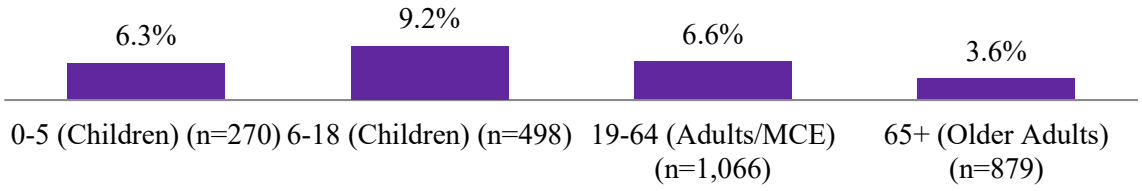
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

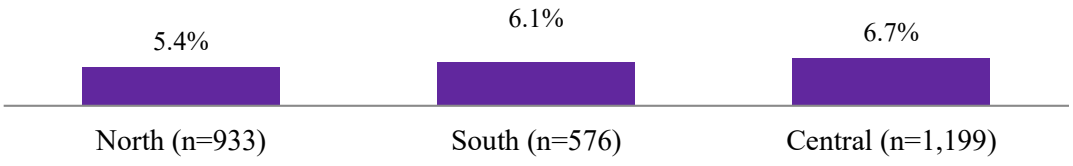
CalOptima language:



Age Category:

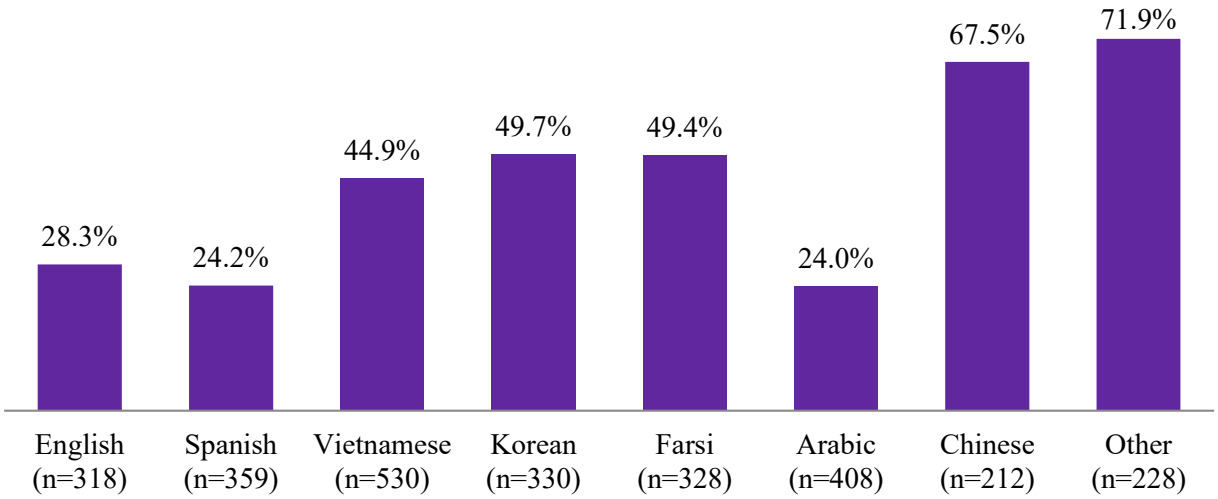


Region:

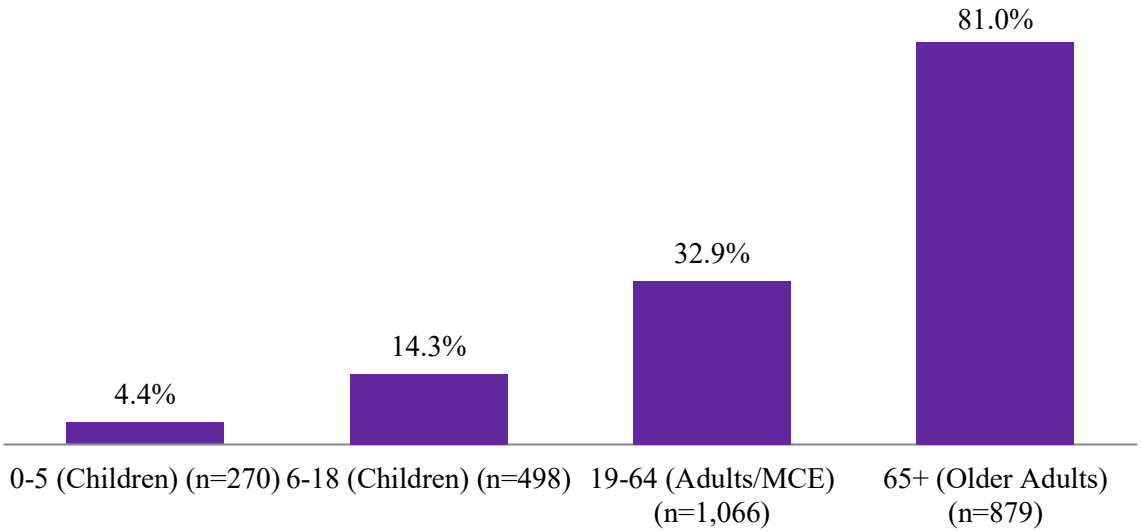


Receive SSI or SSDI as a public benefit:

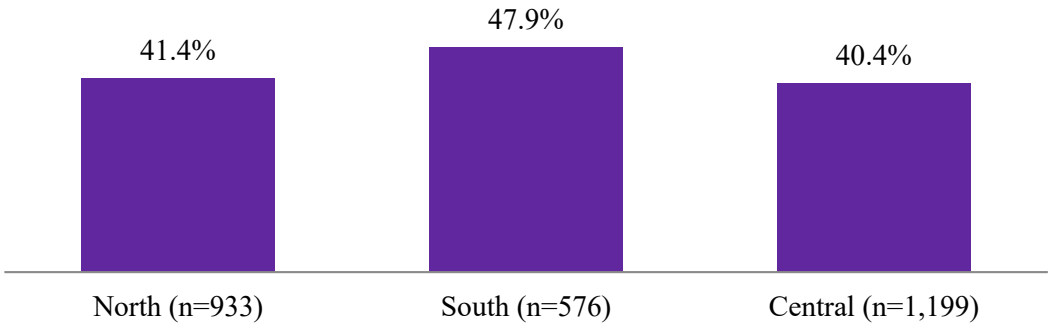
CalOptima language:



Age Category:

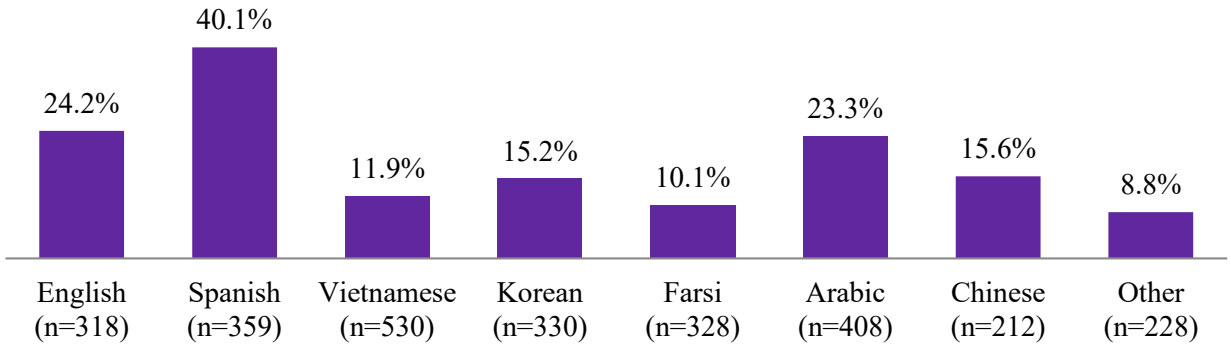


Region:

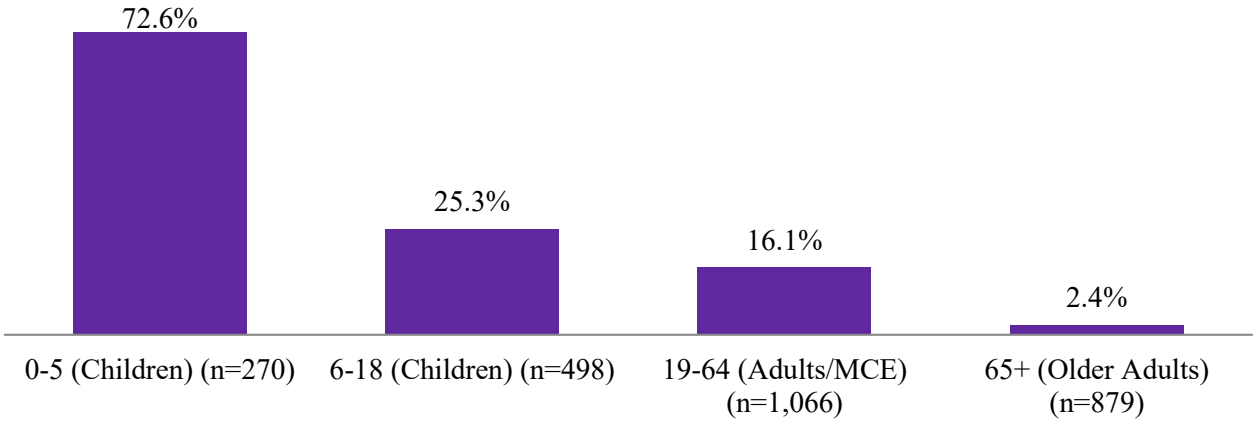


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

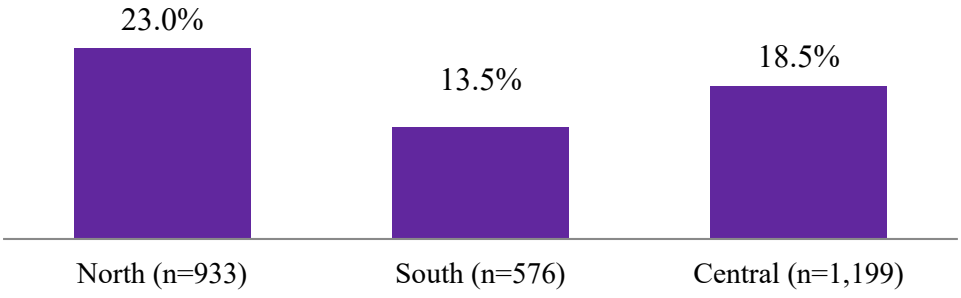


Exhibit 15. Personal activities participation:

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

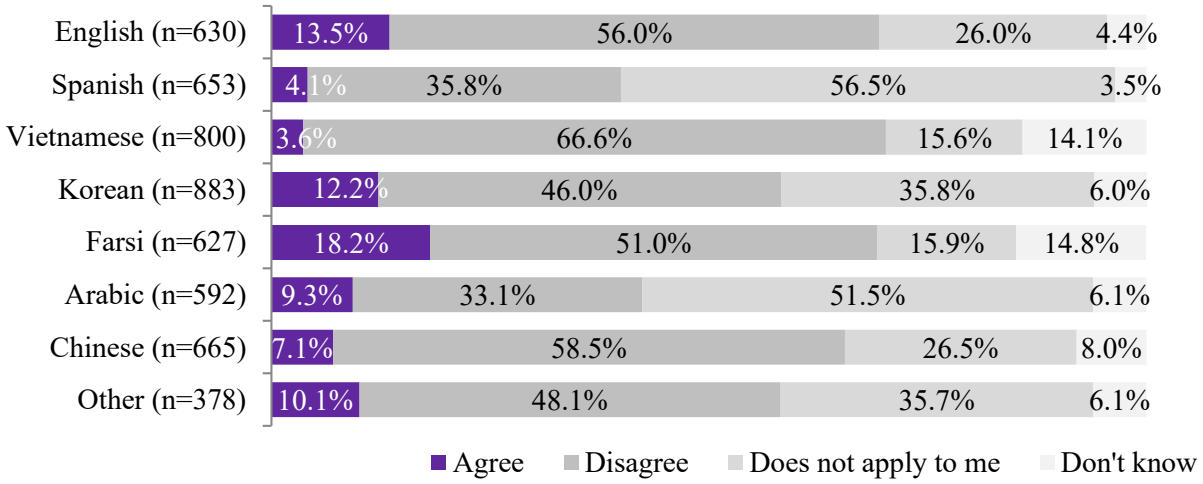
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

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

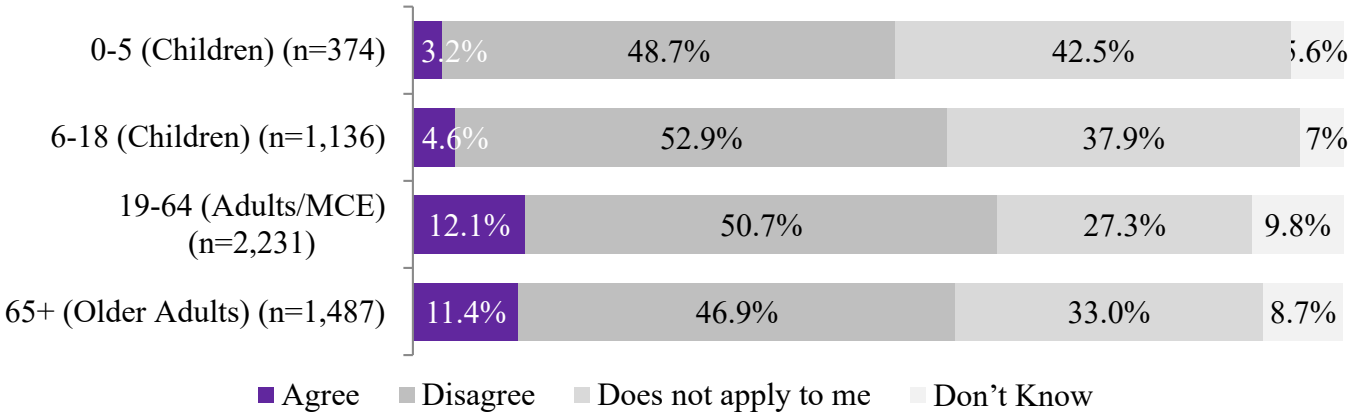
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

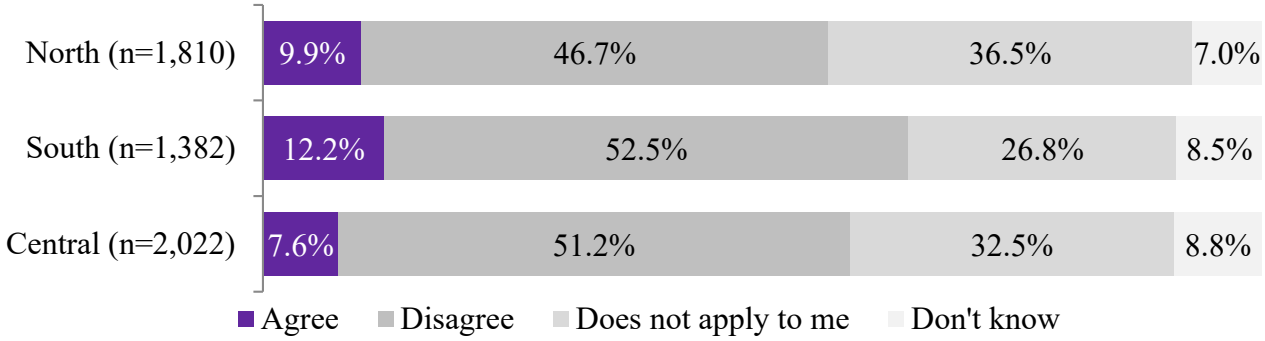
CalOptima language:



Age Category:

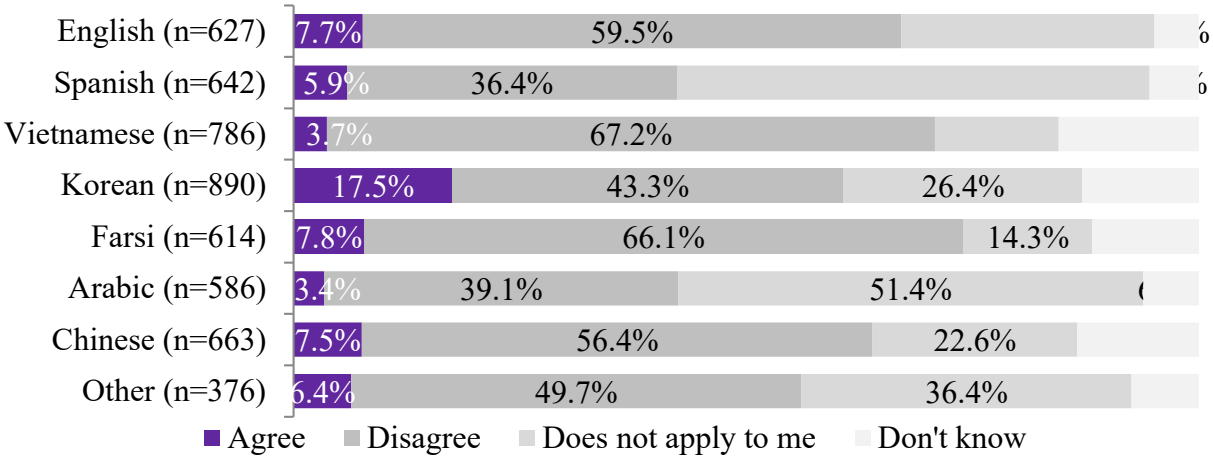


Region:

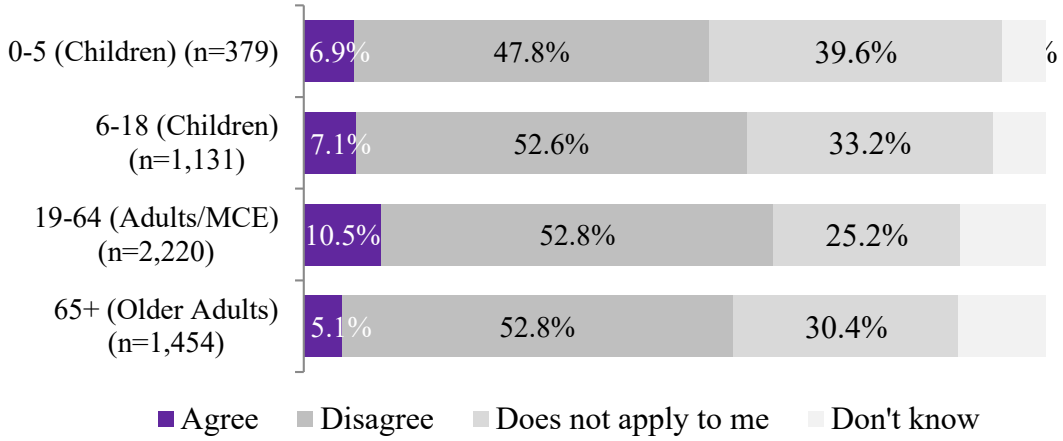


Feel not treated equally because of ethnic and culutral backgrounds:

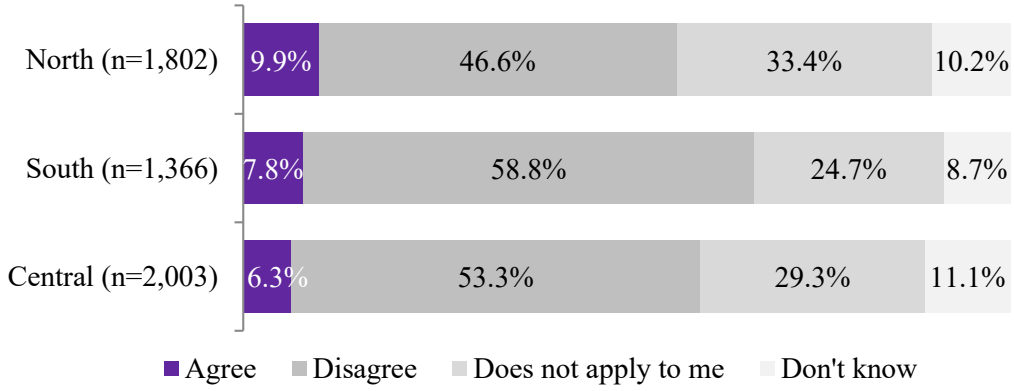
CalOptima language:



Age Category:

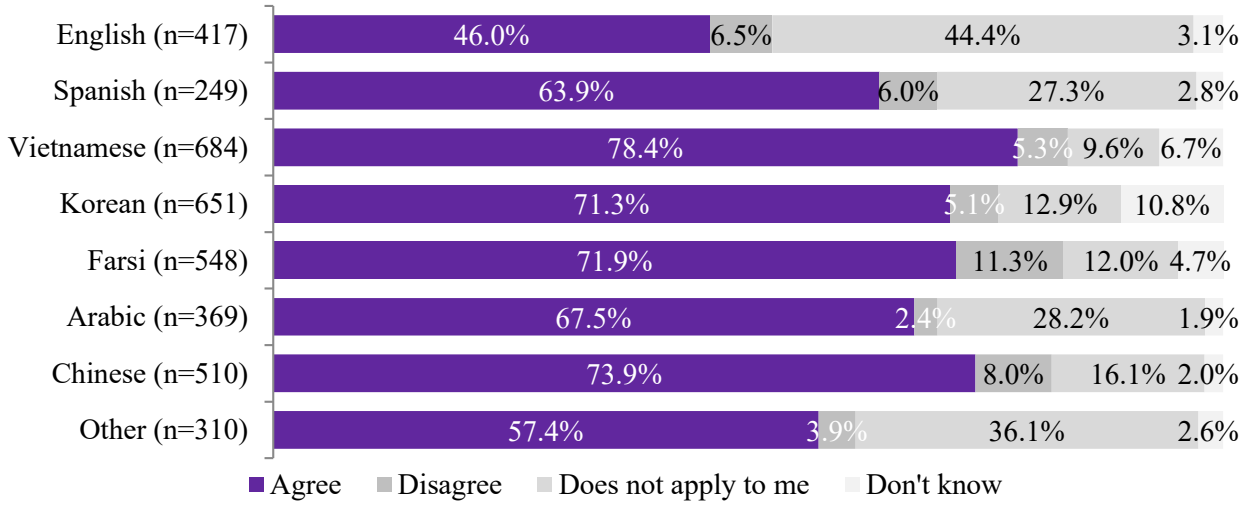


Region:



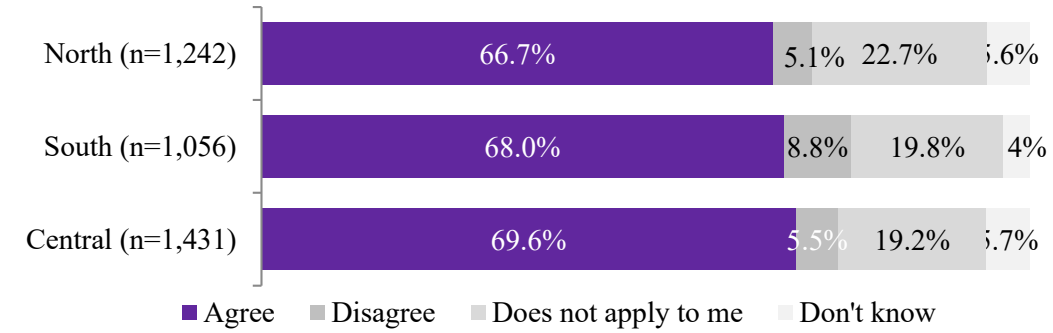
Feel child respects them as a parent[9]:

CalOptima language:



Age Category:

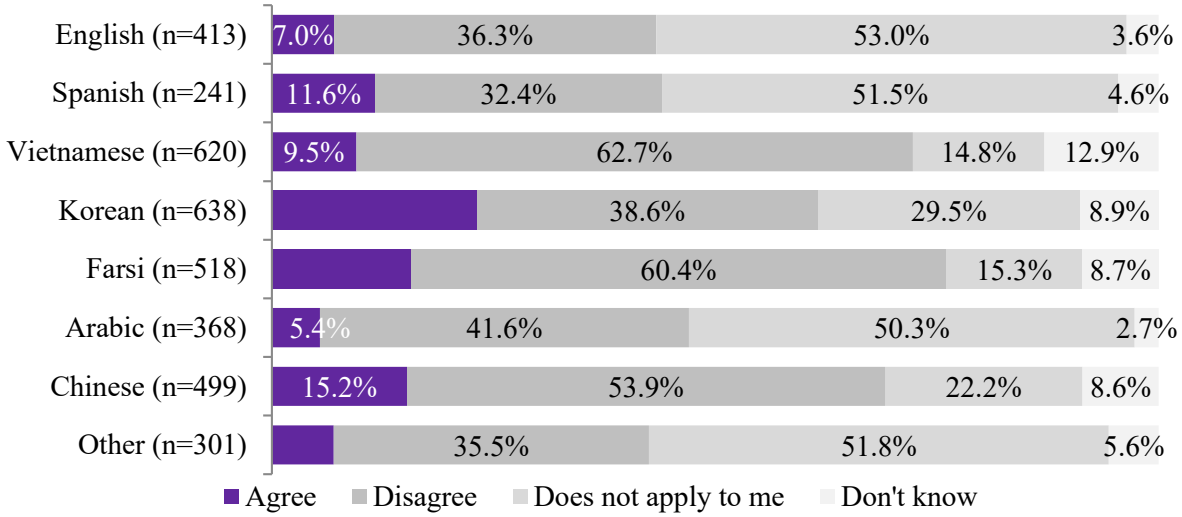
Region:



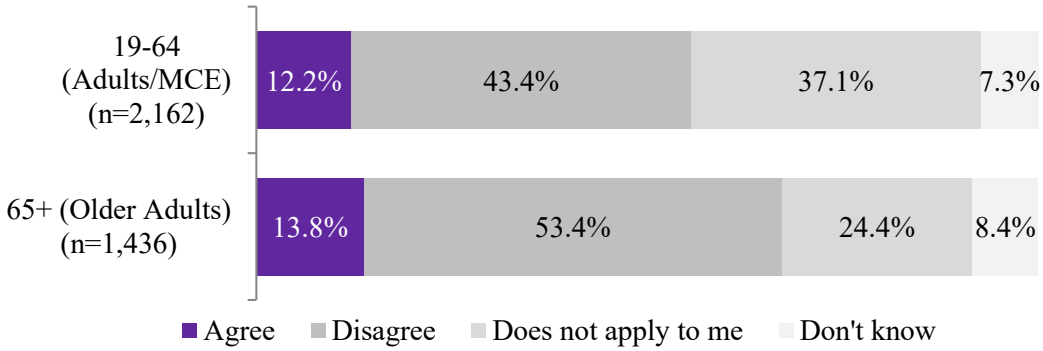
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

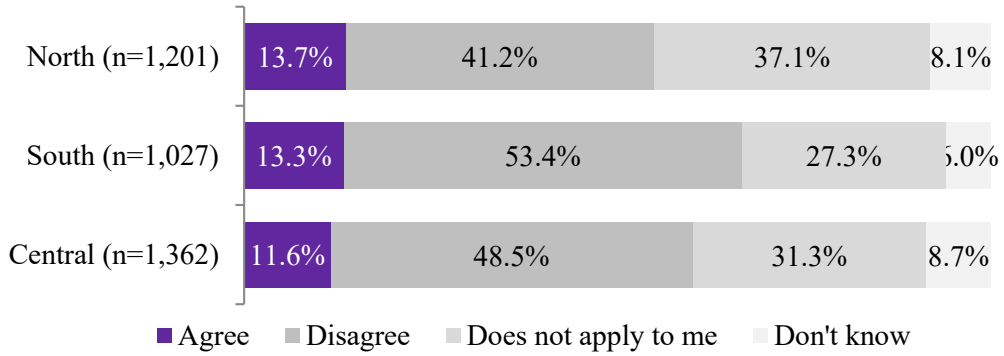
CalOptima language:



Age Category:



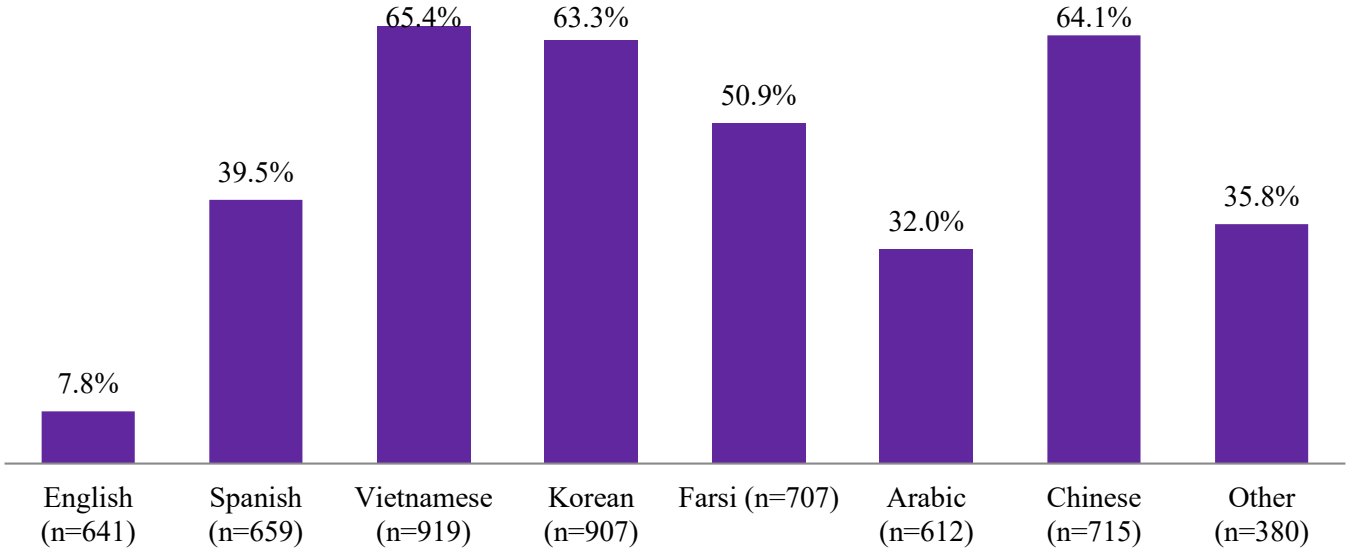
Region:



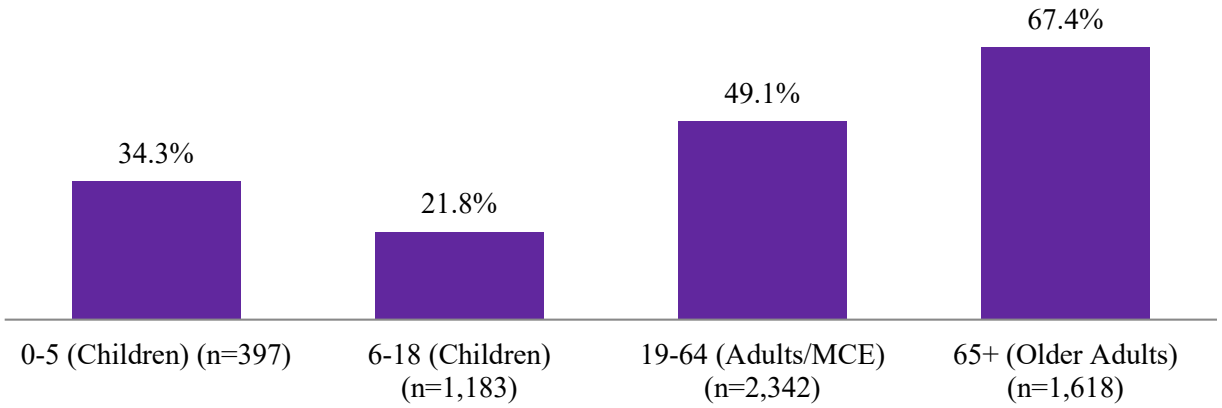
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

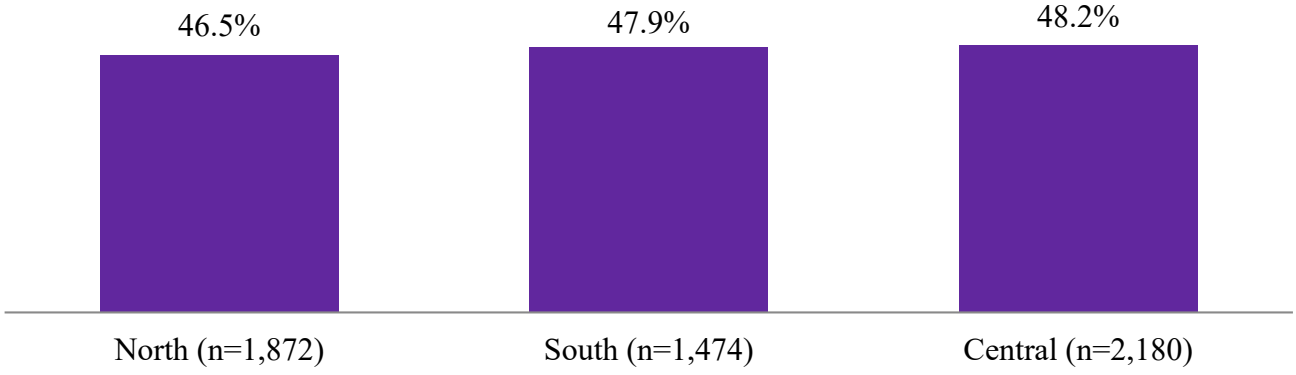


Exhibit 18. Employment status[11,12]

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

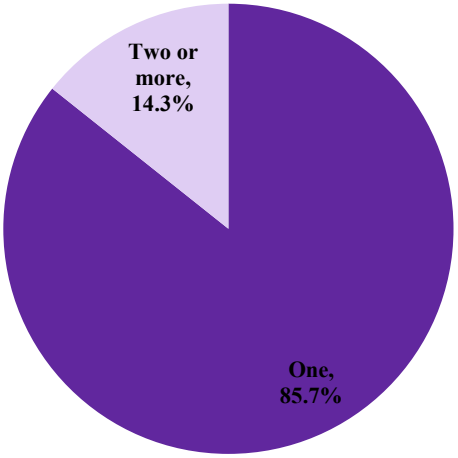
Region:

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

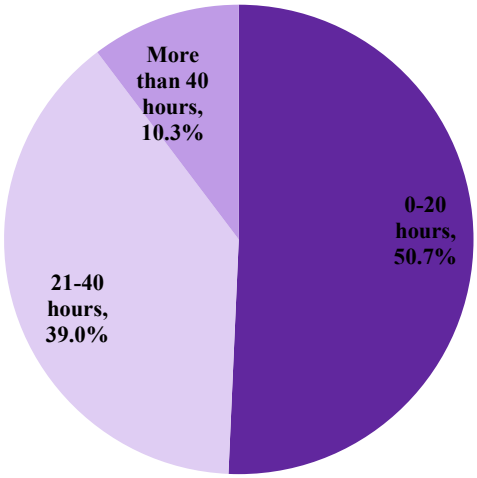
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

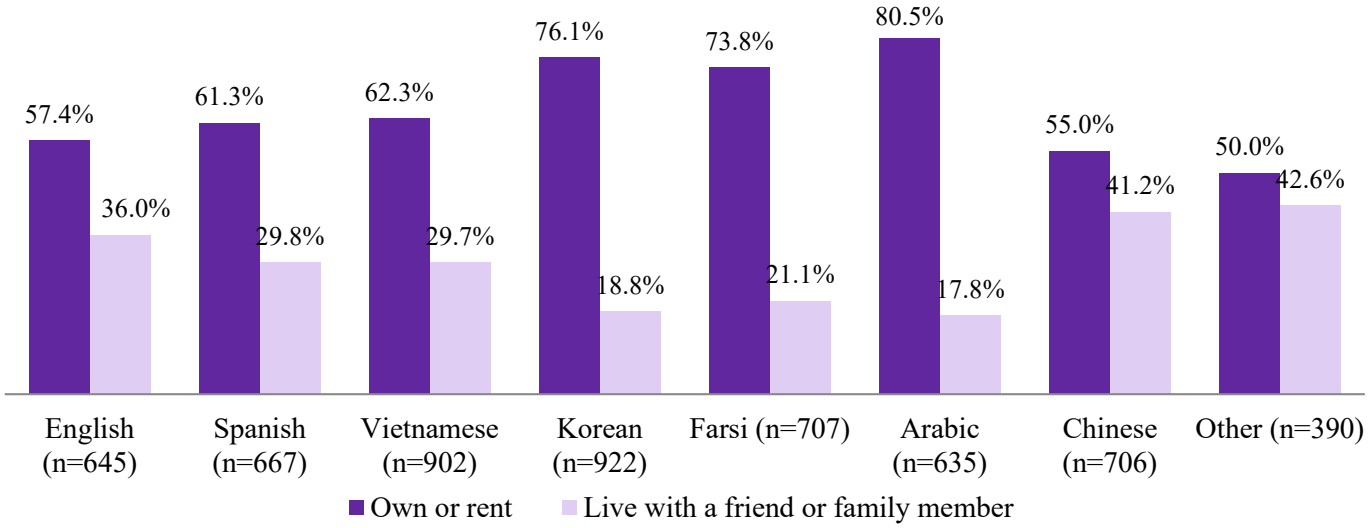


Number of hours that members work each week

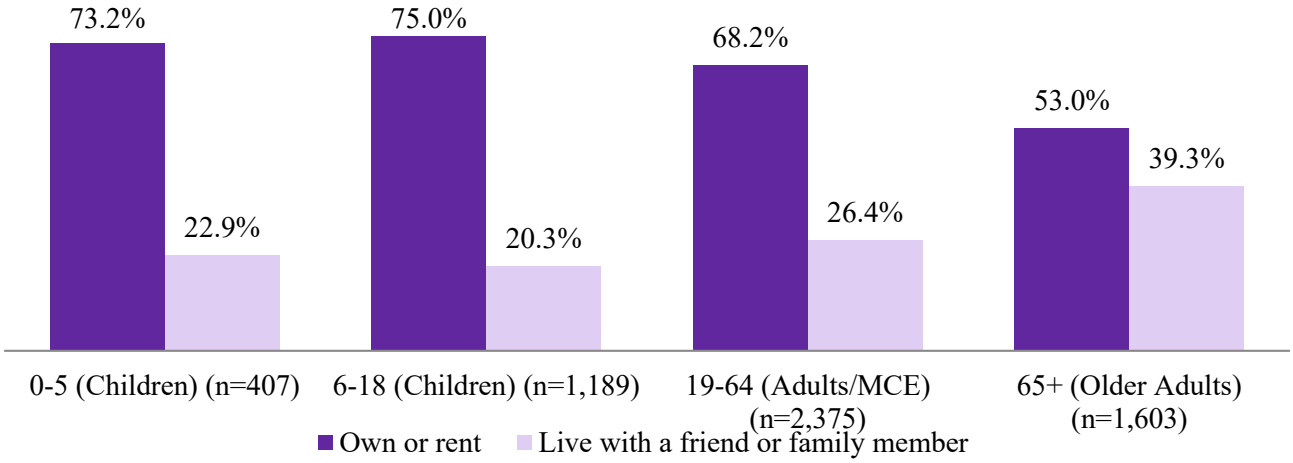


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

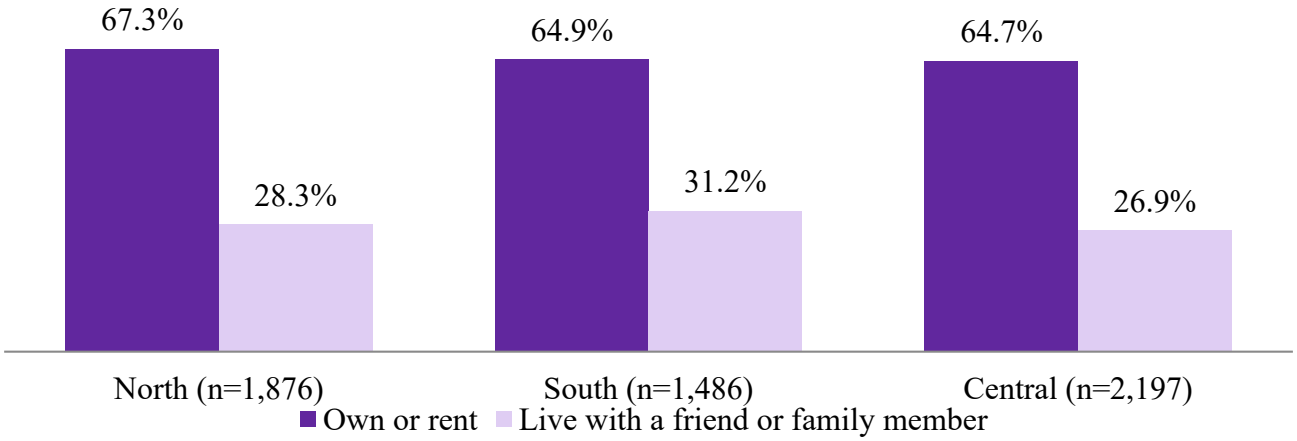
Exhibit 20. Members' living situation[14]



Age Category:



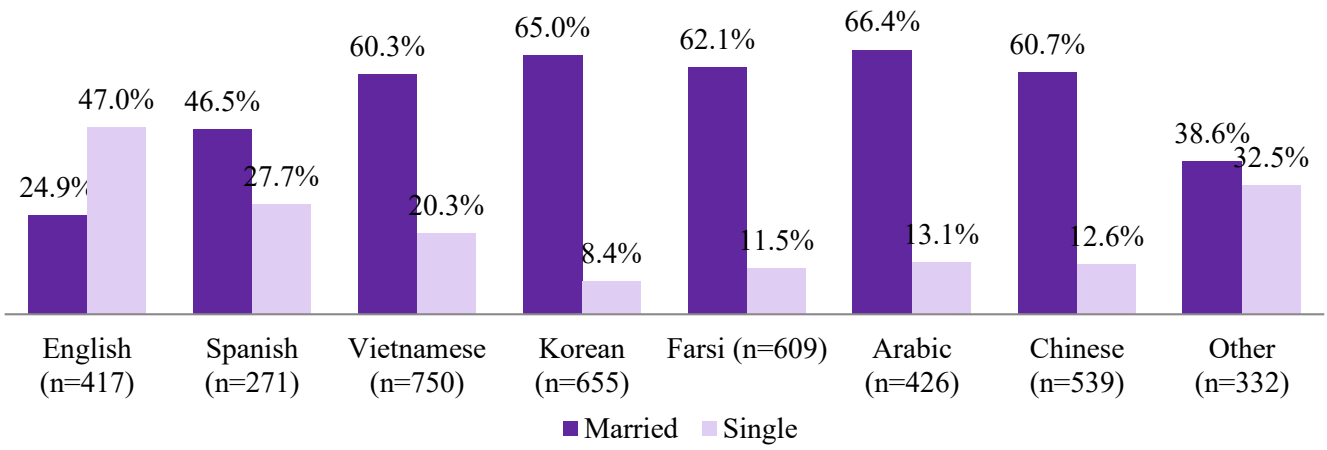
Region:



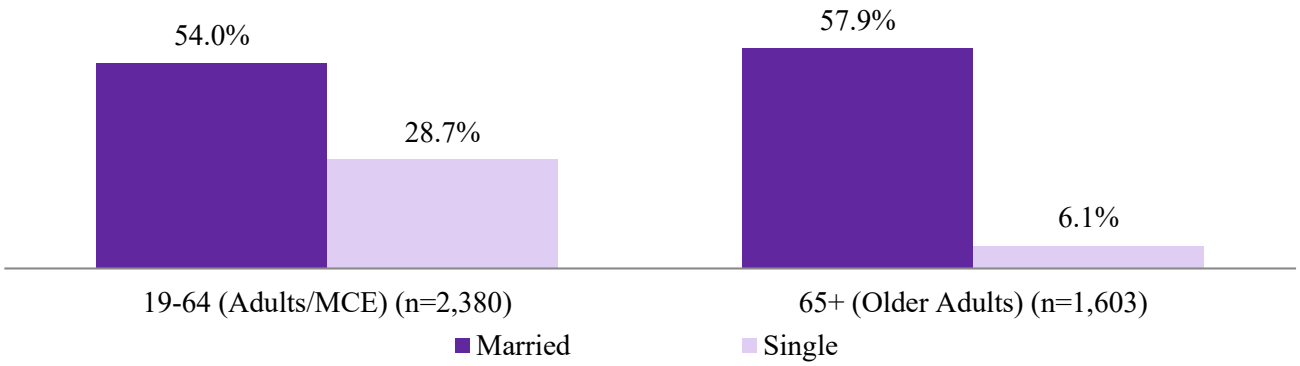
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

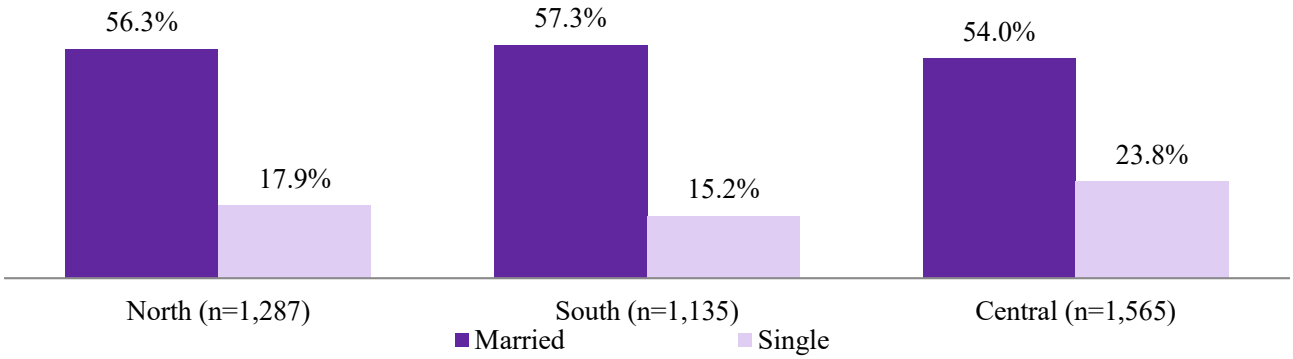
CalOptima language:



Age Category:



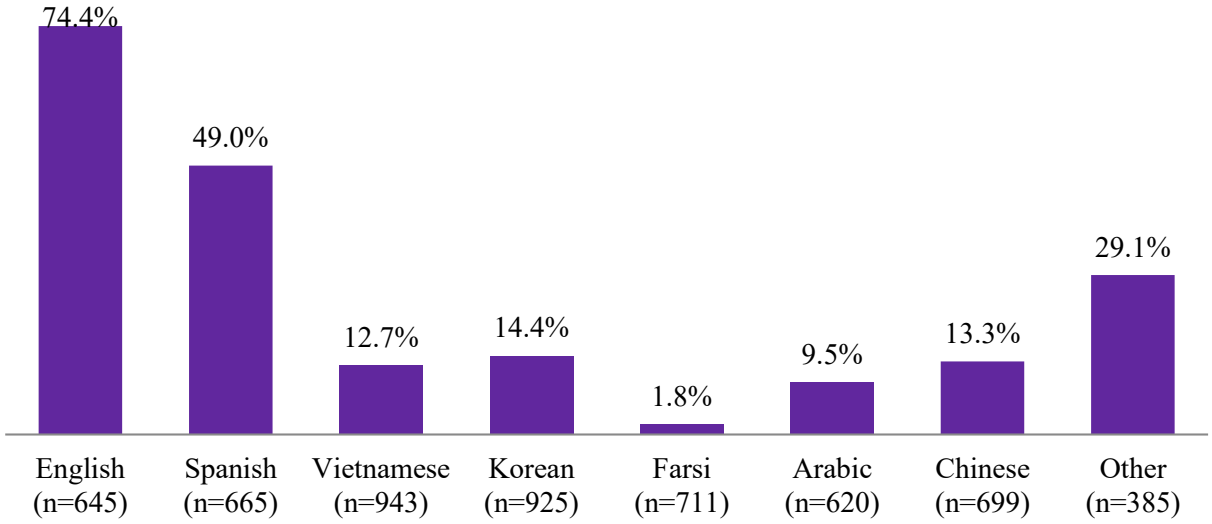
Region:



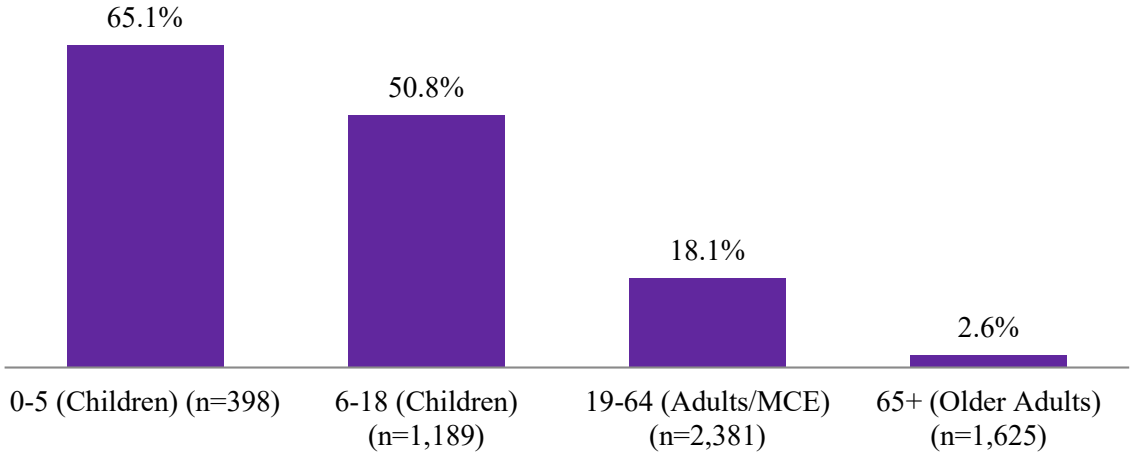
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

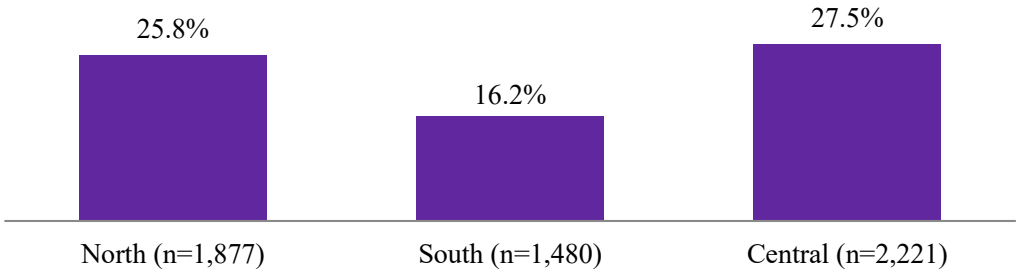
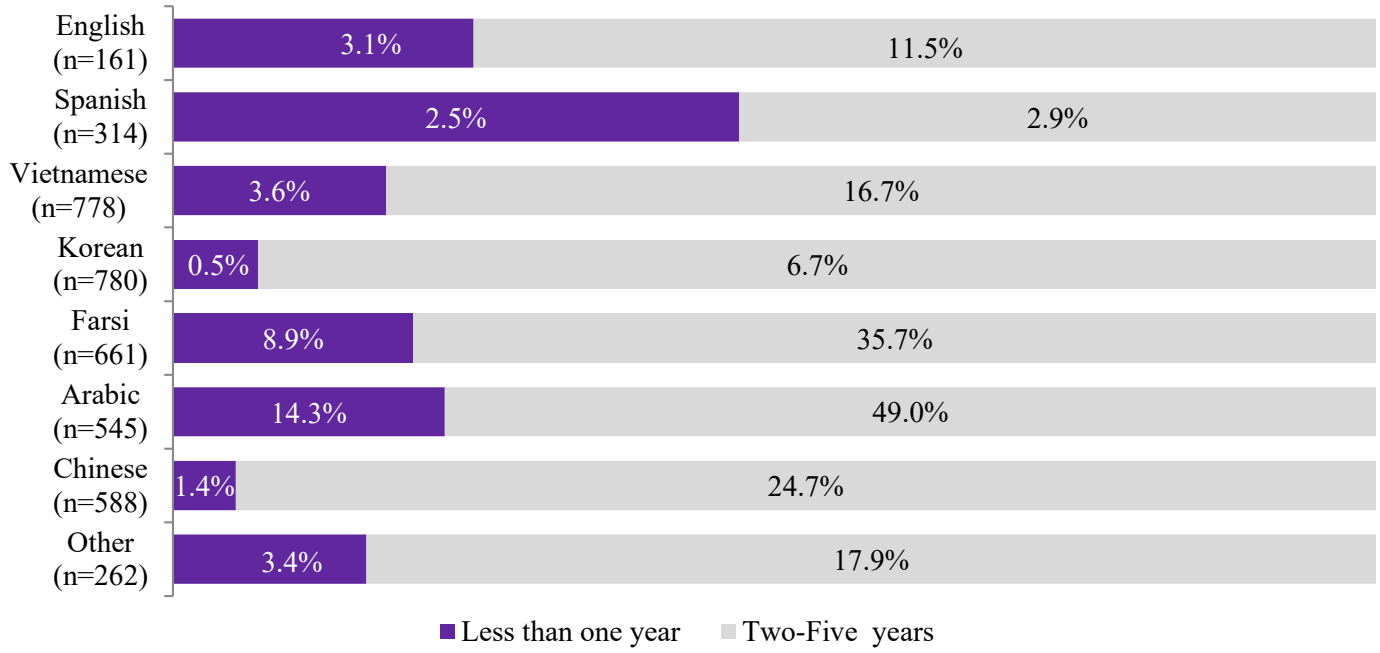
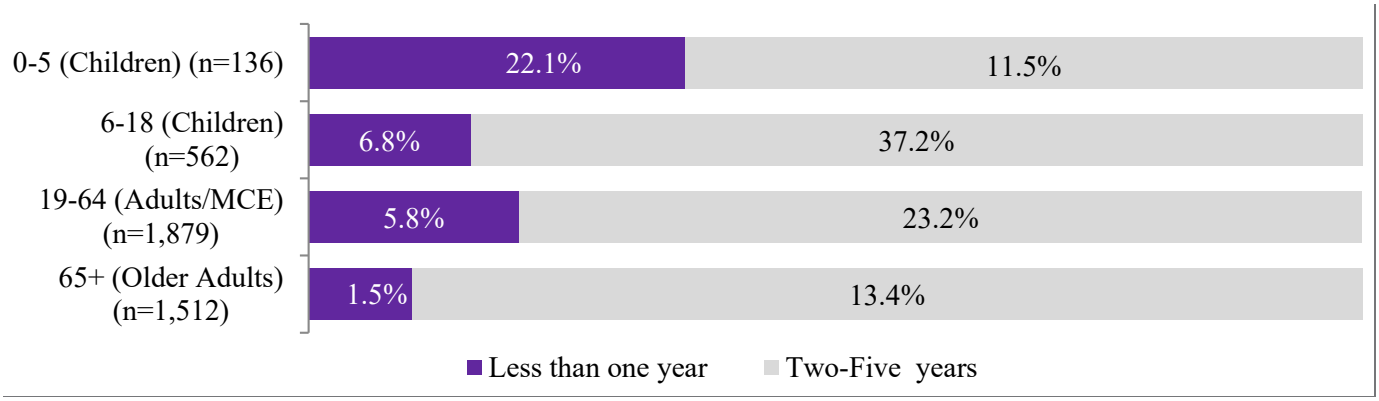


Exhibit 23. Length of time lived in the United States of those not born in the United States

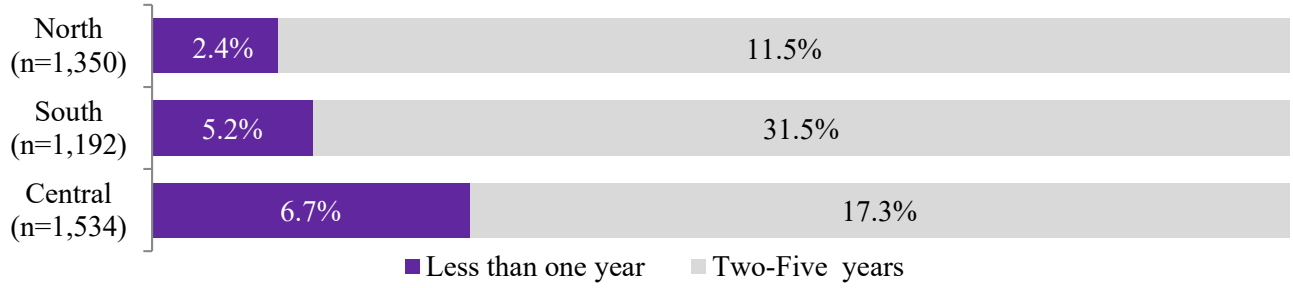
CalOptima language:



Age Category:



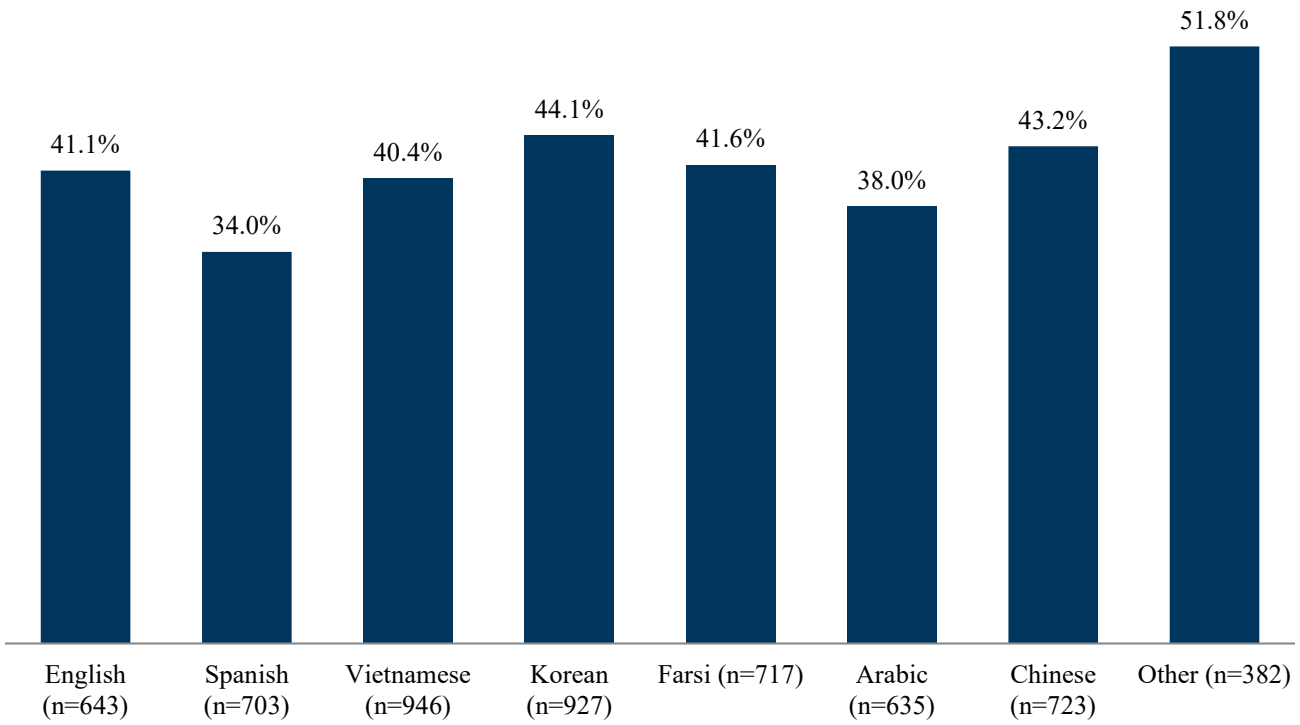
Region:



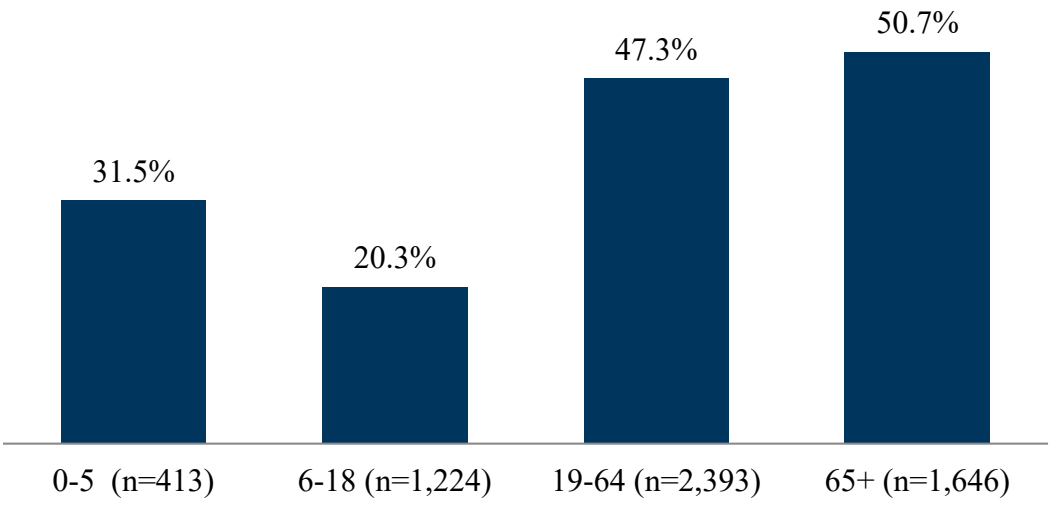
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

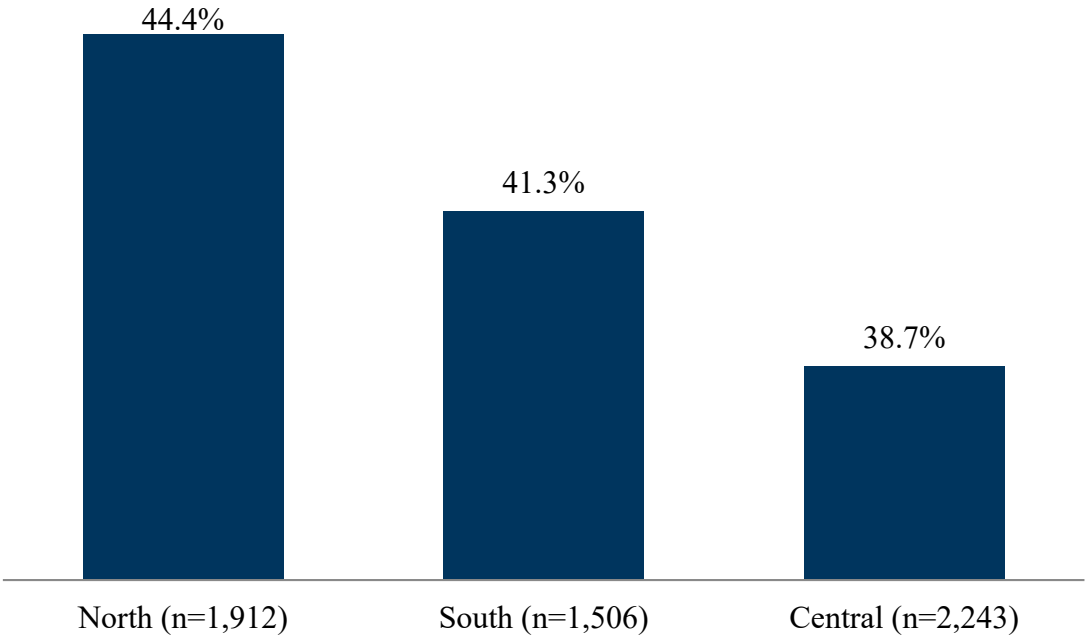


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

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)

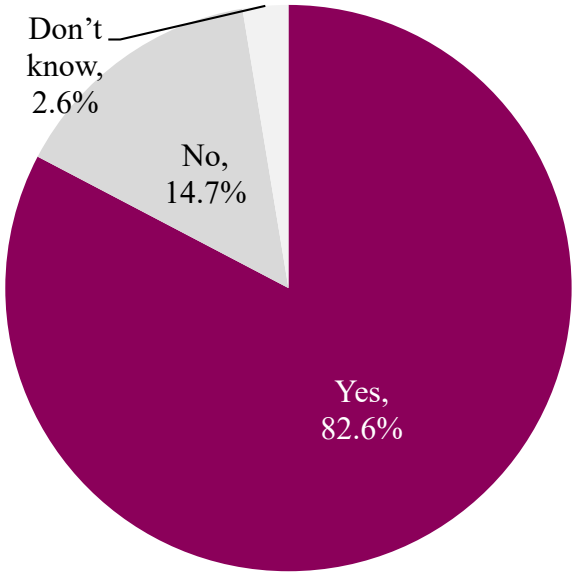


Exhibit 28. Where respondents go to see their doctor (n=5,743)

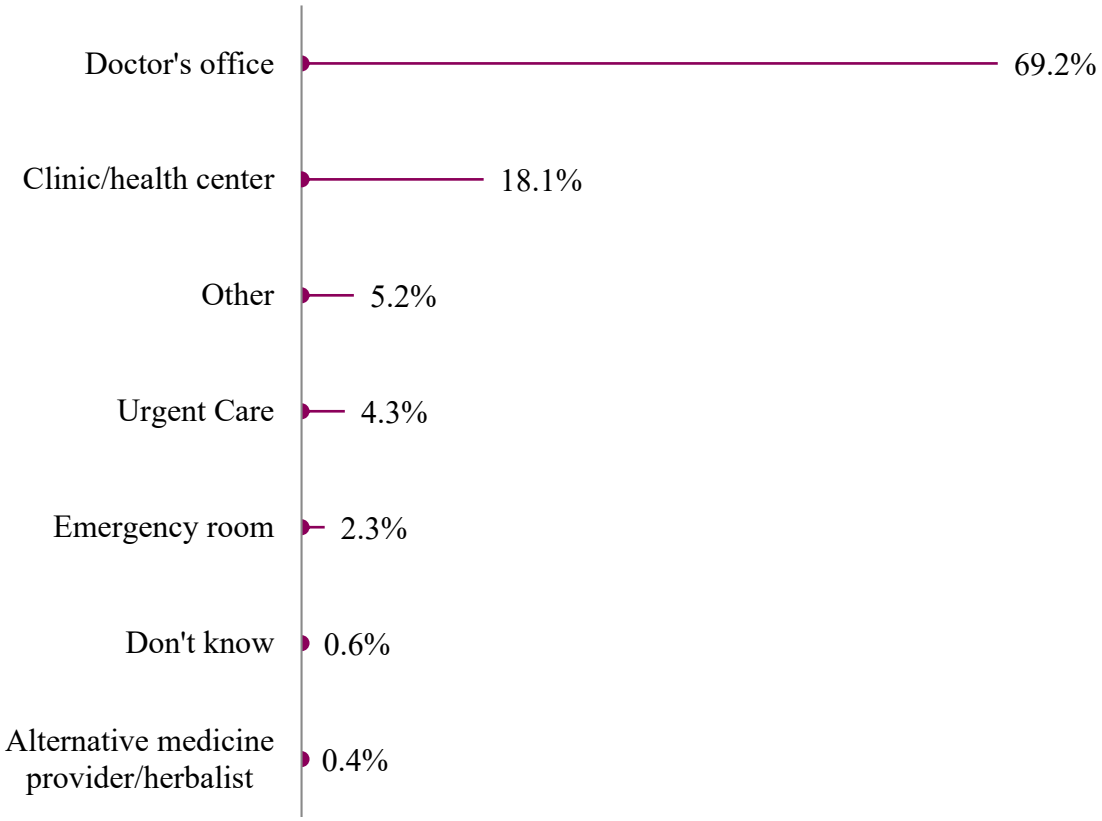


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

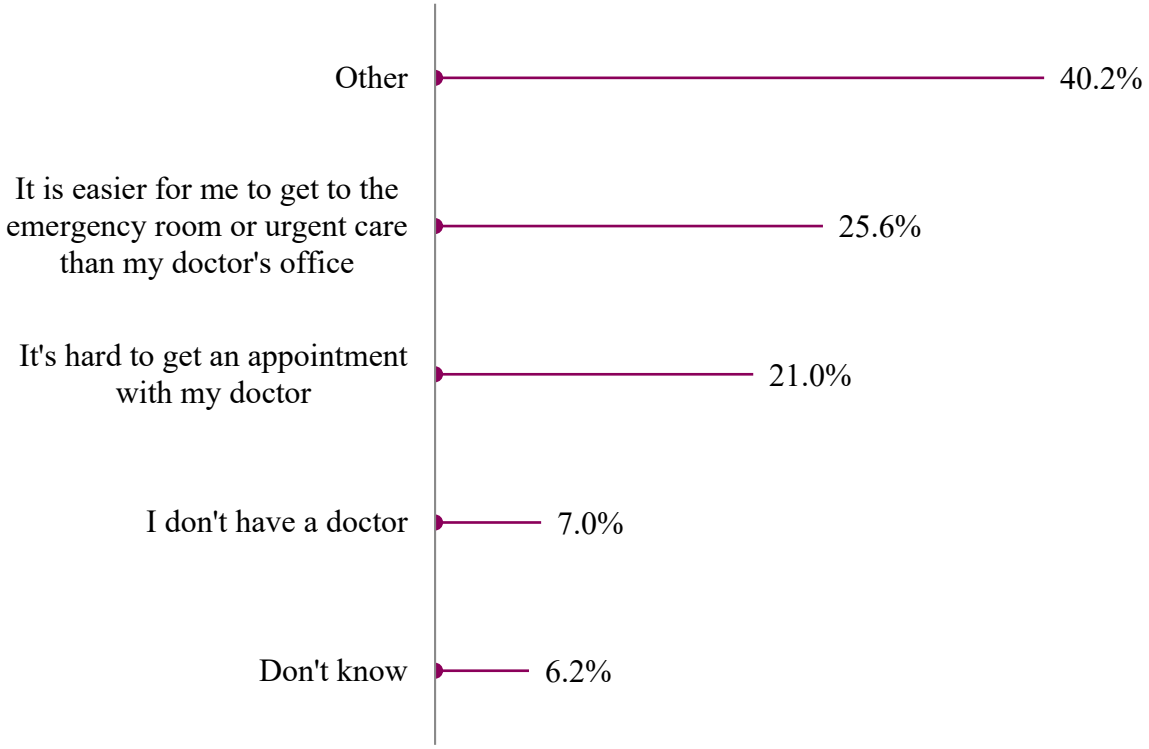


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

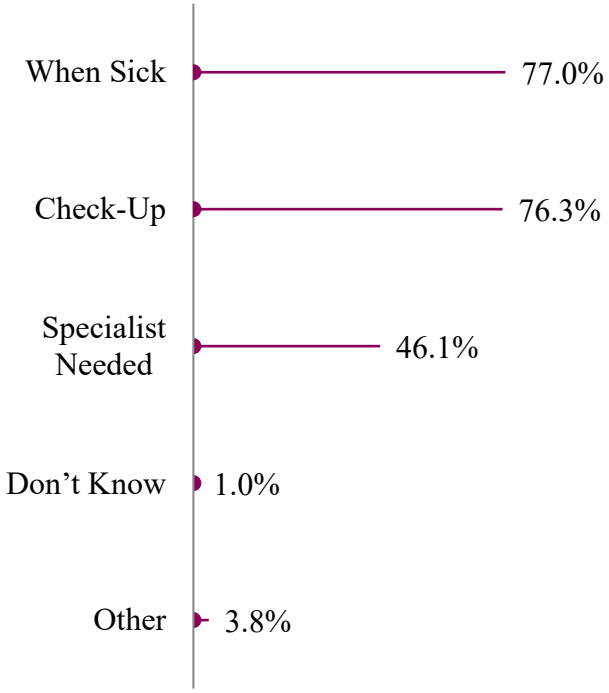
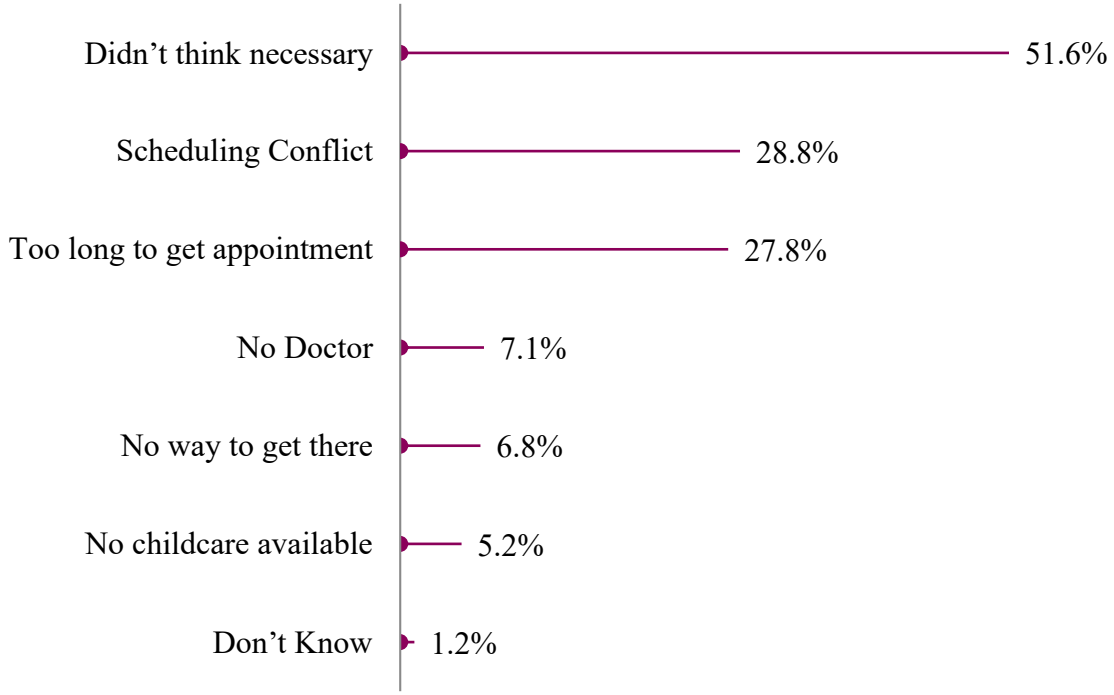


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[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]

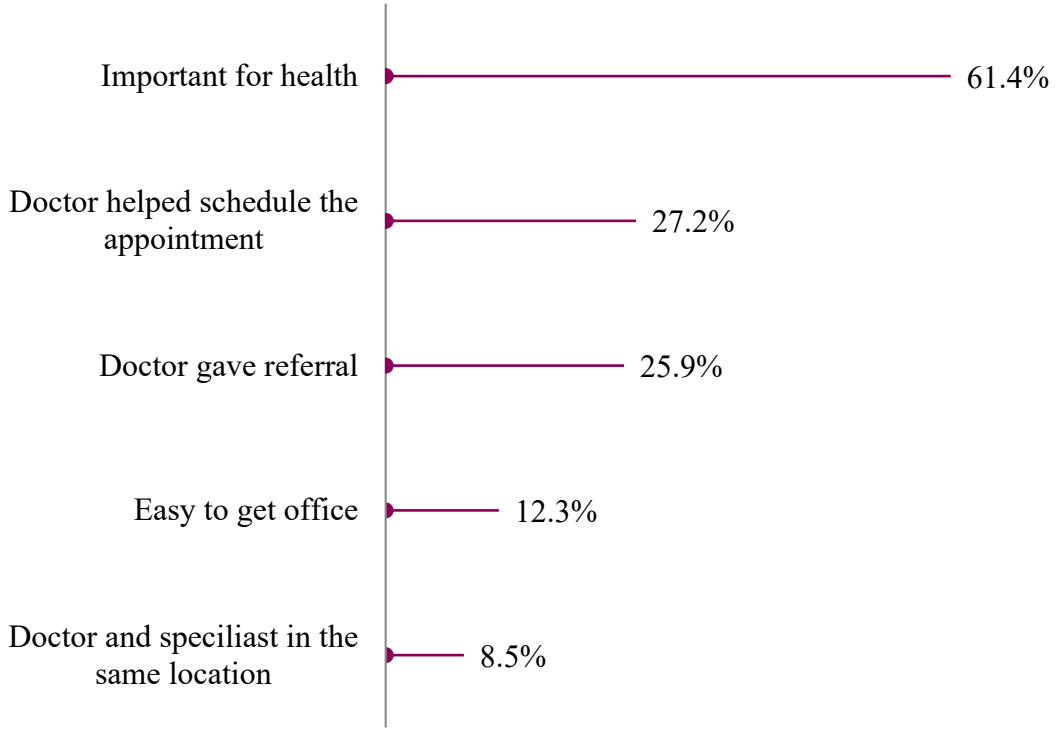
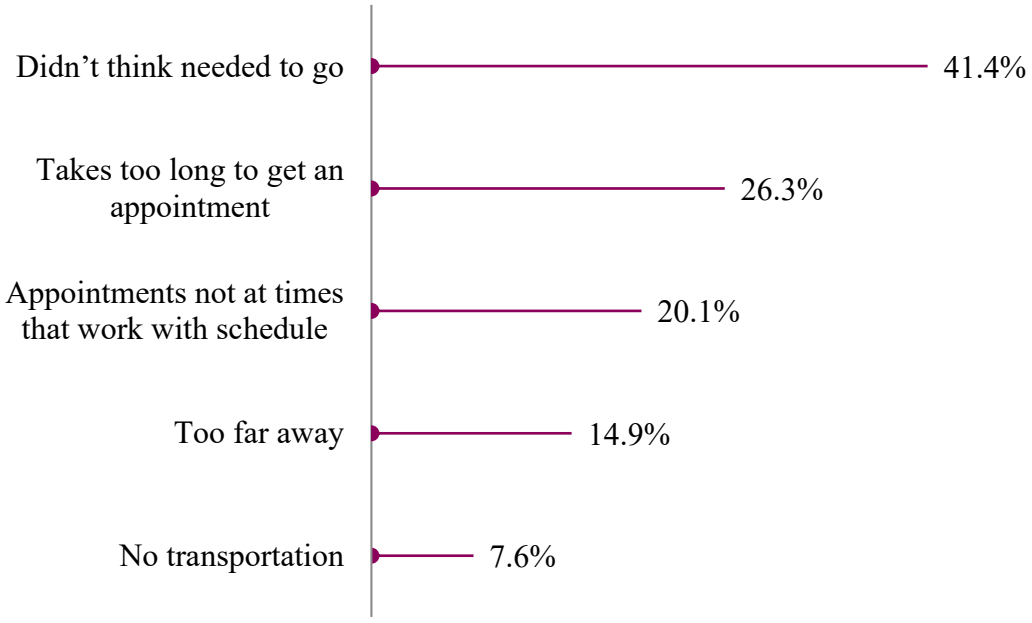
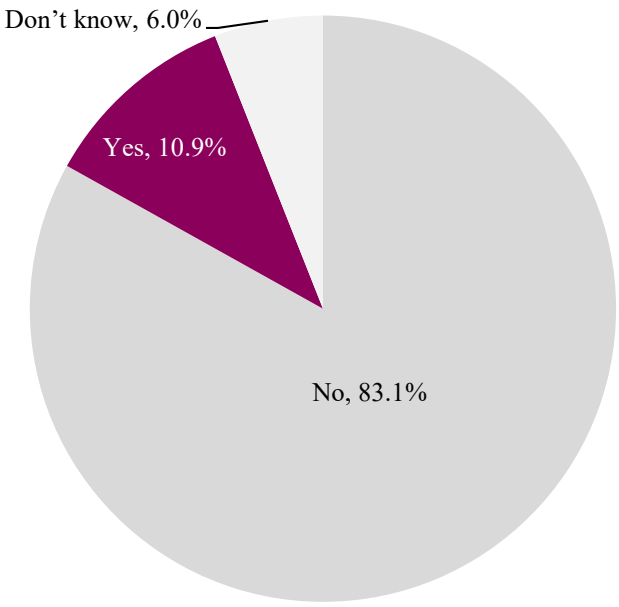


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[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)

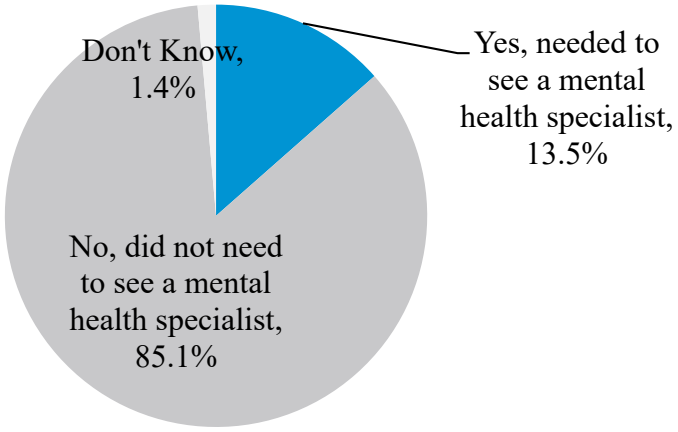


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

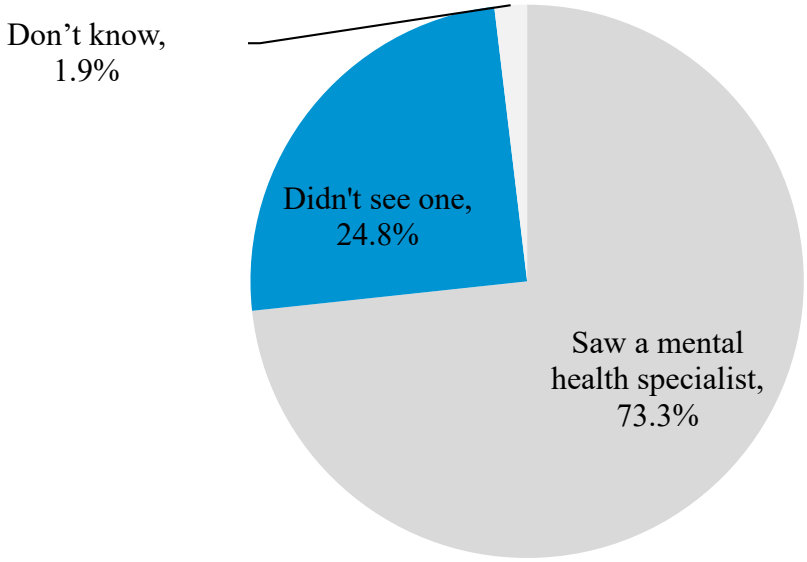


Exhibit 37. Reasons why members didn't see mental health specialist[24]

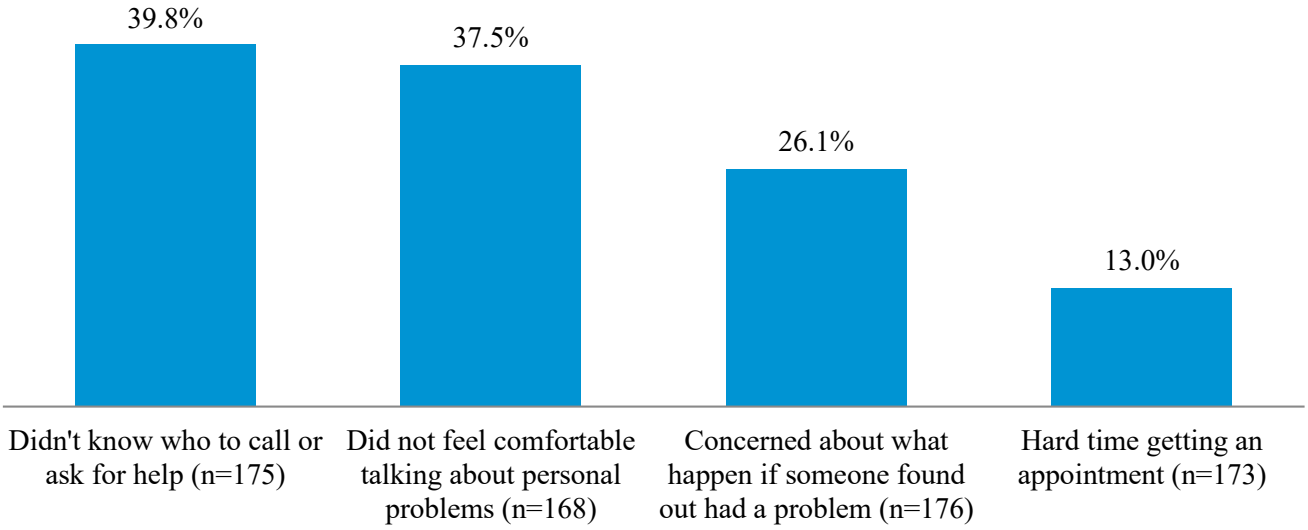
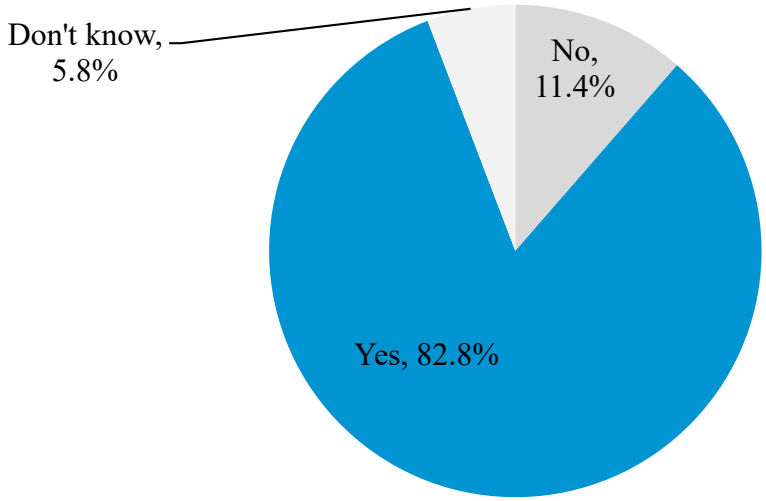


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[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:

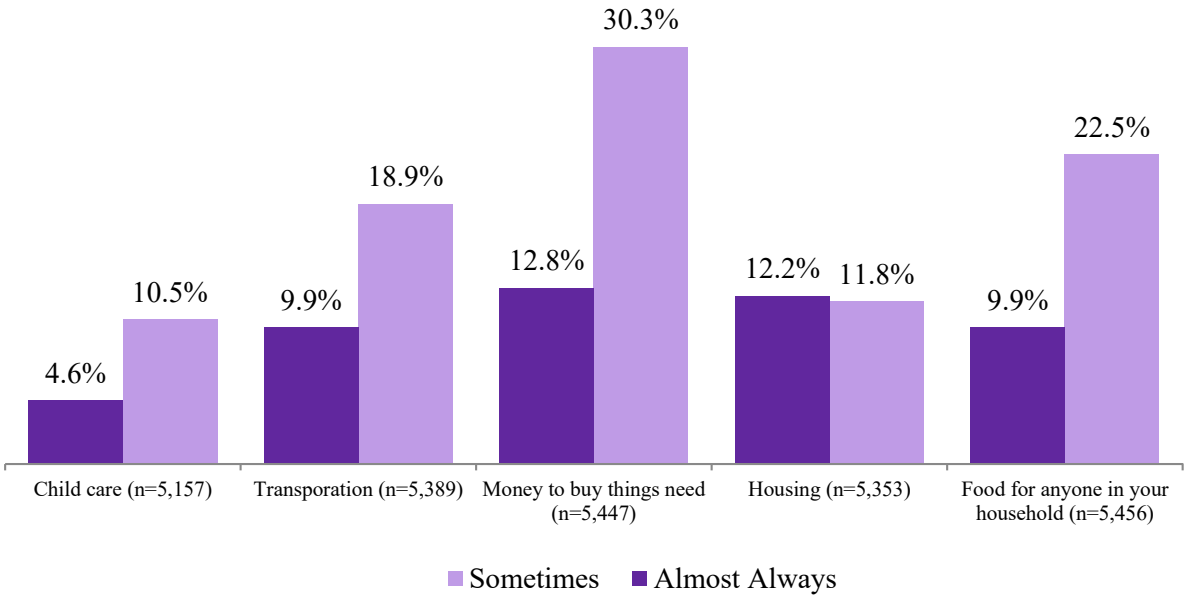


Exhibit 41. Percent of members who receive public benefits (n=5,117):

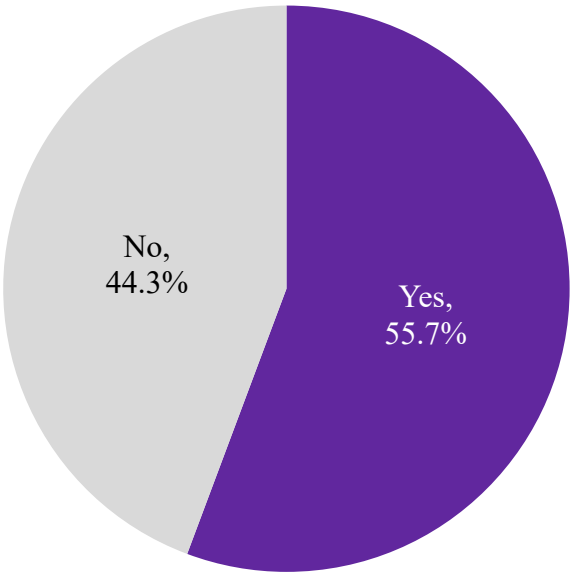
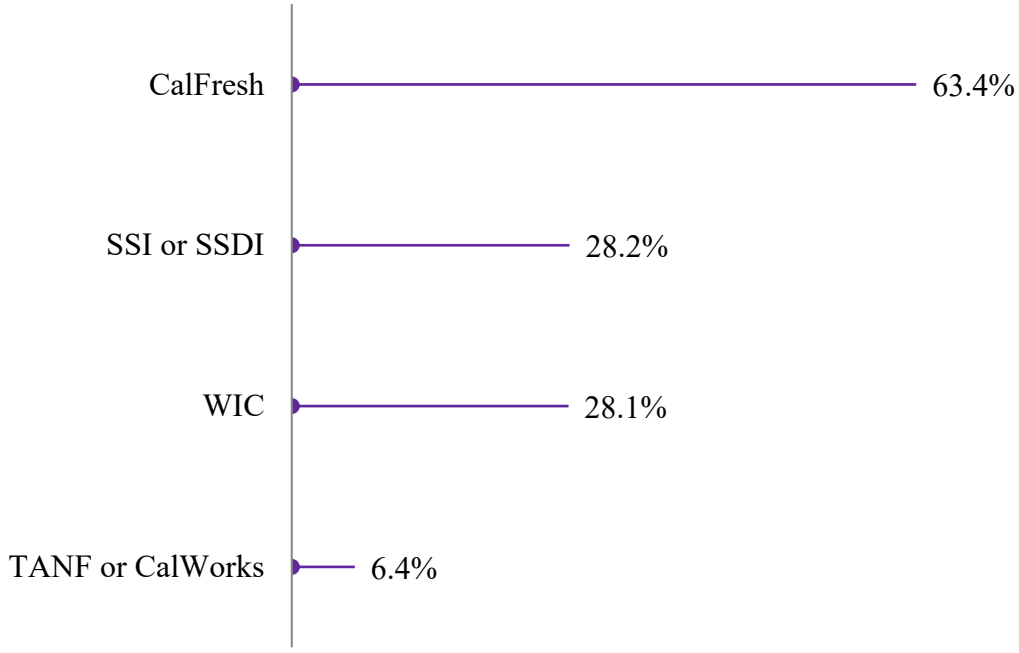


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

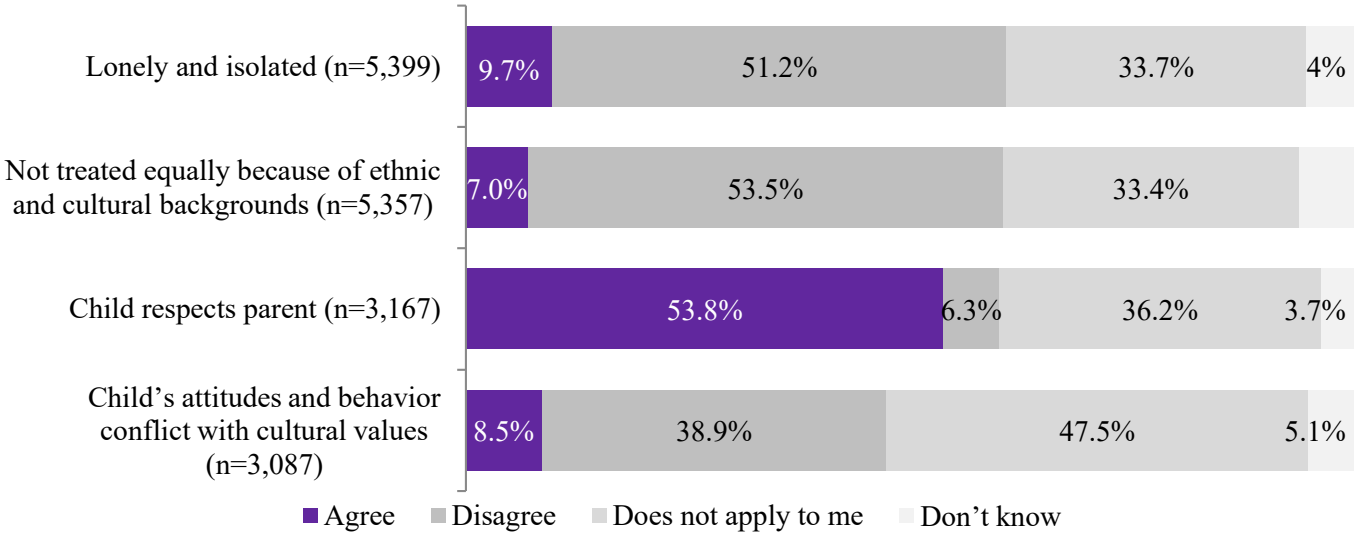


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

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%	
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)

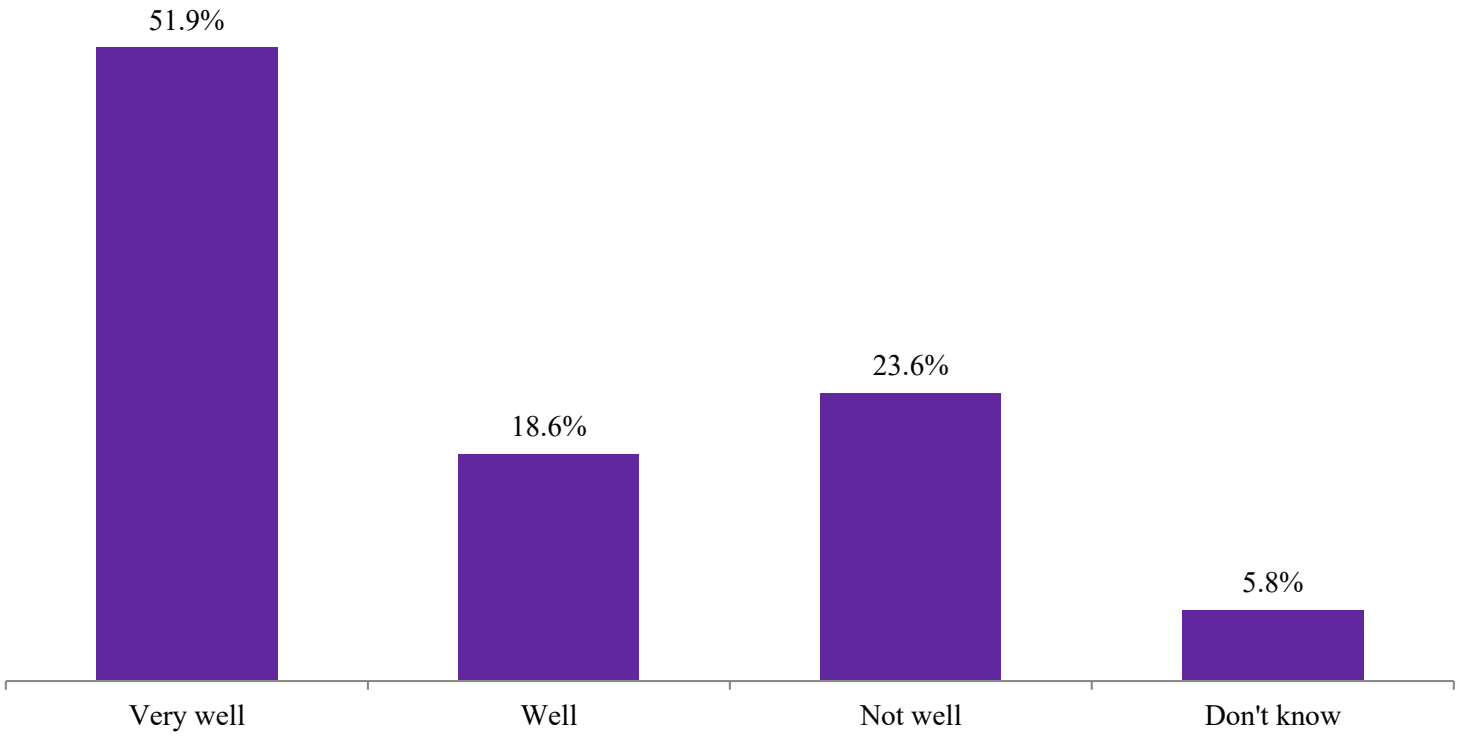


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

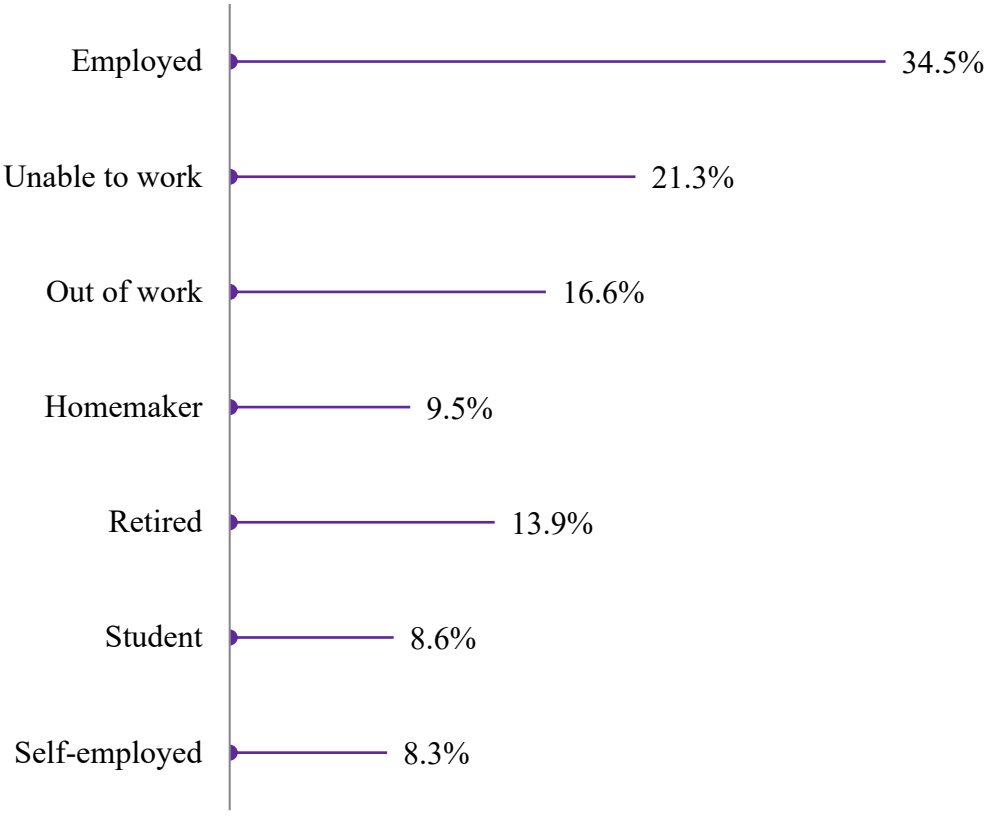
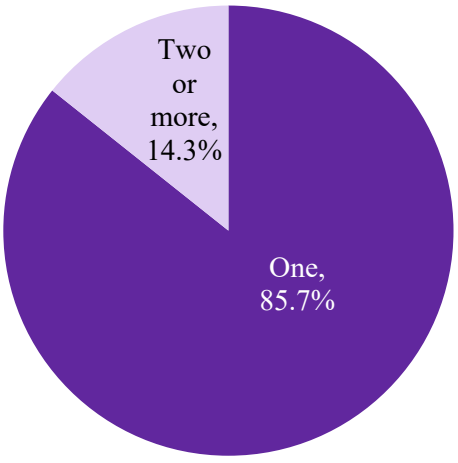
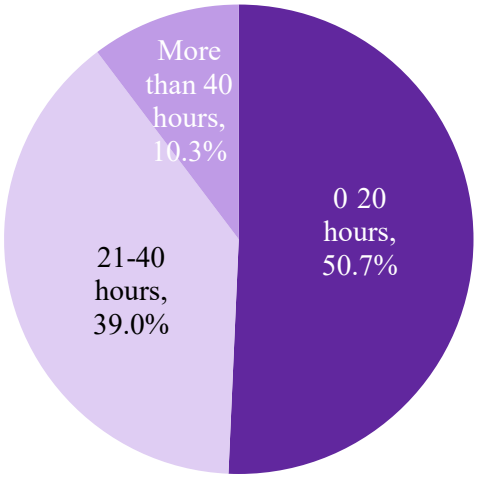


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

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)

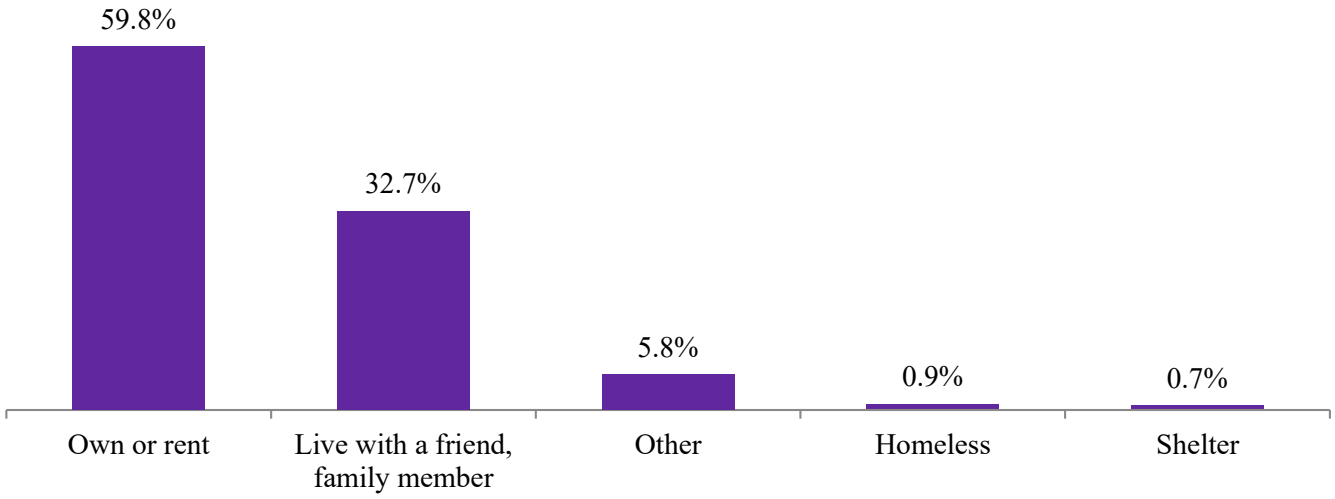
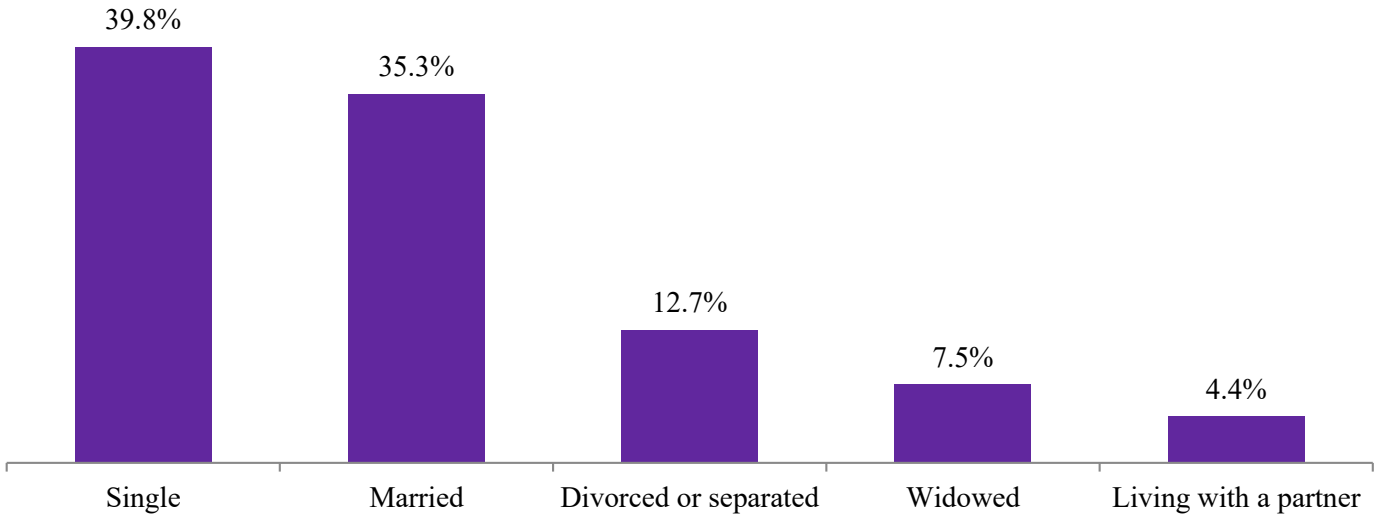


Exhibit 49. Marital status of members (n=3,271)[30]



[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)

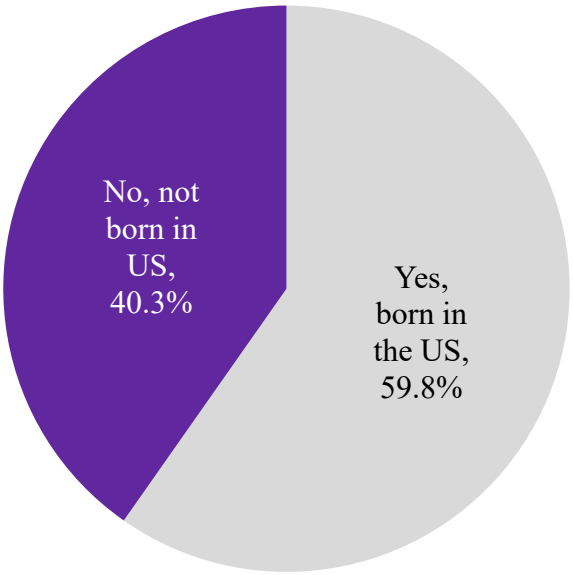
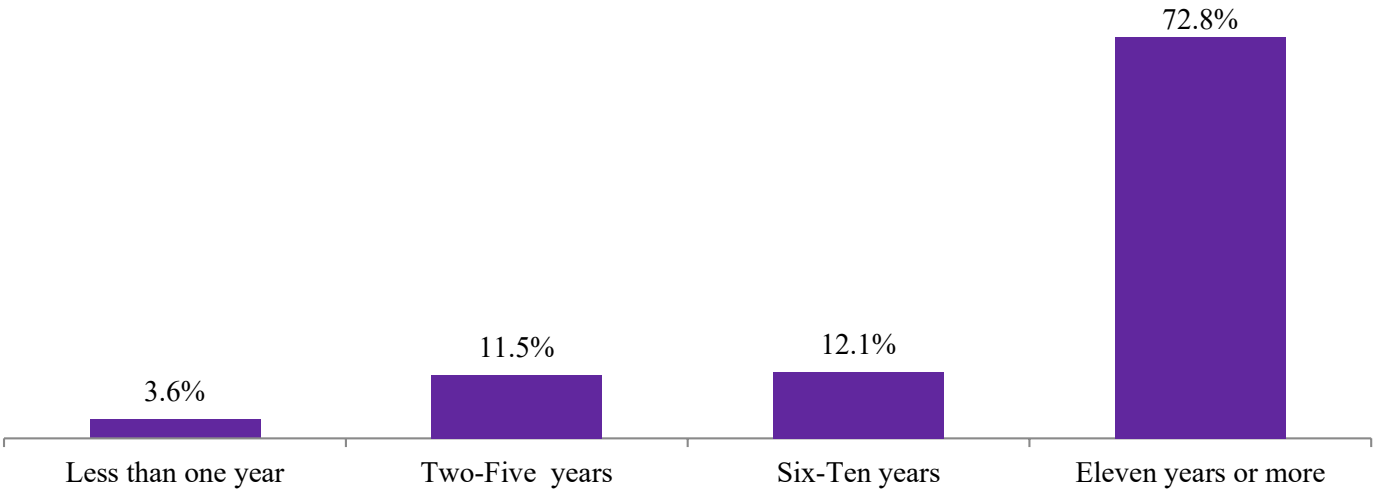


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

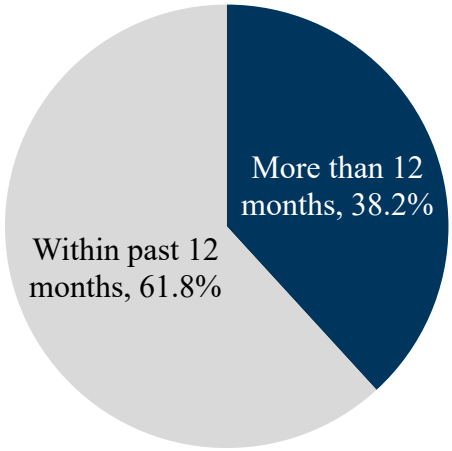
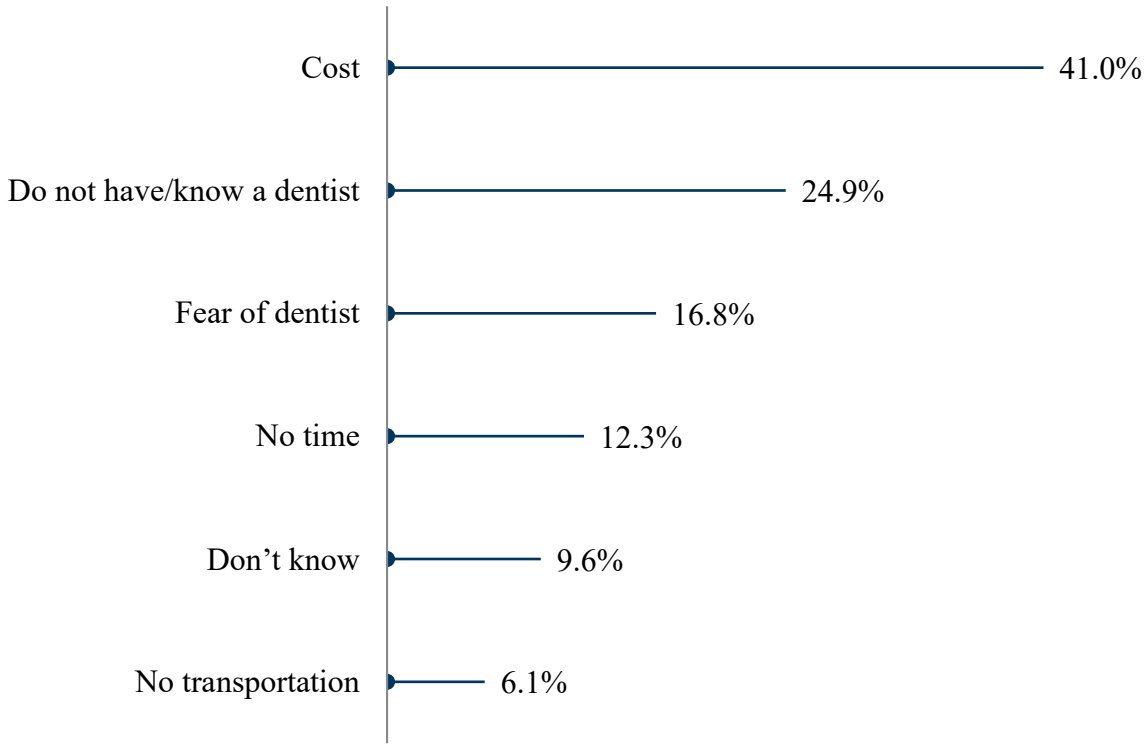
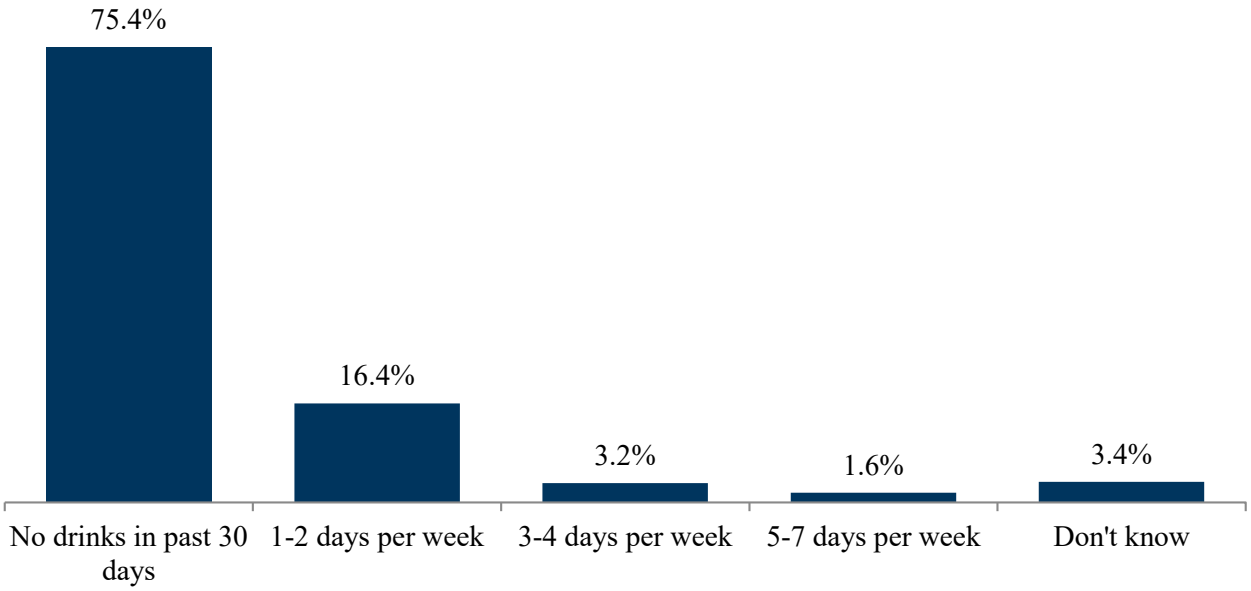


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[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 — *5/30/2018*
Authorized Signature — **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

A Public Agency

CalOptima

Better. Together.

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

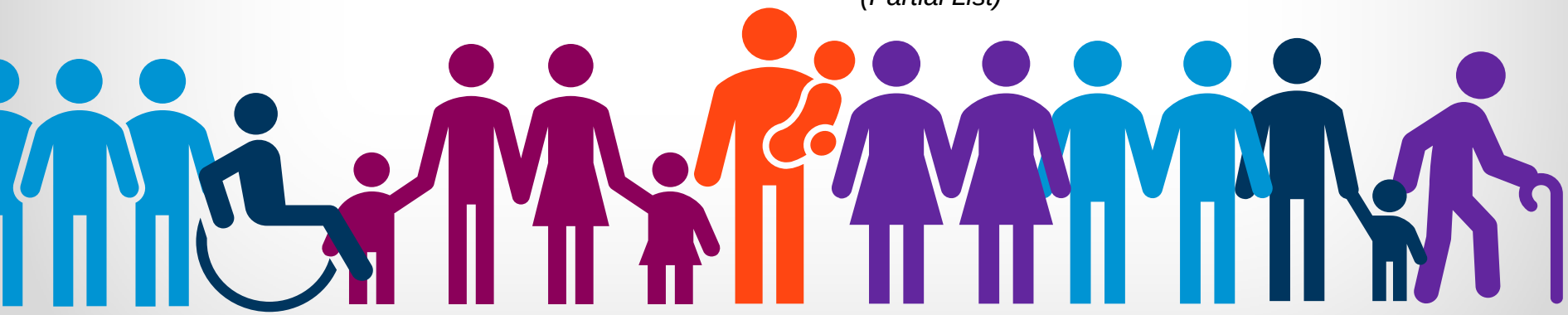
Back to Agenda

CalOptima
Better Together

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.)

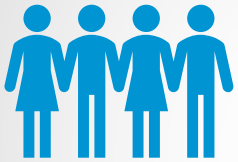
- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In 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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

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

CalOptima
A Public Agency
Better. Together.

Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Back to Agenda

CalOptima
Better Together

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

CalOptima
A Public Agency
Better. Together.

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)

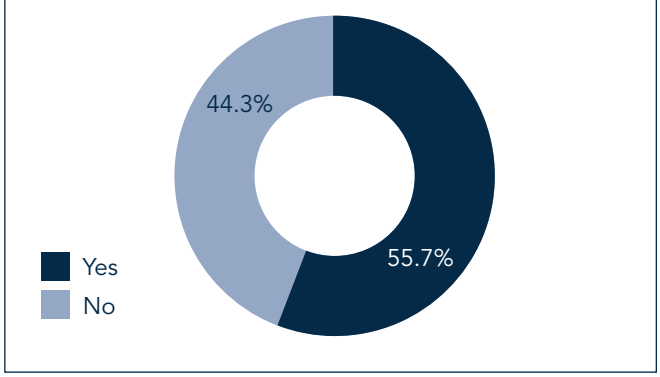
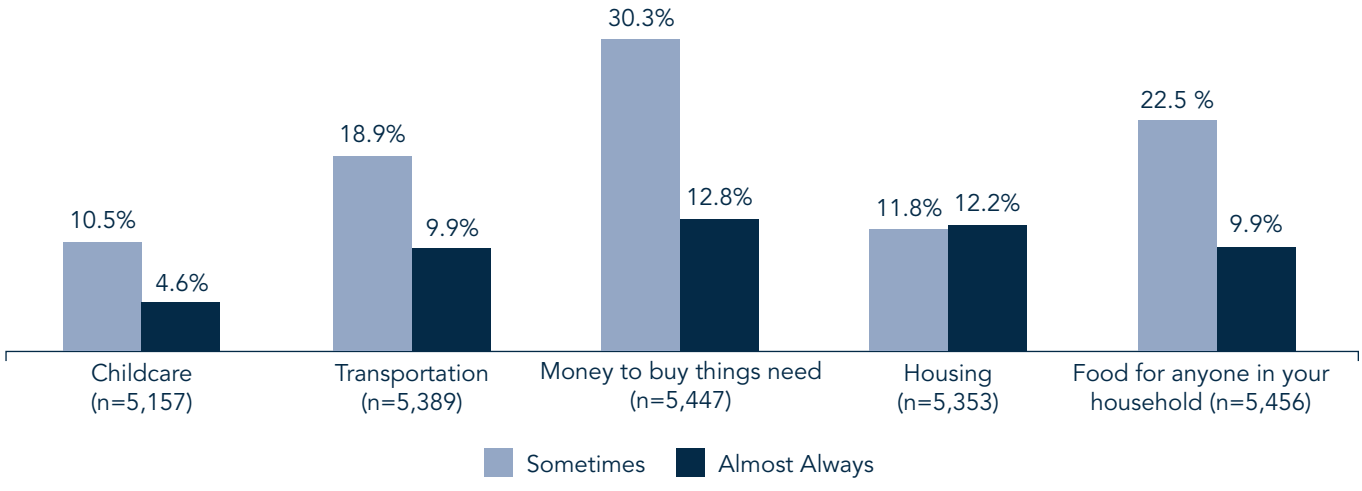


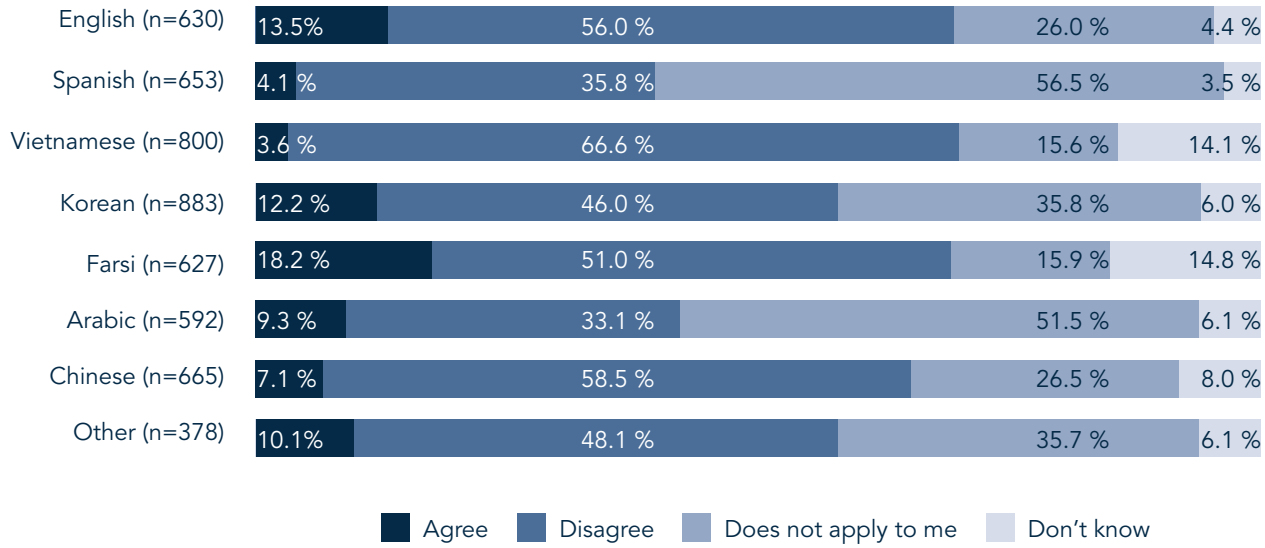
Exhibit 3: Percent of members who needed help with basic needs in the past six months



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)

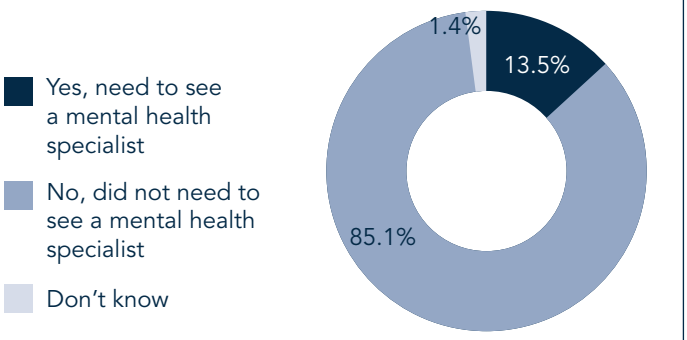
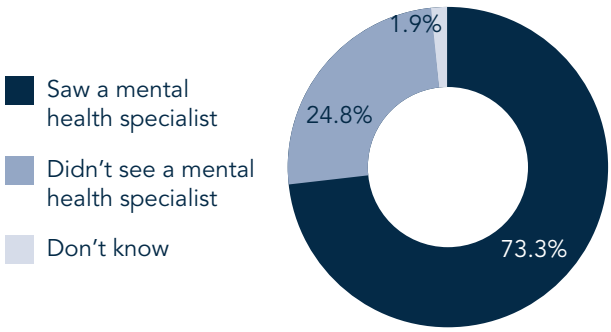
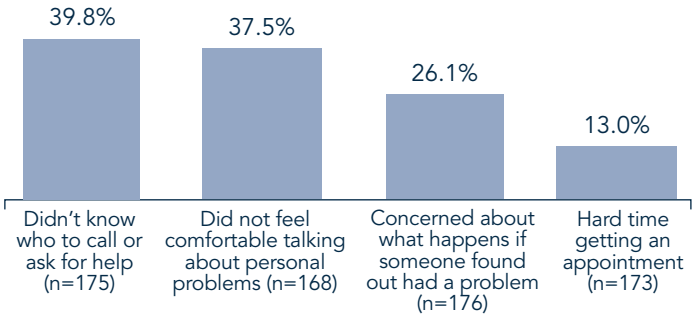


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



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)

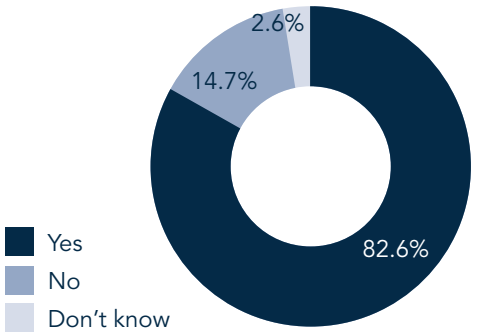
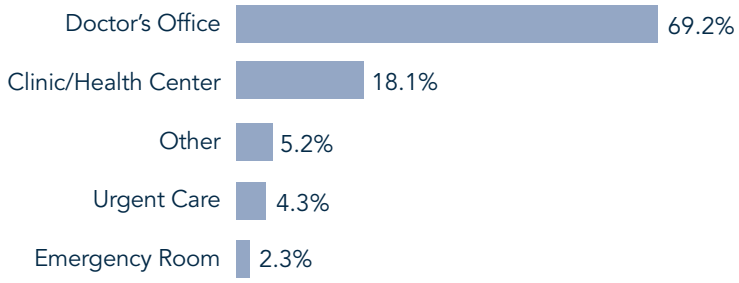


Exhibit 9: Where respondents go to see their doctor (n=5,743)

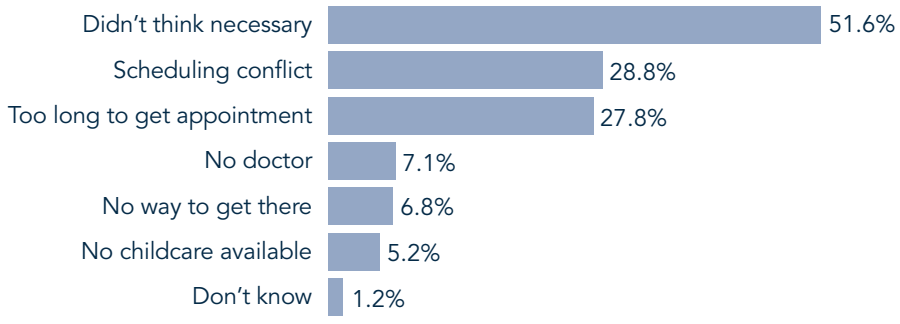


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited 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)

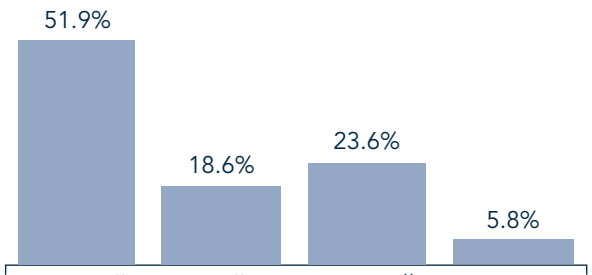
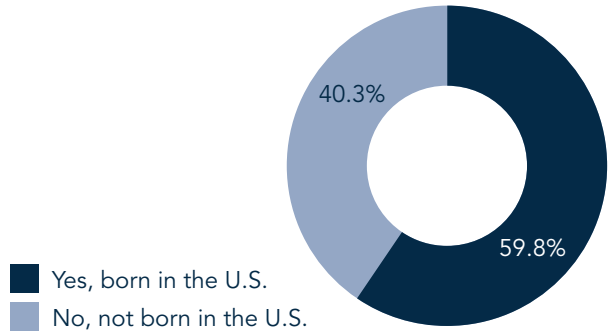


Exhibit 12: Percent of members who were born in the United States (n=5,599)



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)

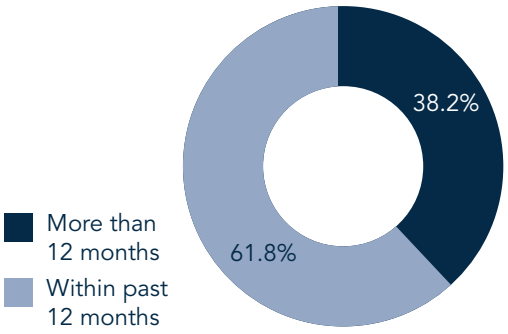
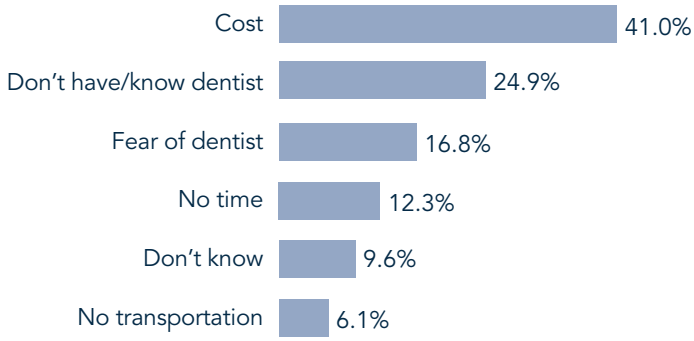


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3] [4]



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

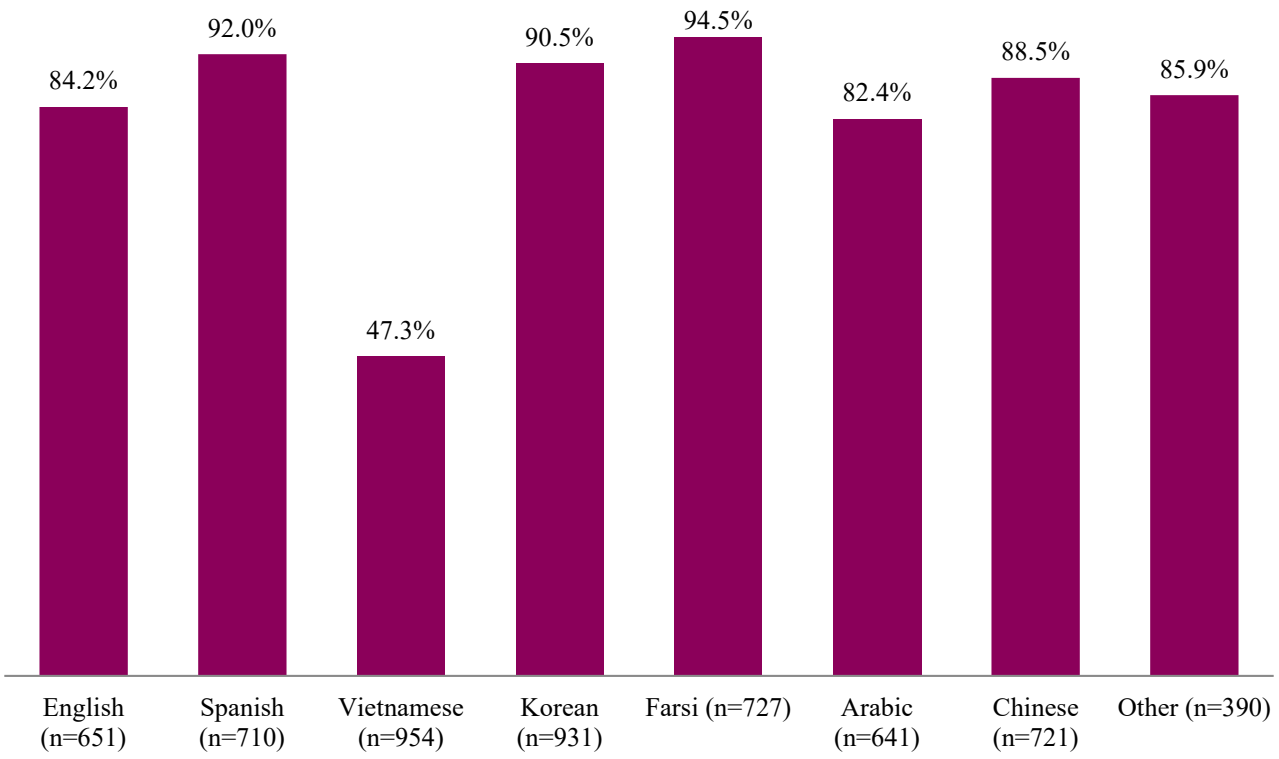
CalOptima A Public Agency Better. Together.

Back to Agenda

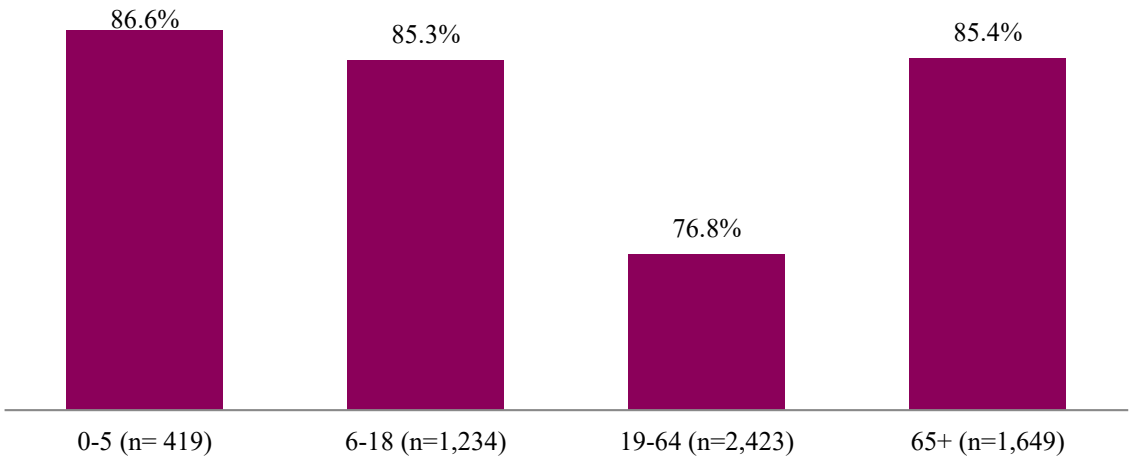
Navigating the Healthcare System

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:

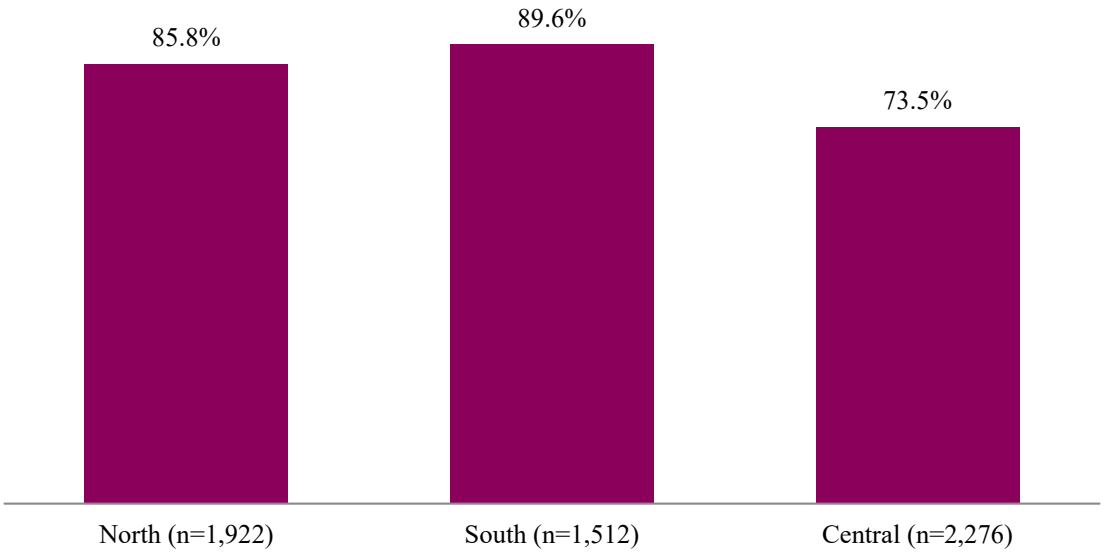


Exhibit 2. Where respondents go to see their doctor

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%.

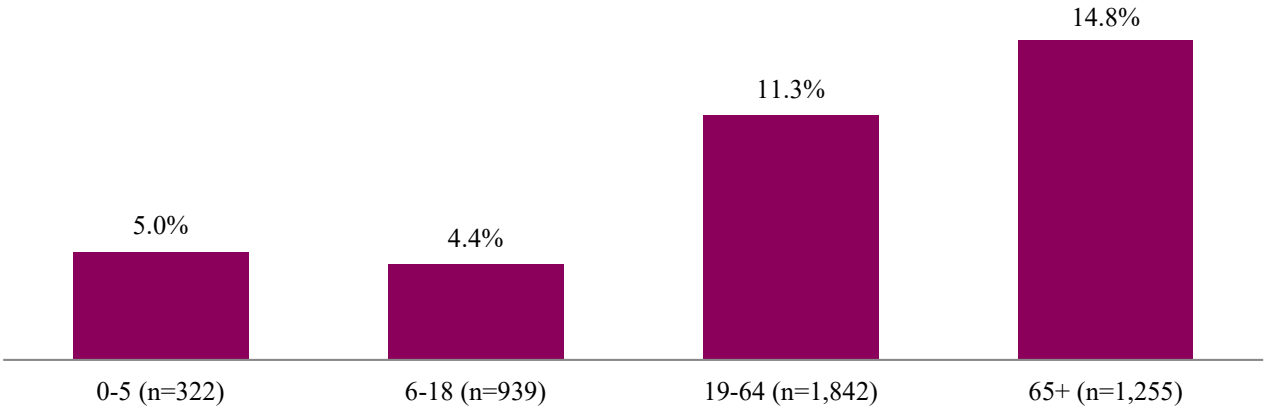
Region:

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

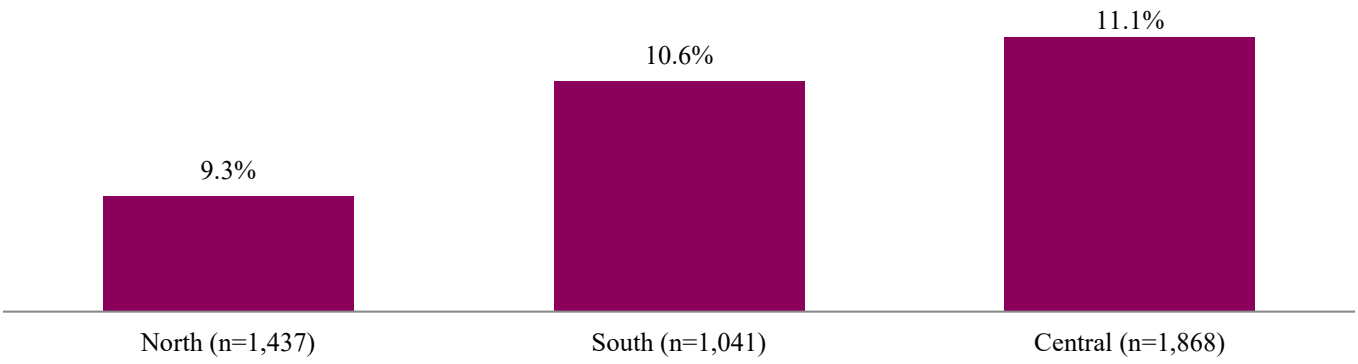
Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

CalOptima language:

Age Category:



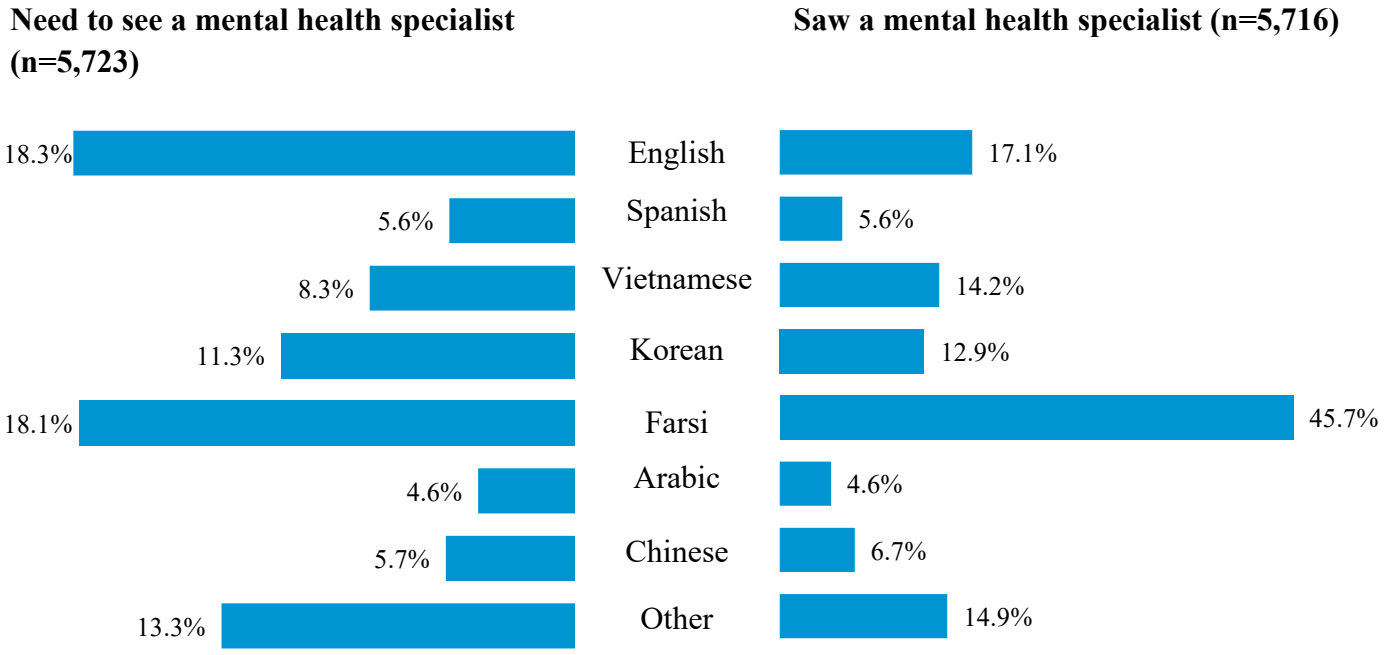
Region:



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:

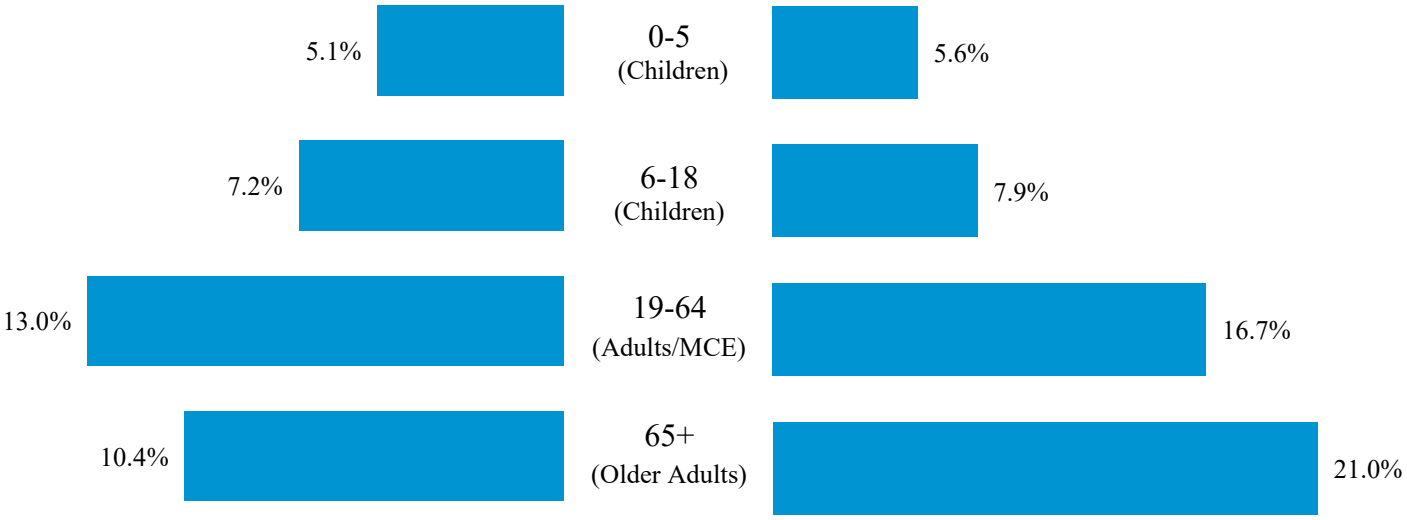


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

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)

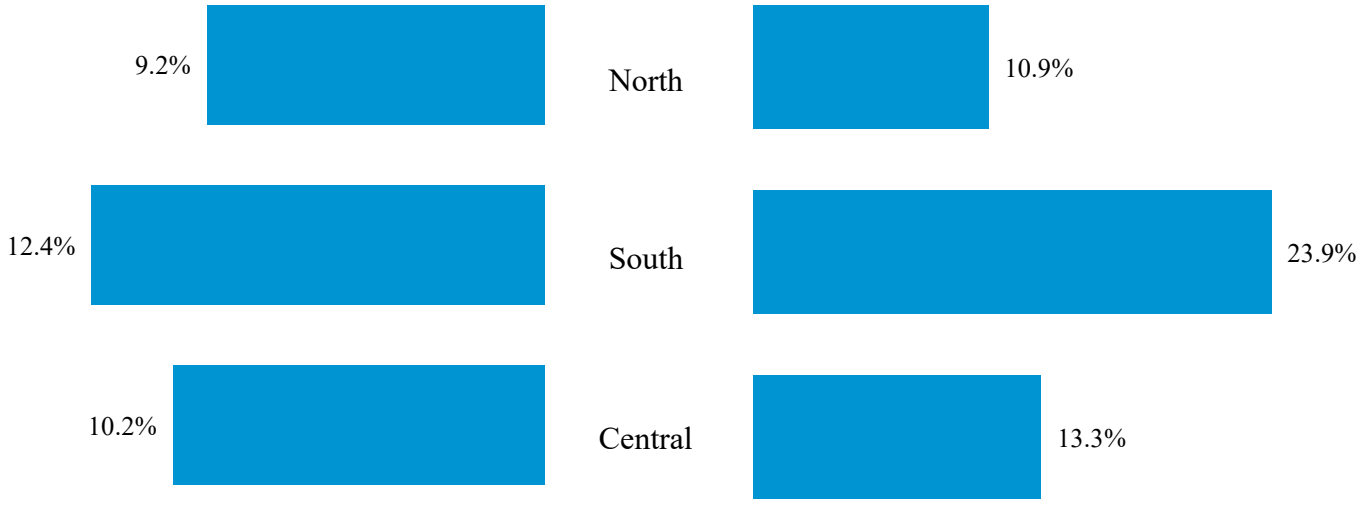
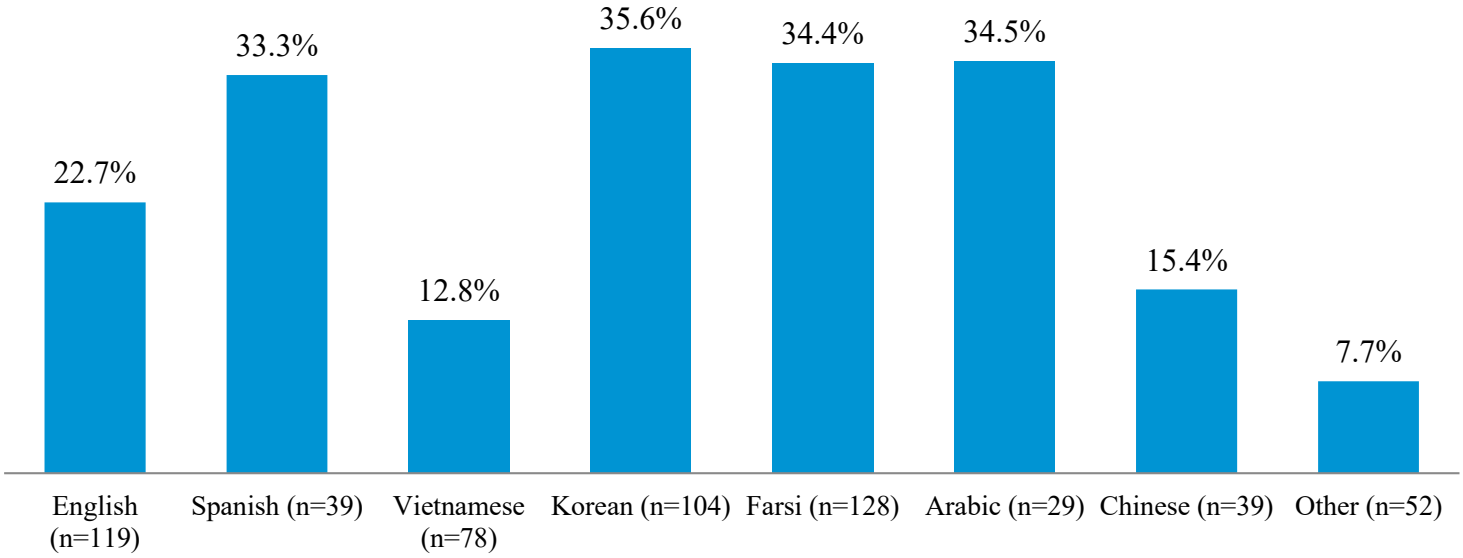
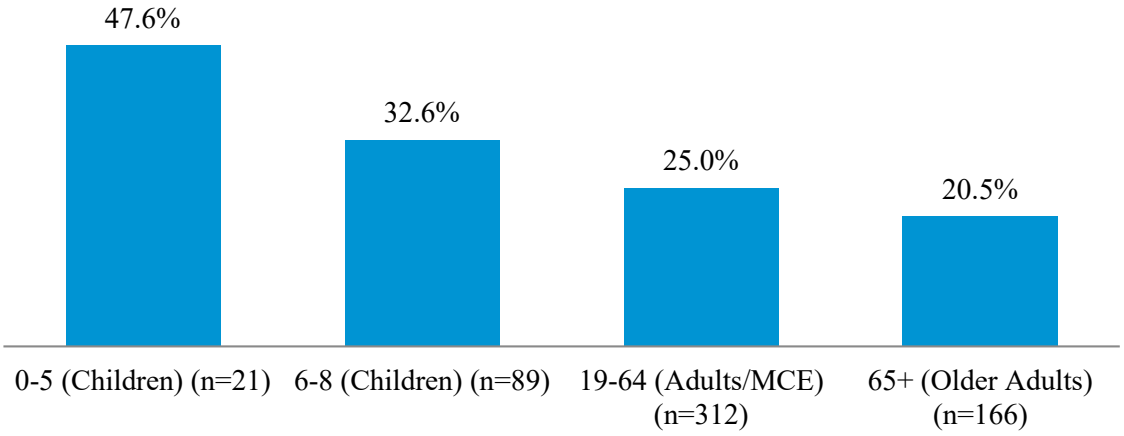


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

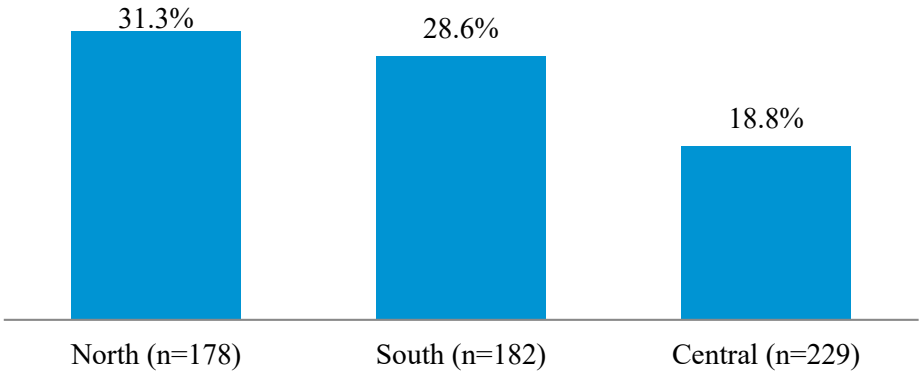
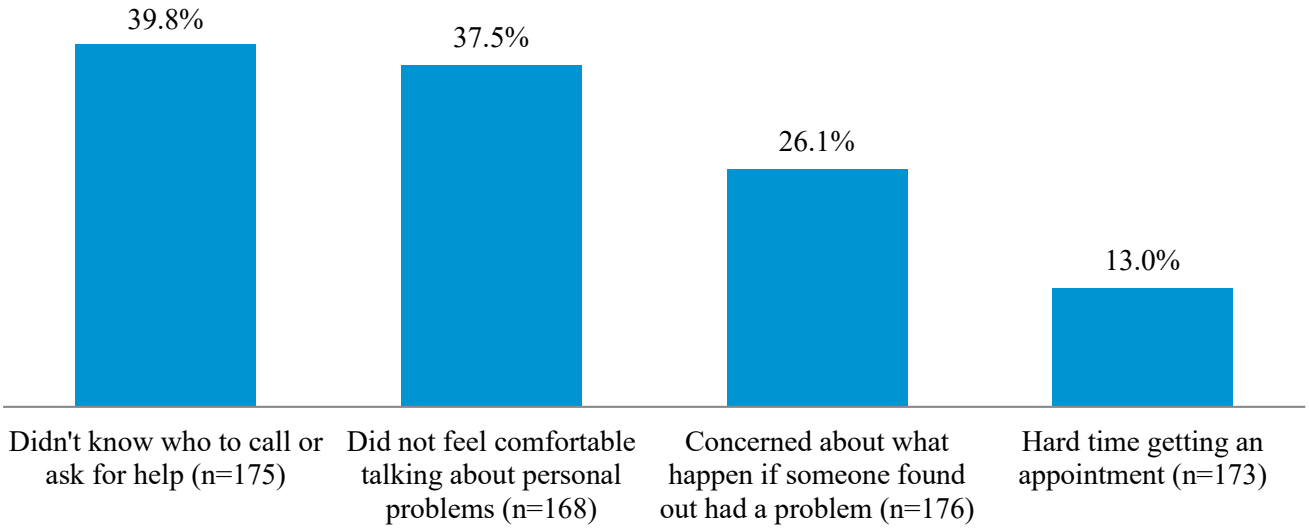


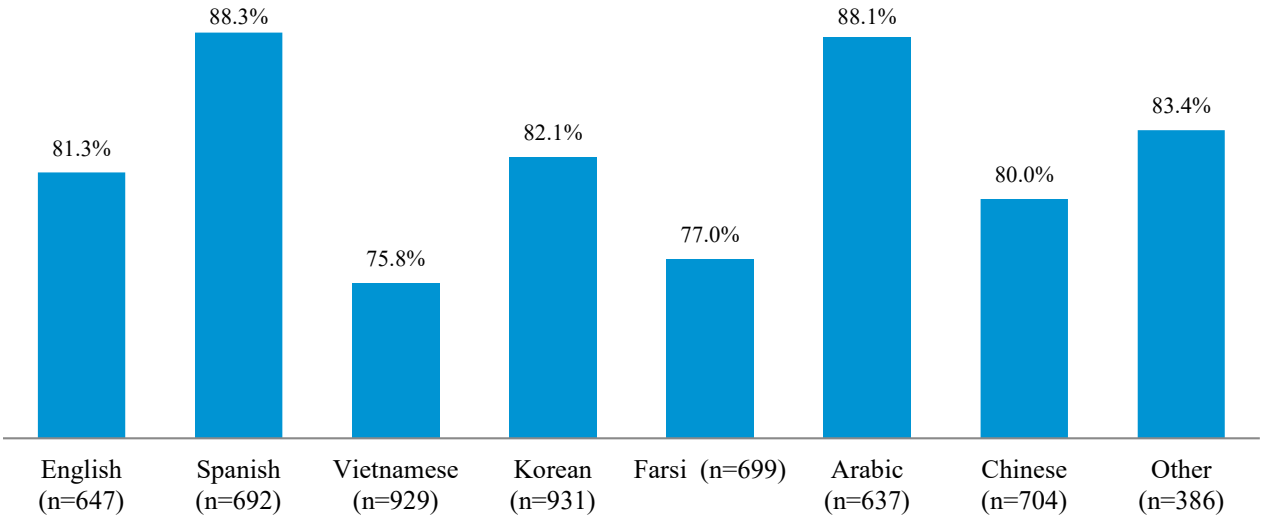
Exhibit 11. Reasons why members didn't see mental health specialist[7]



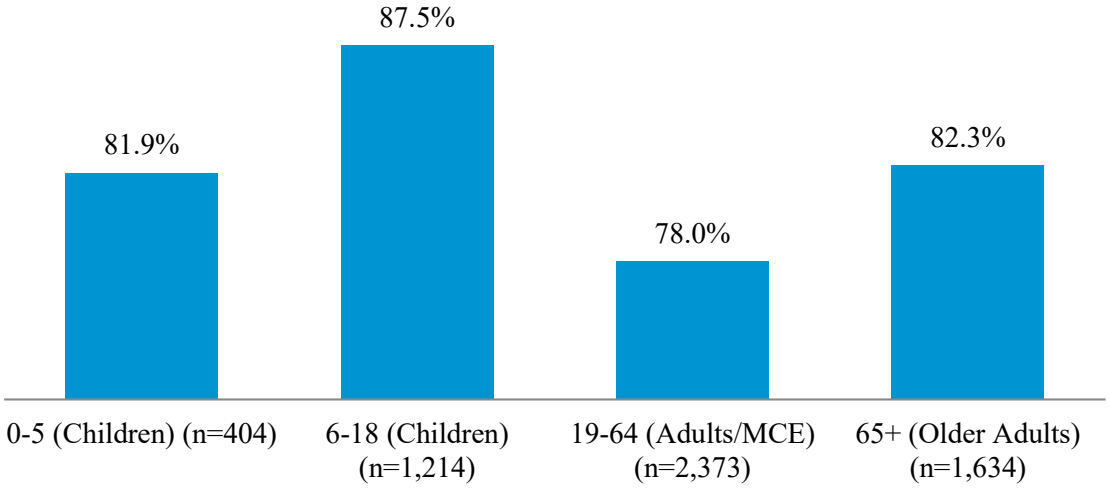
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

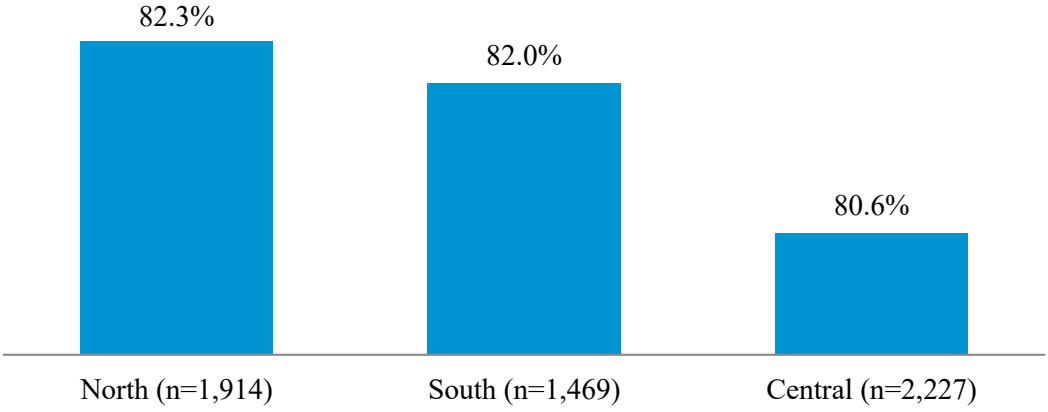
CalOptima language:



Age Category:



Region:

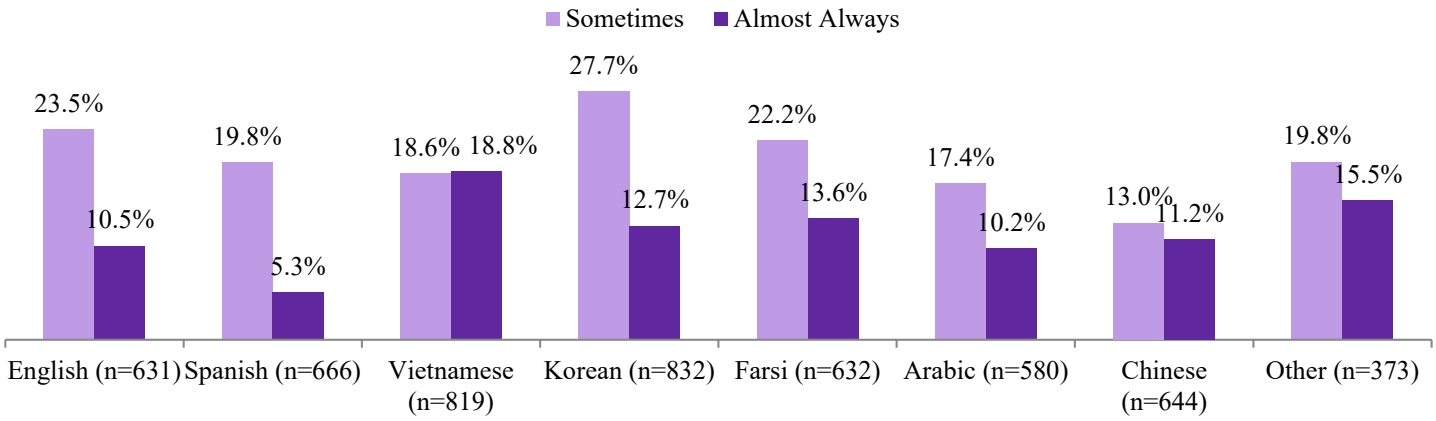


Social Determinants of Health

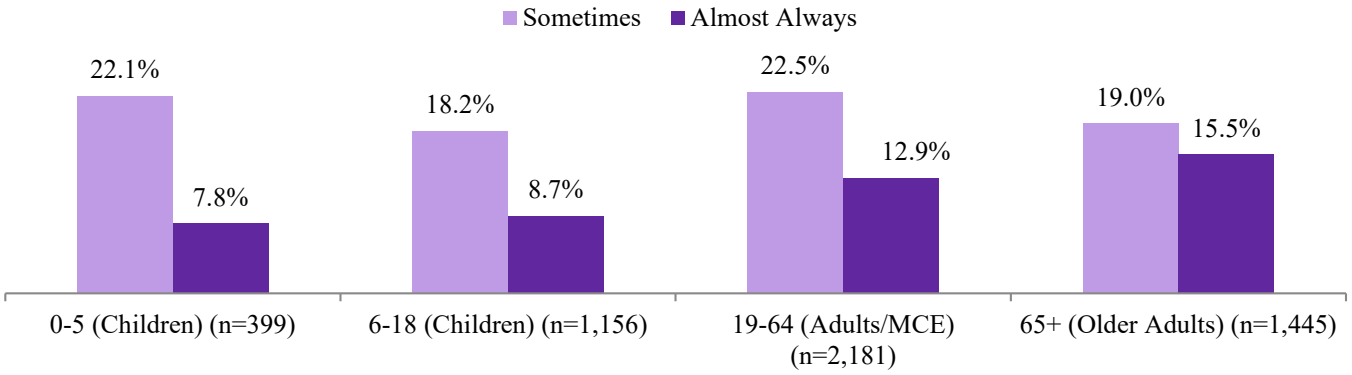
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

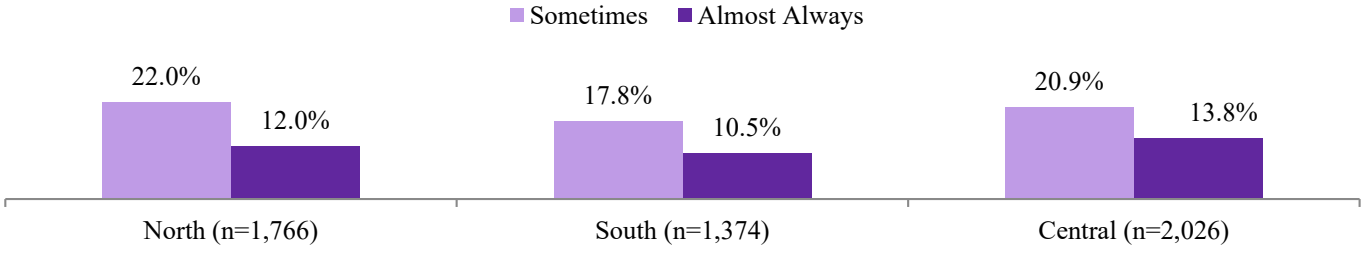
CalOptima language:



Age Category:

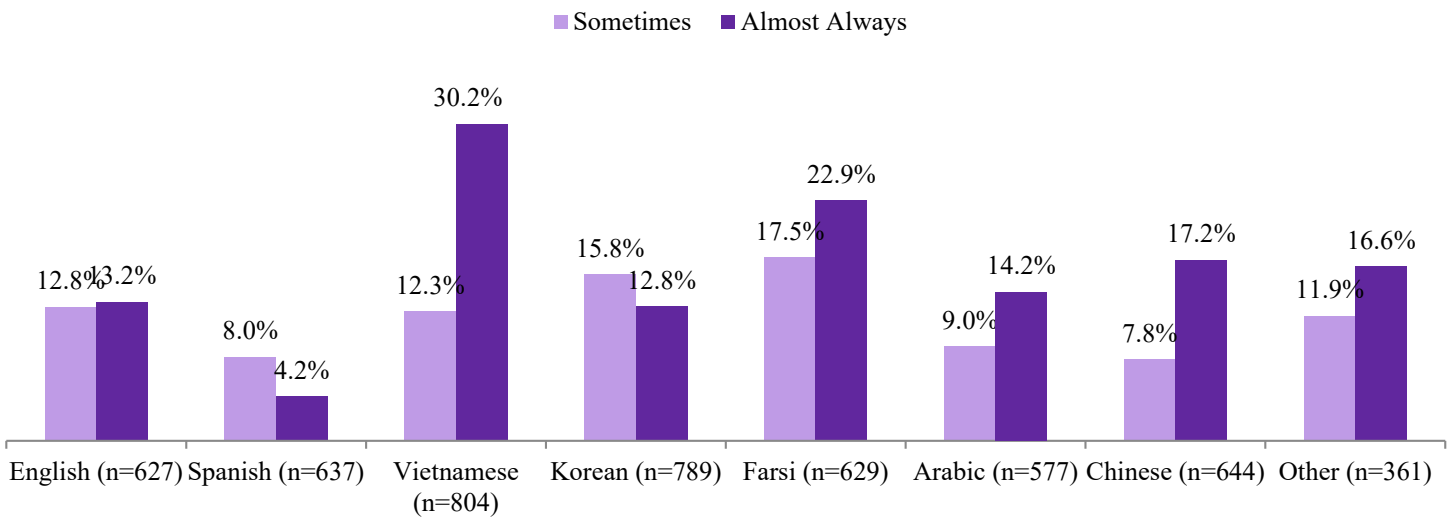


Region:

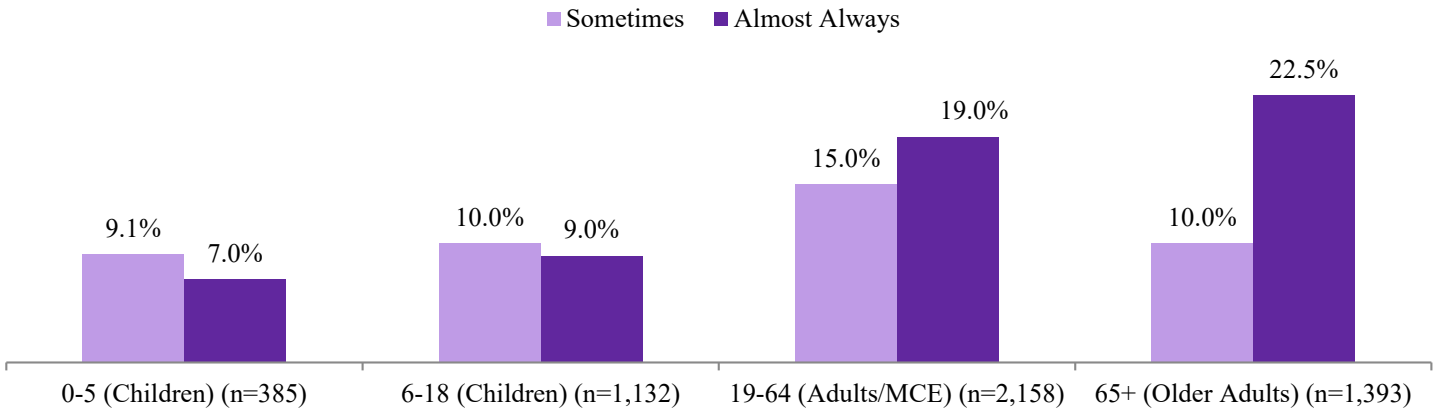


Housing:

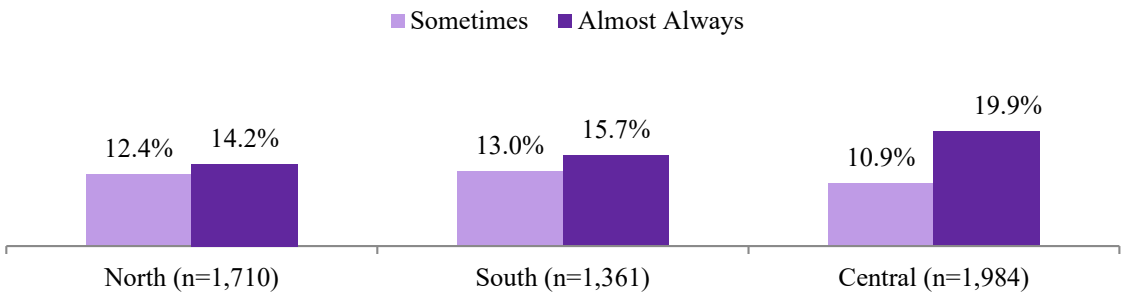
CalOptima language:



Age Category:

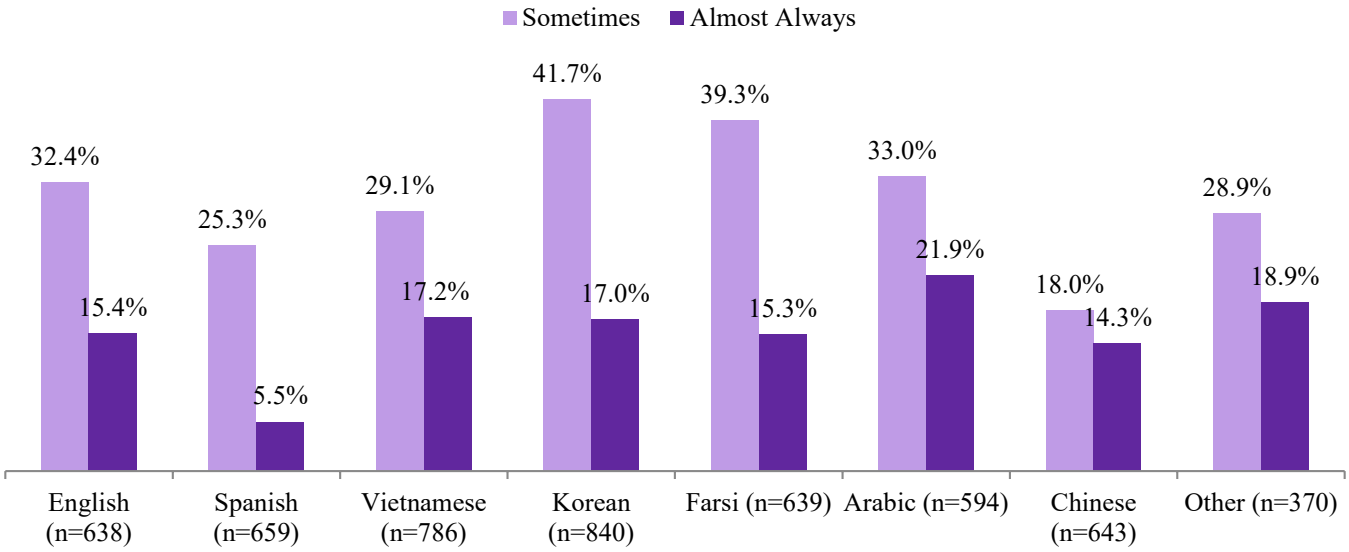


Region:

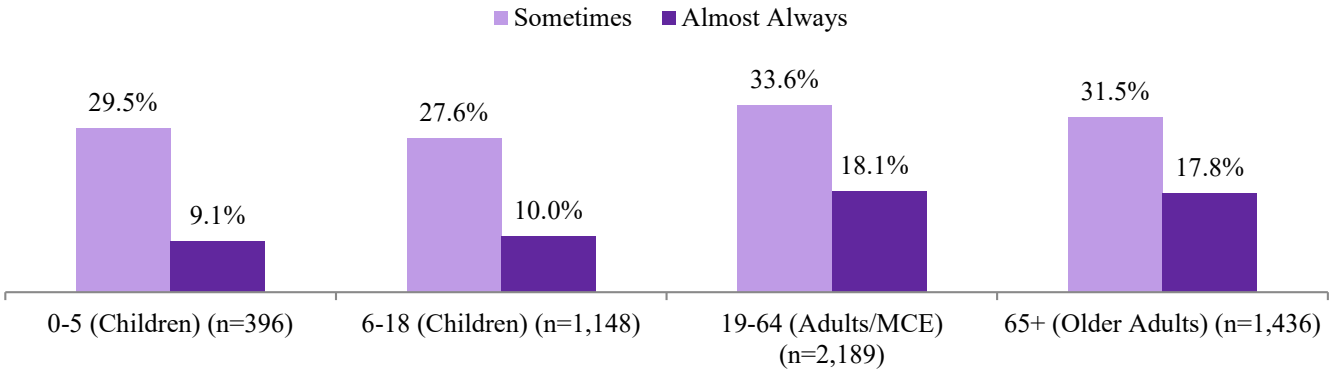


Money to buy things need:

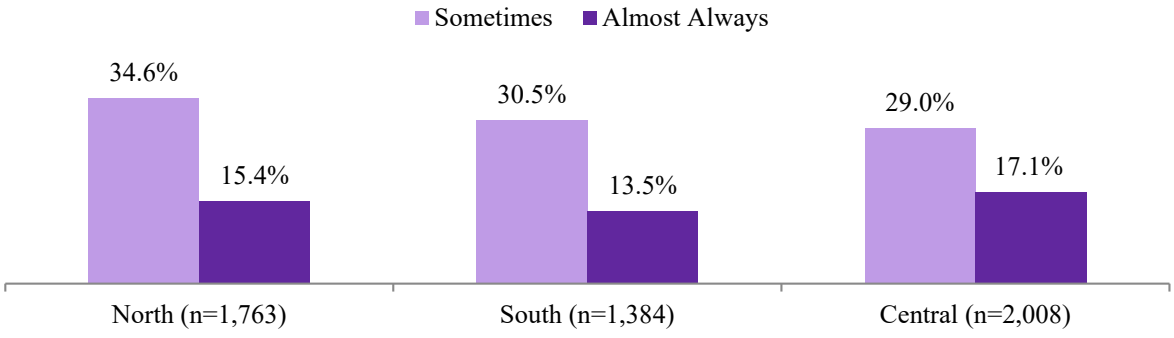
CalOptima language:



Age Category:

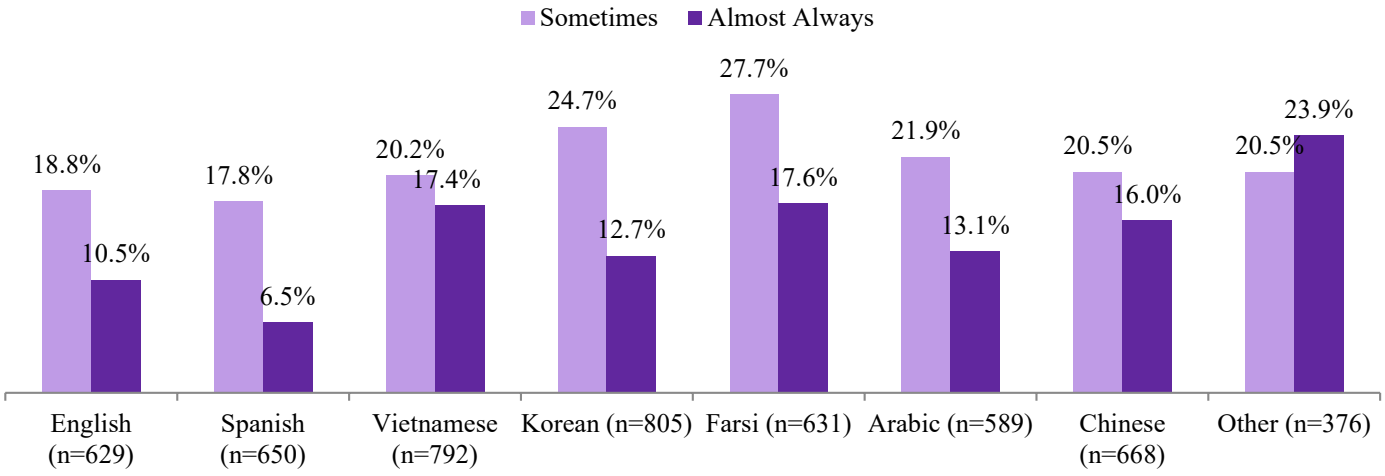


Region:

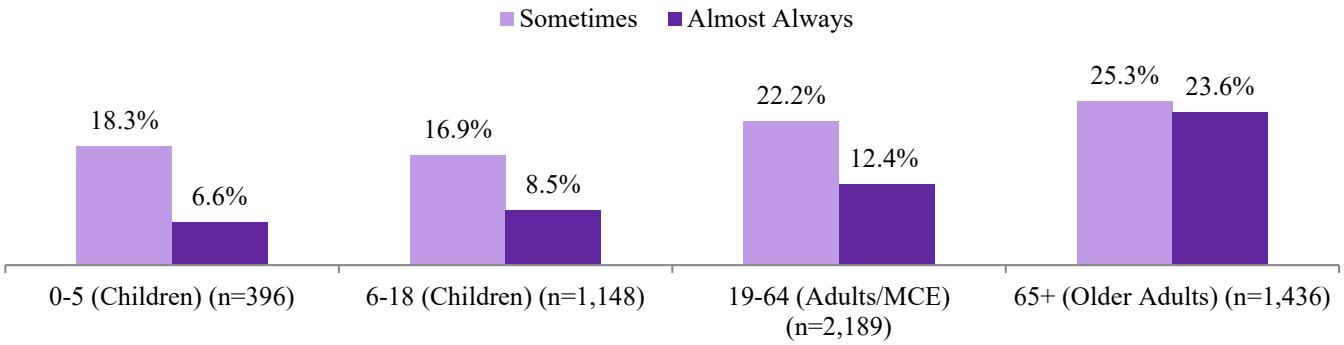


Transportation:

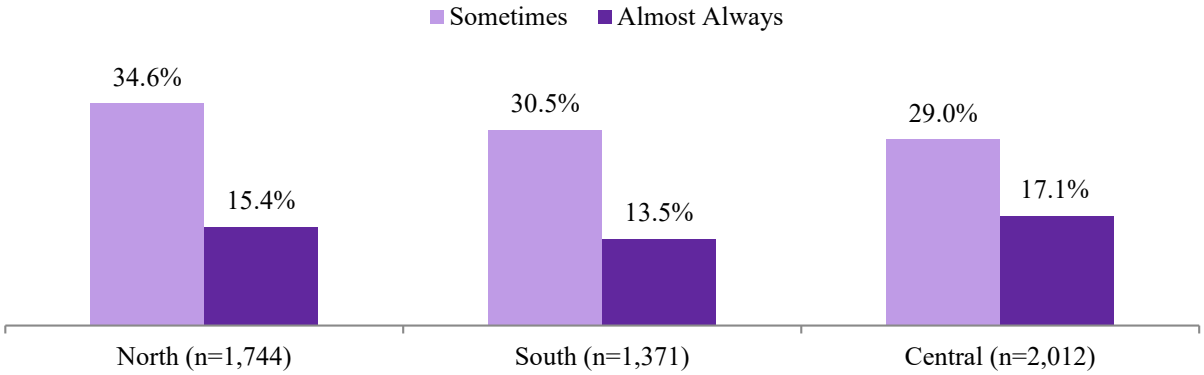
CalOptima language:



Age Category:

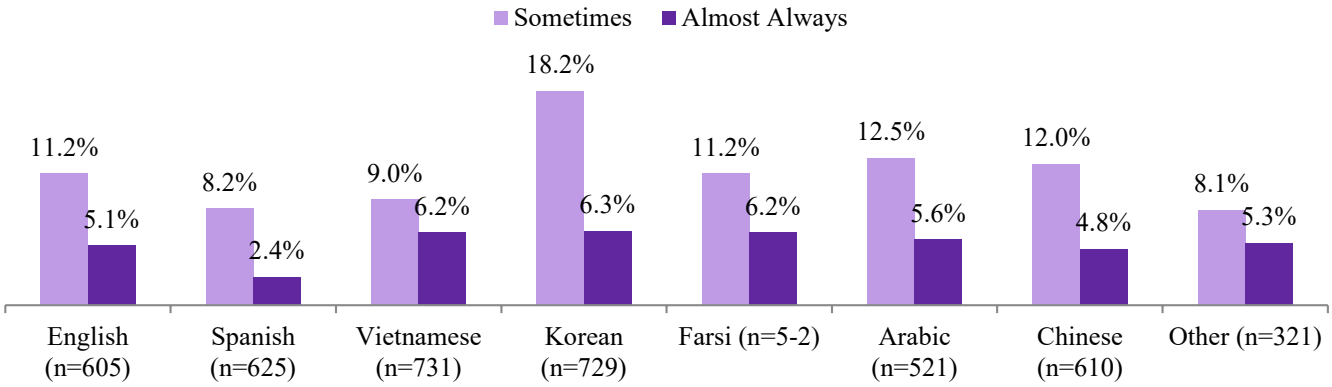


Region:

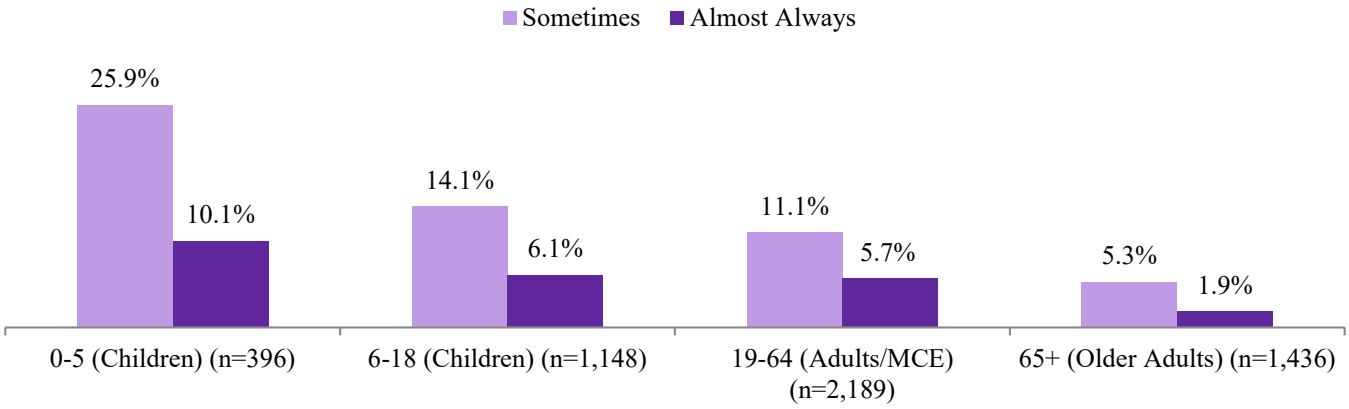


Child care:

CalOptima language:



Age Category:



Region:

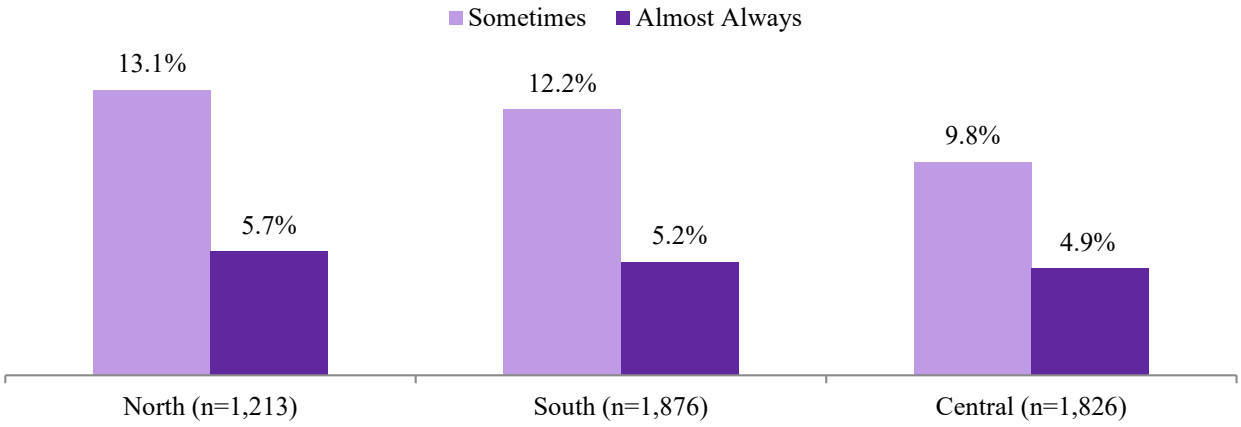
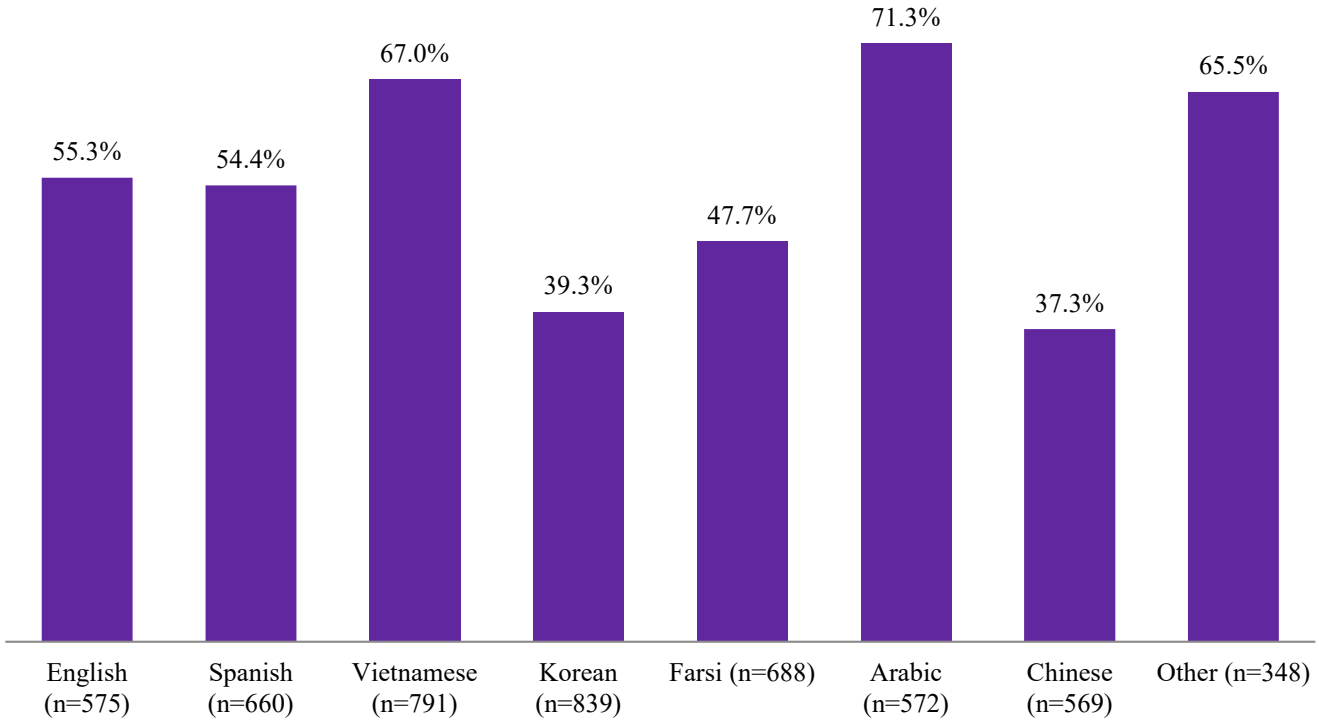


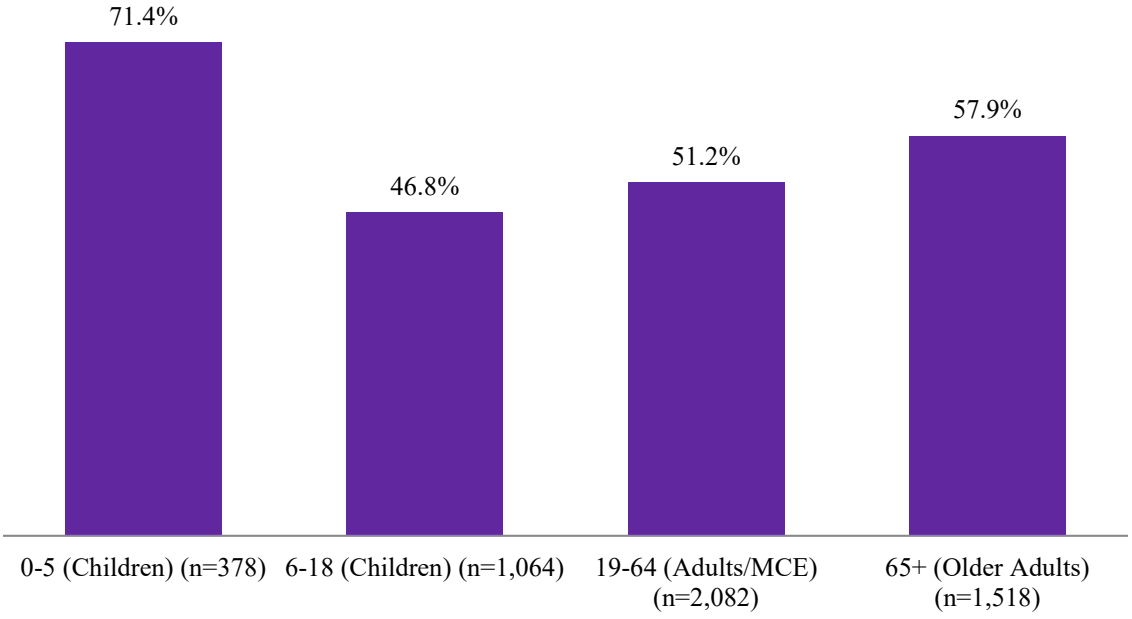
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

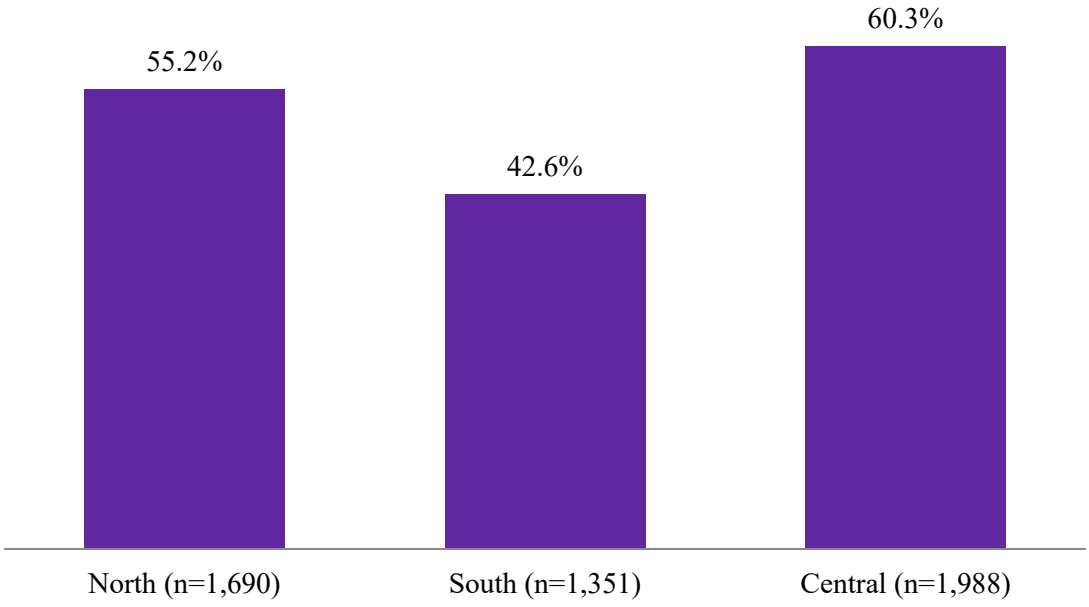
CalOptima language:



Age Category:



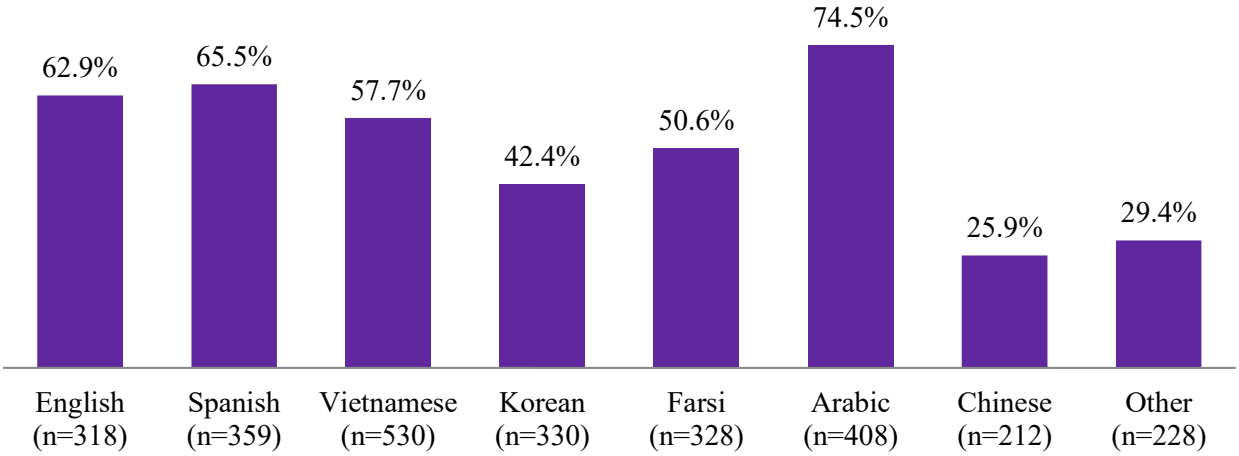
Region:



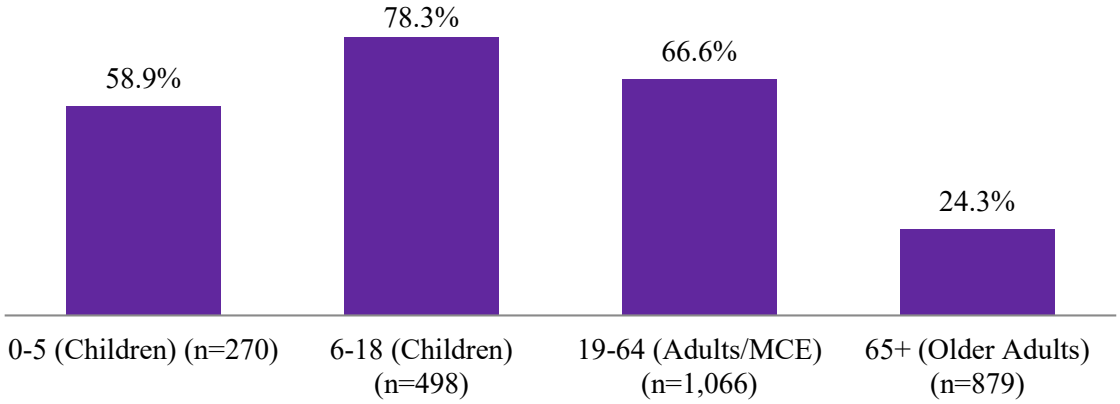
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

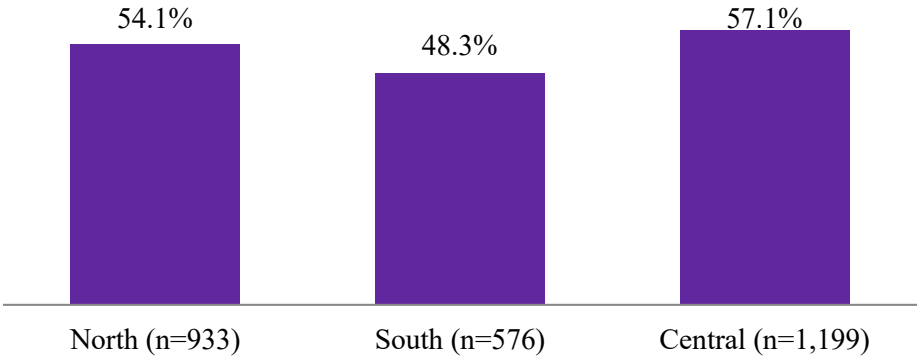
CalOptima language:



Age Category:



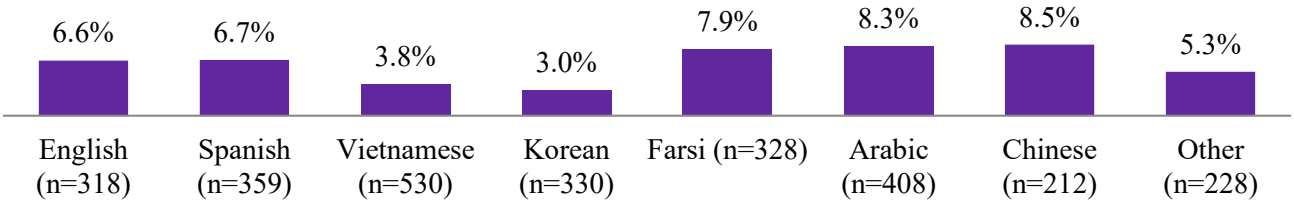
Region:



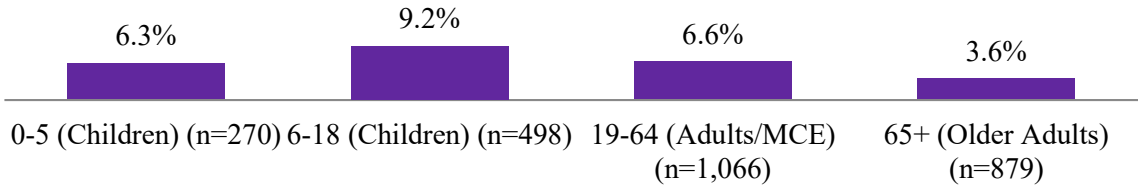
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

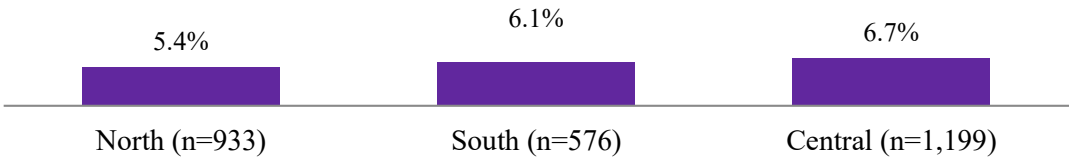
CalOptima language:



Age Category:

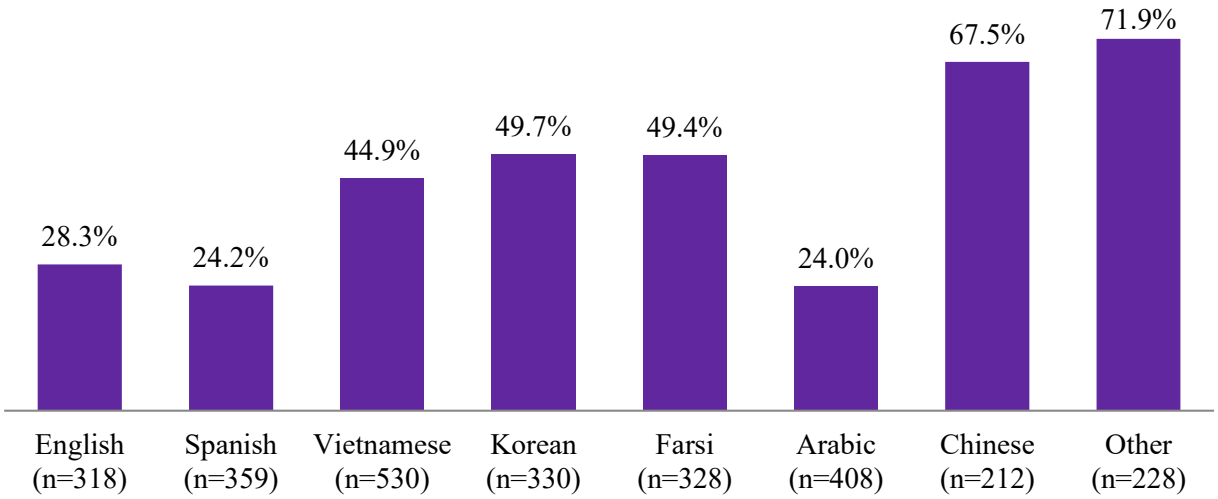


Region:

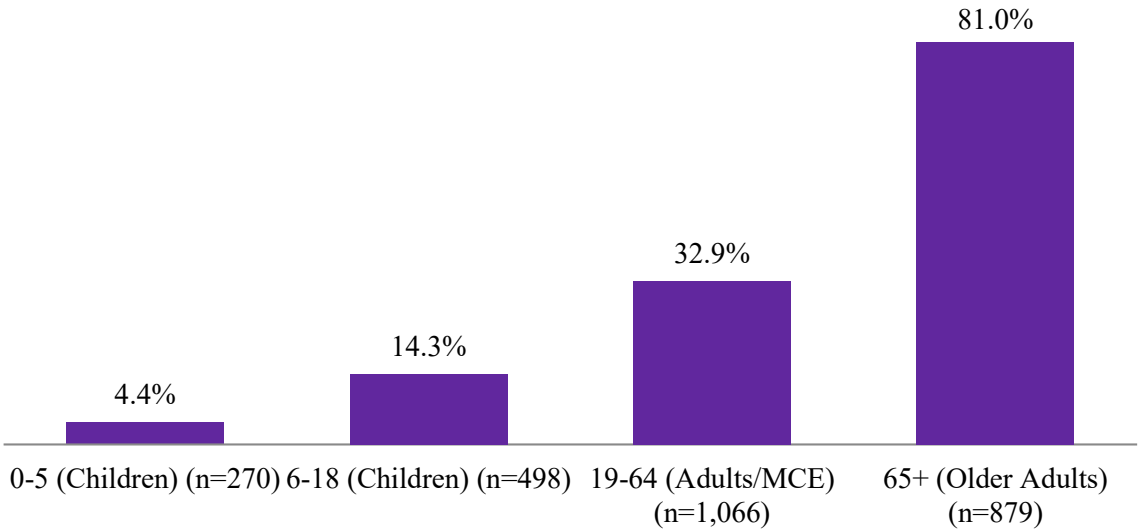


Receive SSI or SSDI as a public benefit:

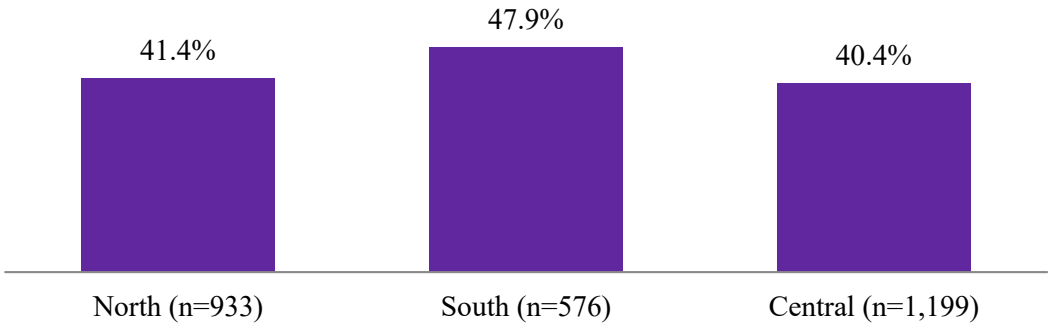
CalOptima language:



Age Category:

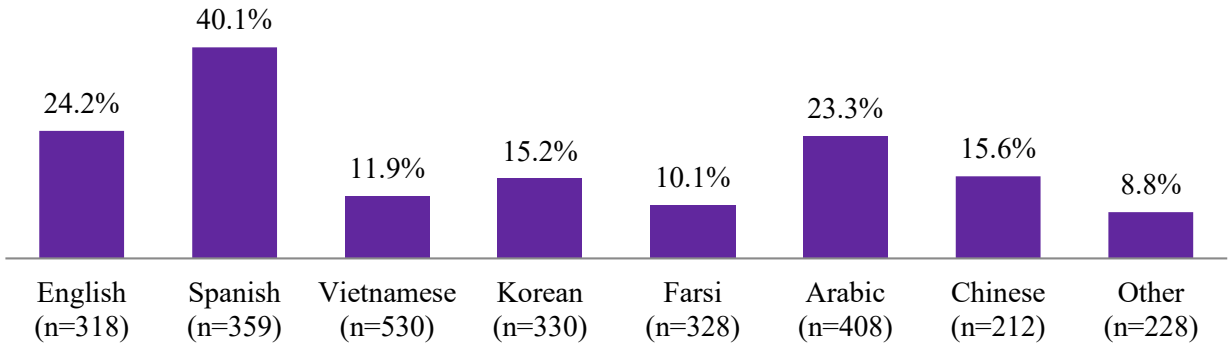


Region:

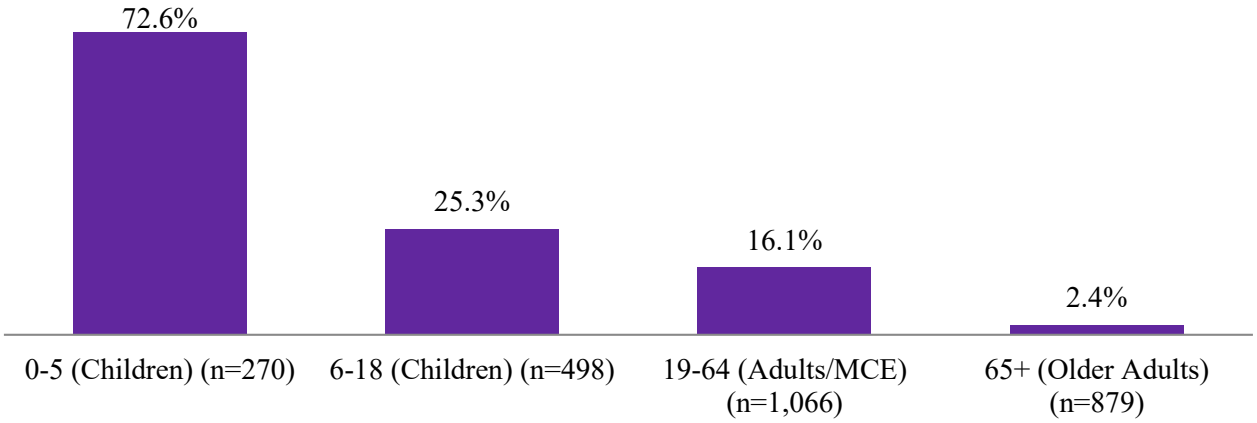


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

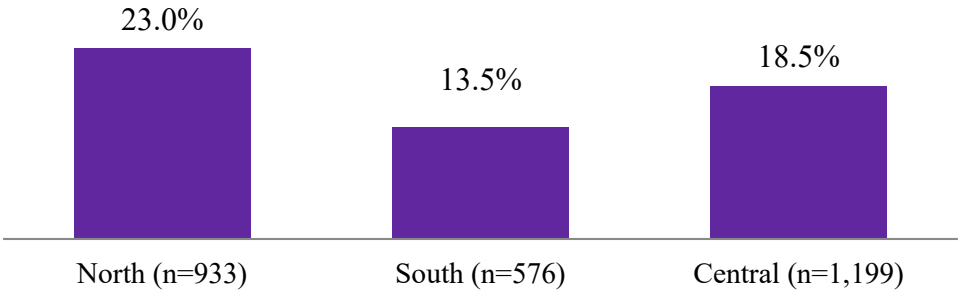


Exhibit 15. Personal activities participation:

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

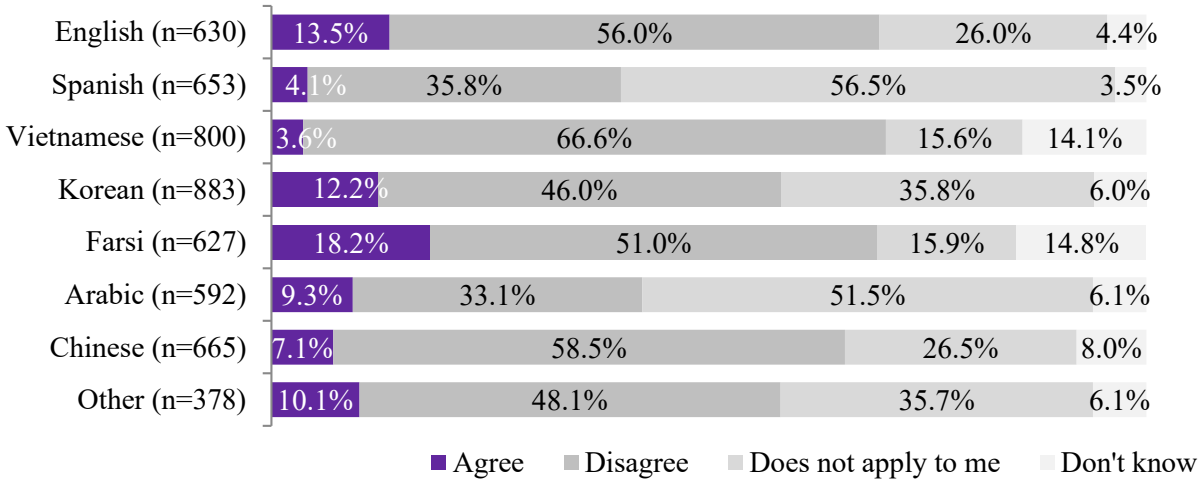
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

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

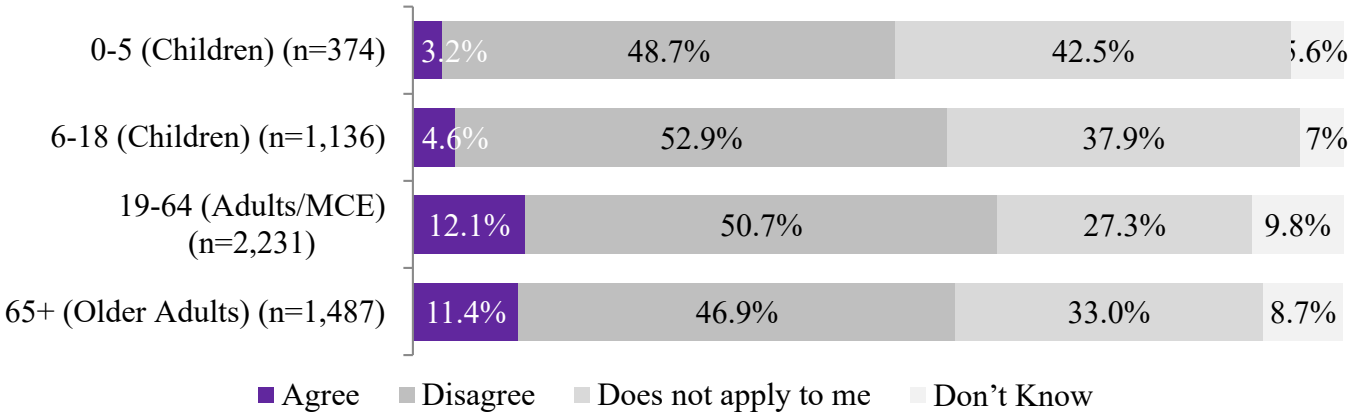
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

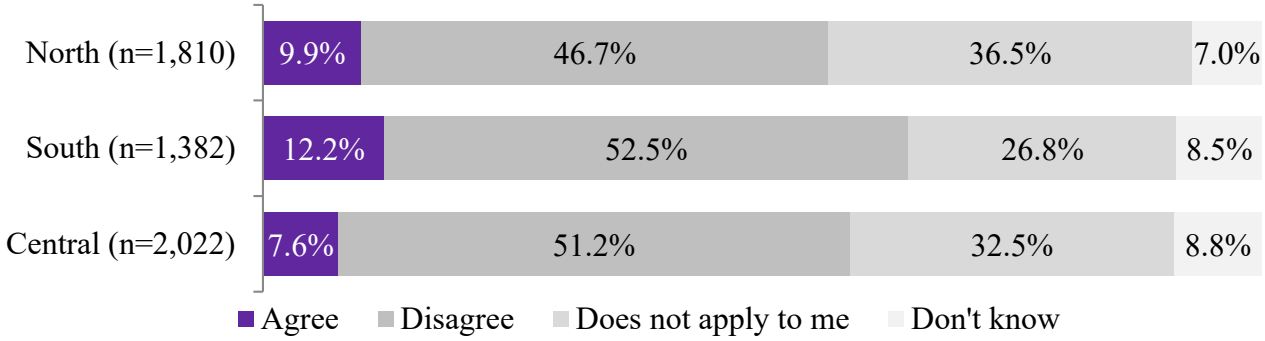
CalOptima language:



Age Category:

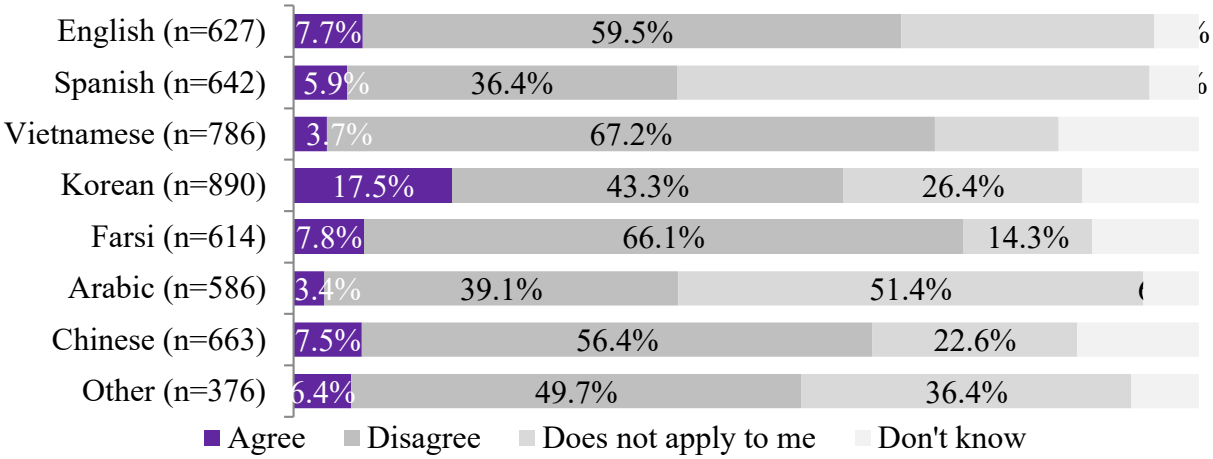


Region:

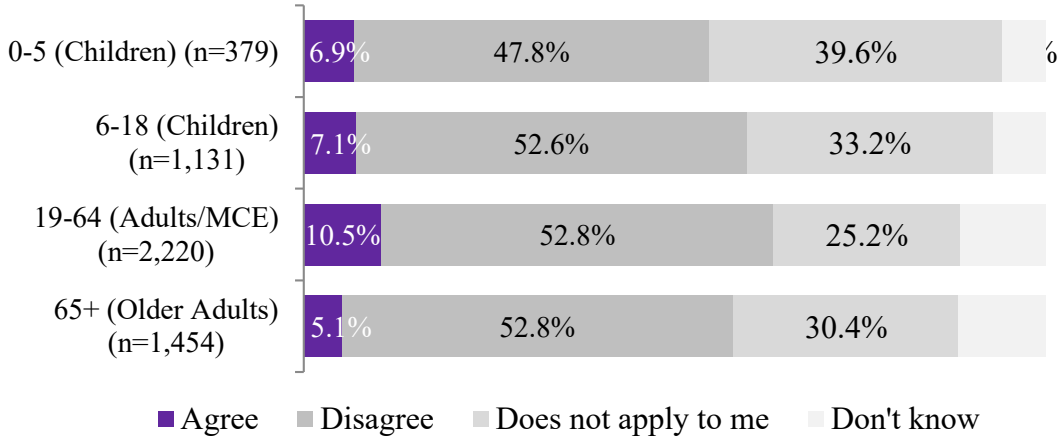


Feel not treated equally because of ethnic and culutral backgrounds:

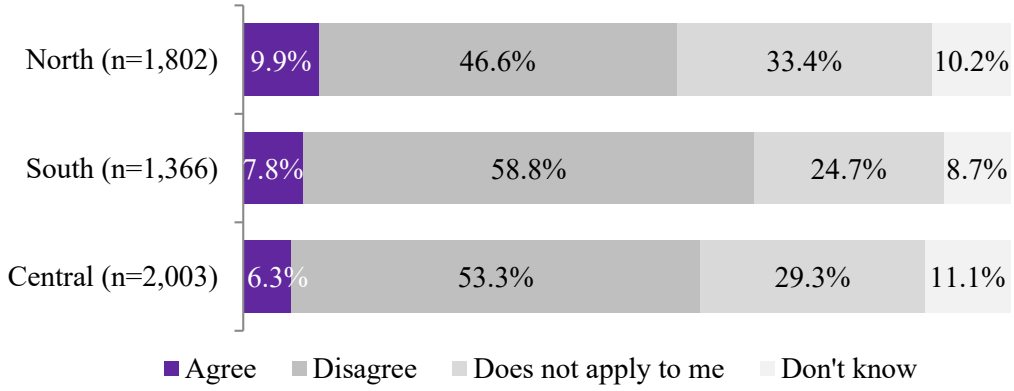
CalOptima language:



Age Category:

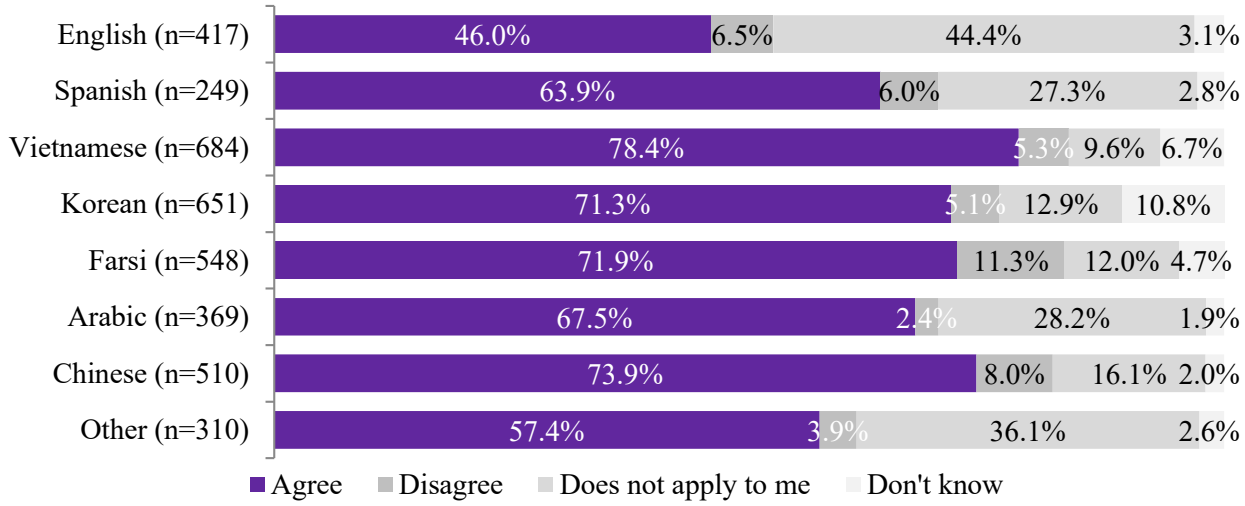


Region:



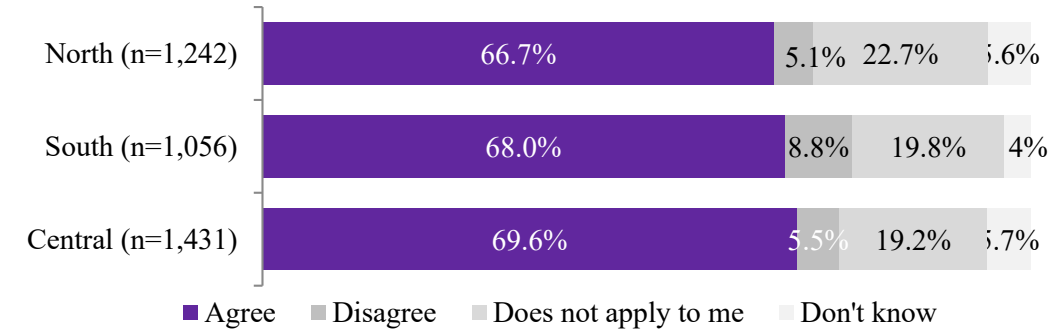
Feel child respects them as a parent[9]:

CalOptima language:



Age Category:

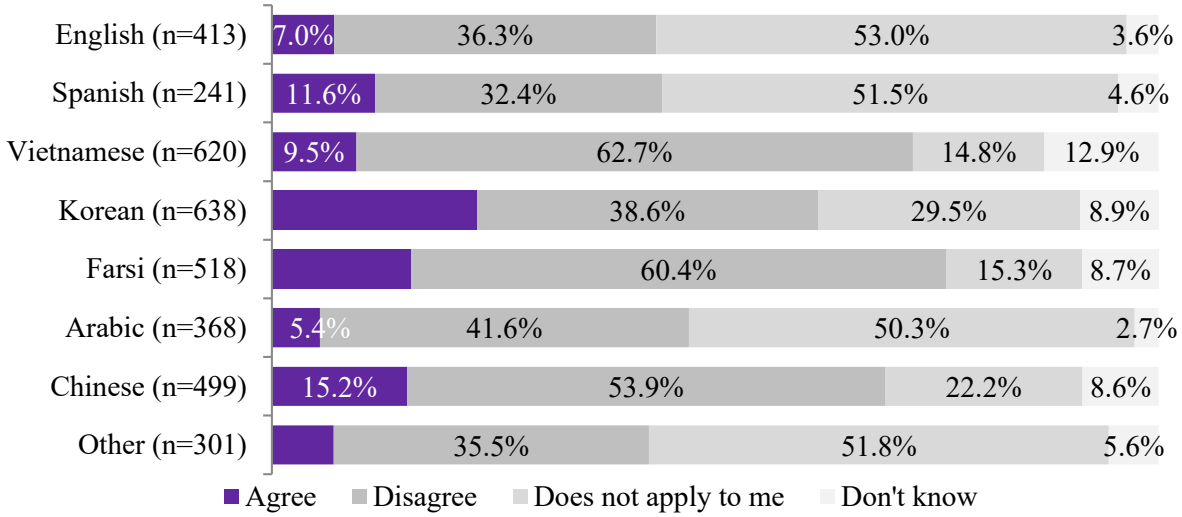
Region:



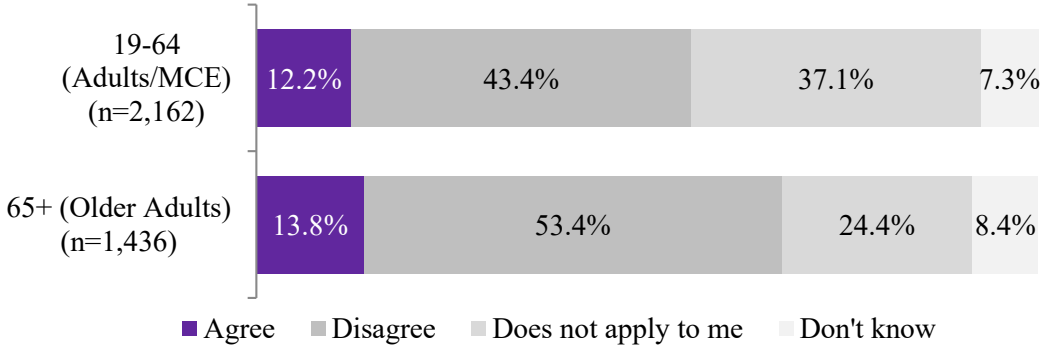
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

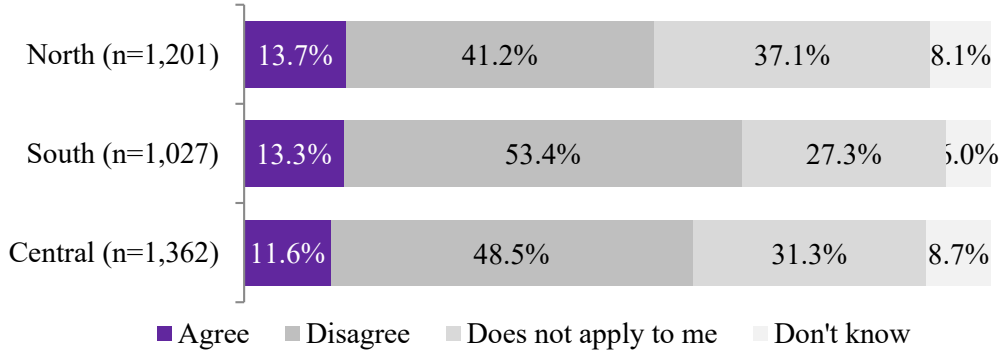
CalOptima language:



Age Category:



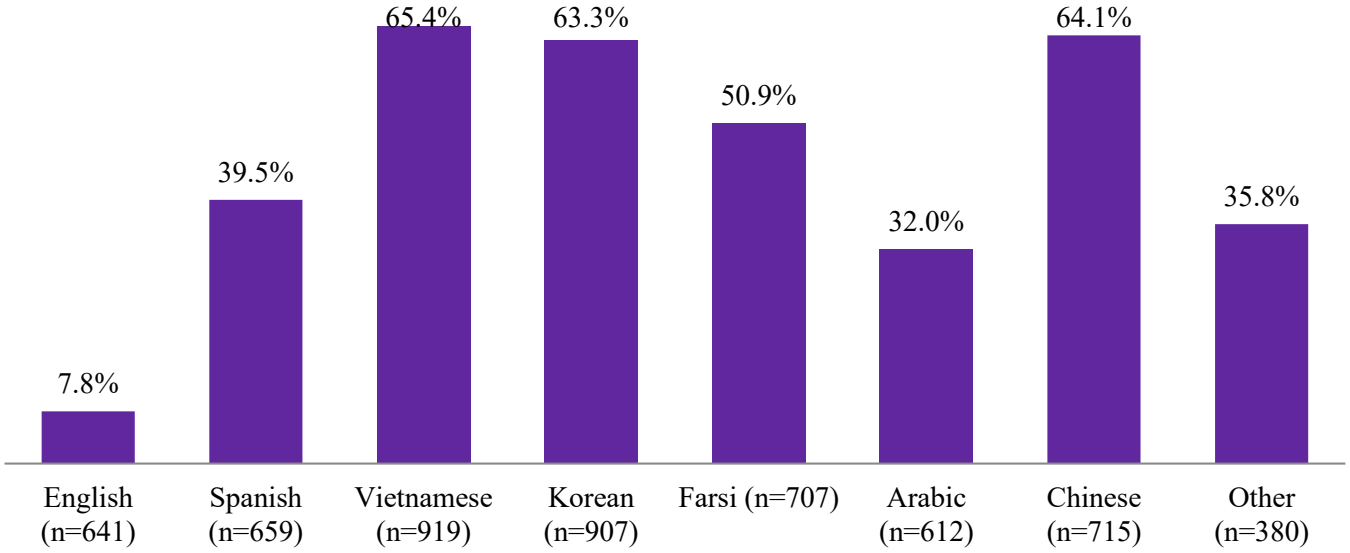
Region:



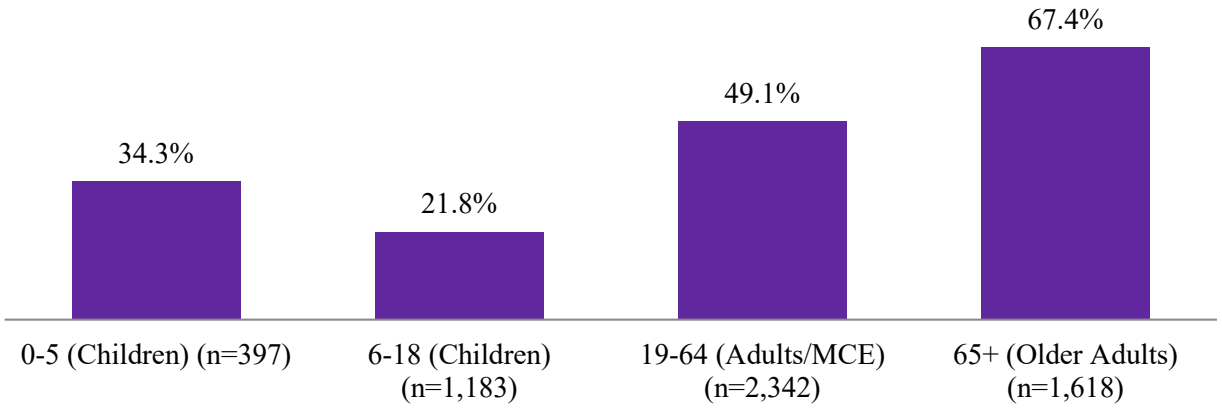
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

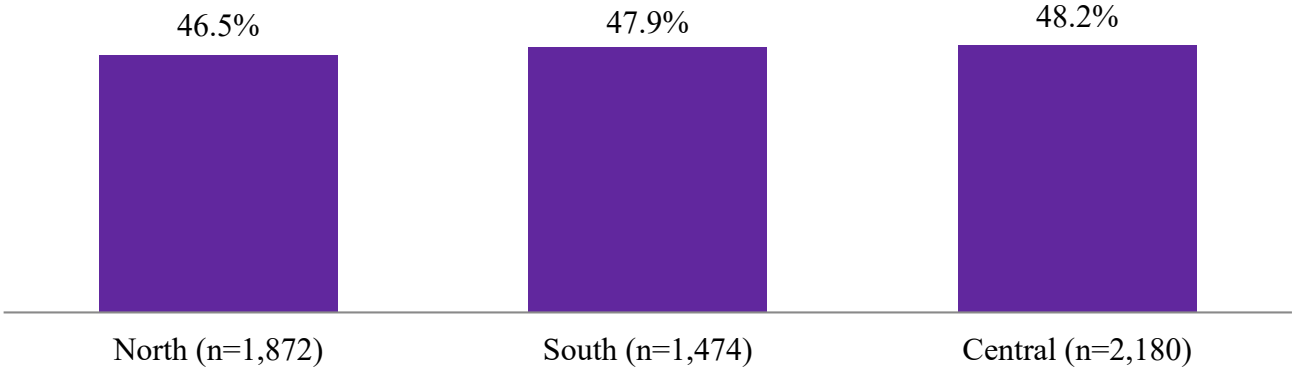


Exhibit 18. Employment status[11,12]

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

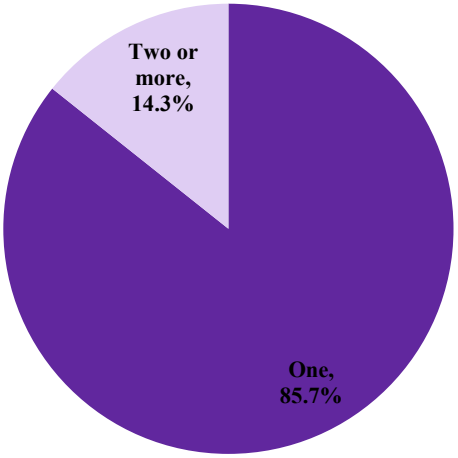
Region:

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

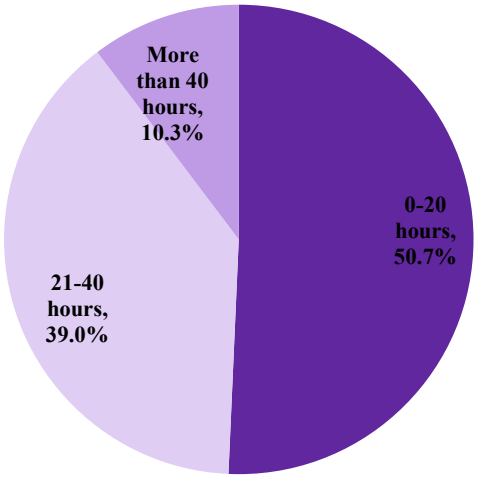
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

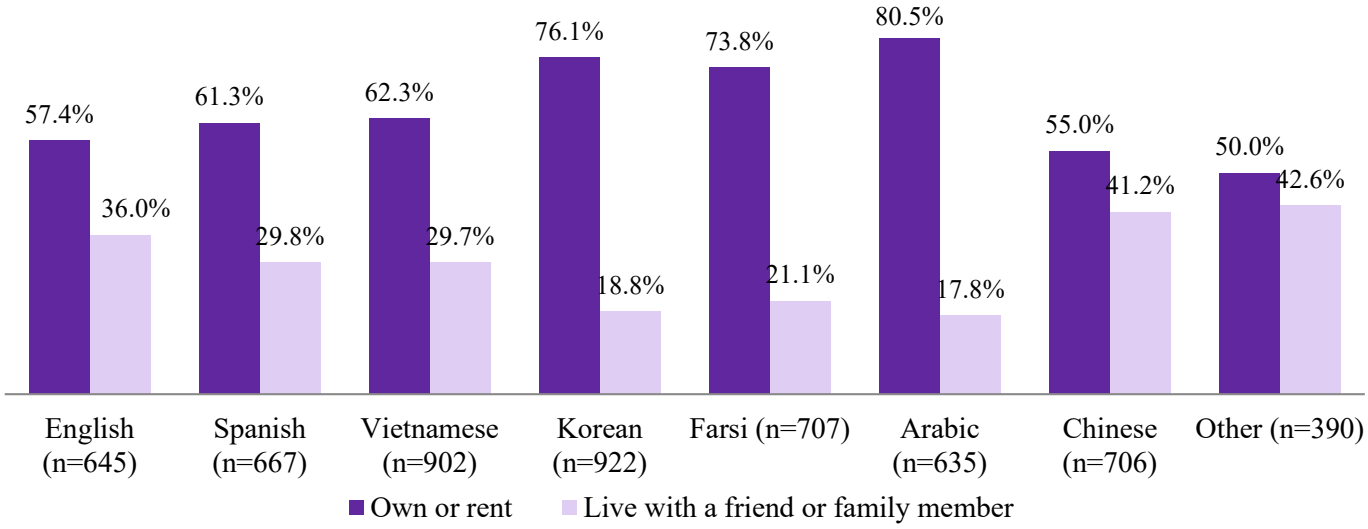


Number of hours that members work each week

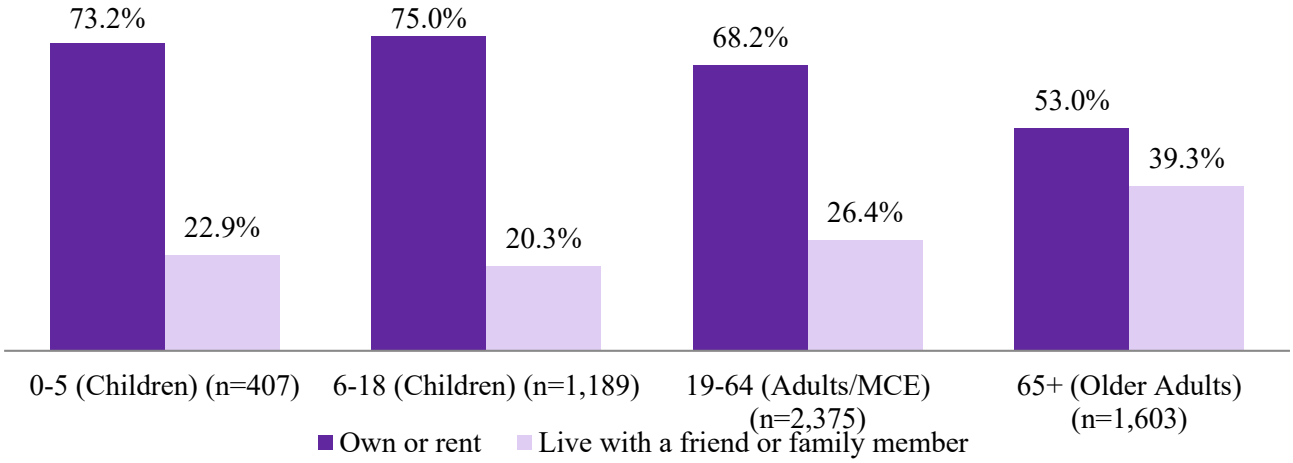


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

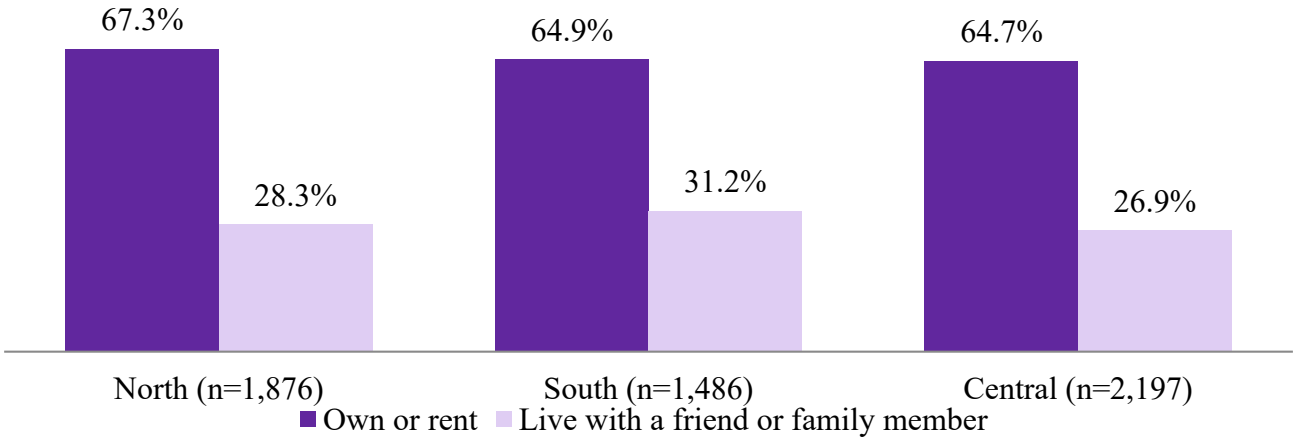
Exhibit 20. Members' living situation[14]



Age Category:



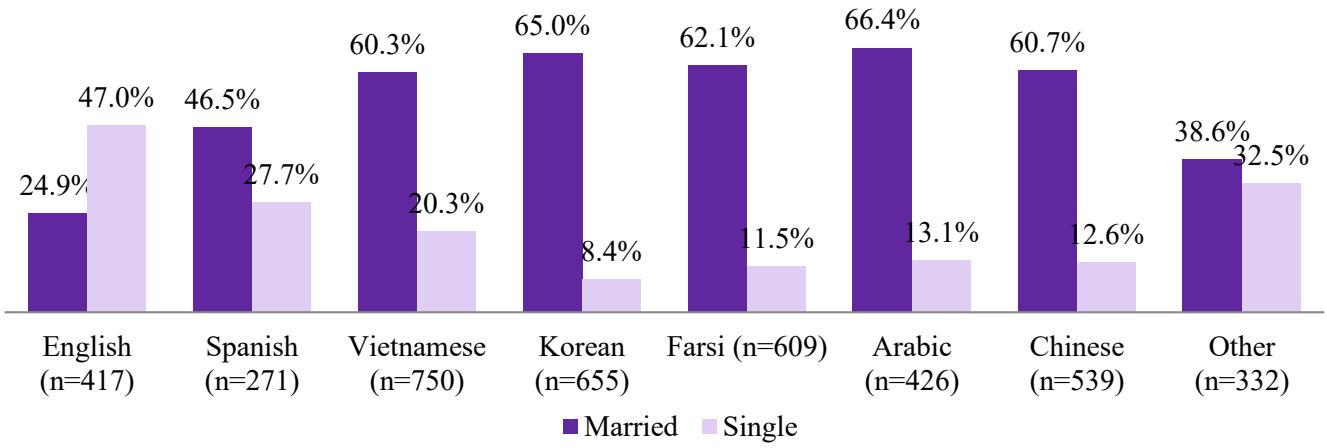
Region:



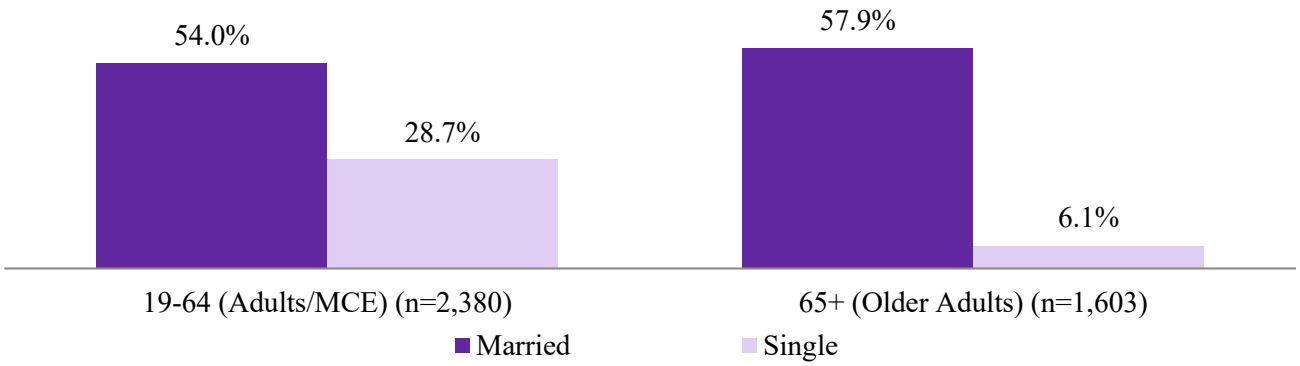
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

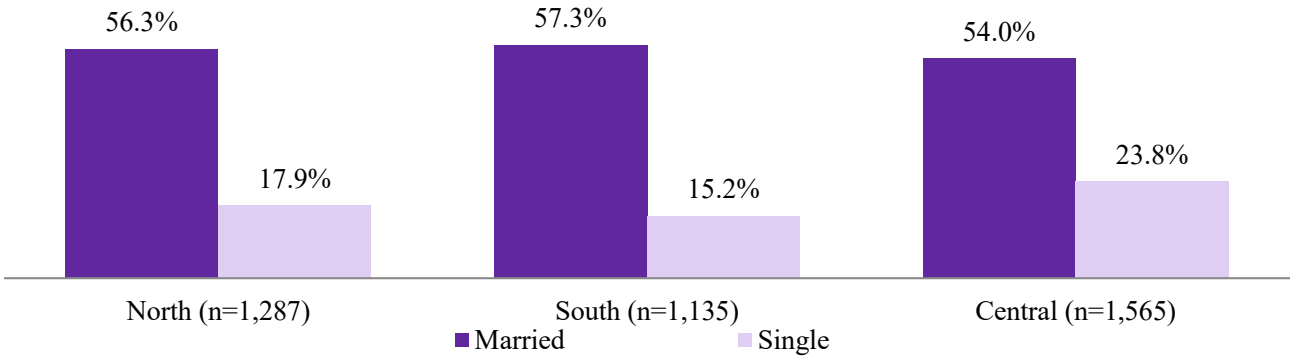
CalOptima language:



Age Category:



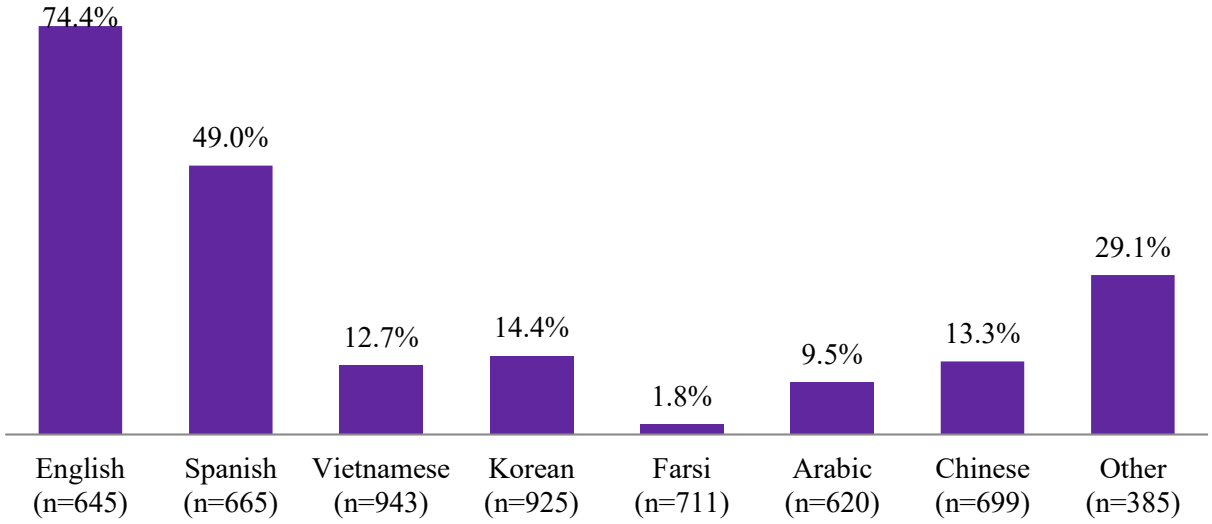
Region:



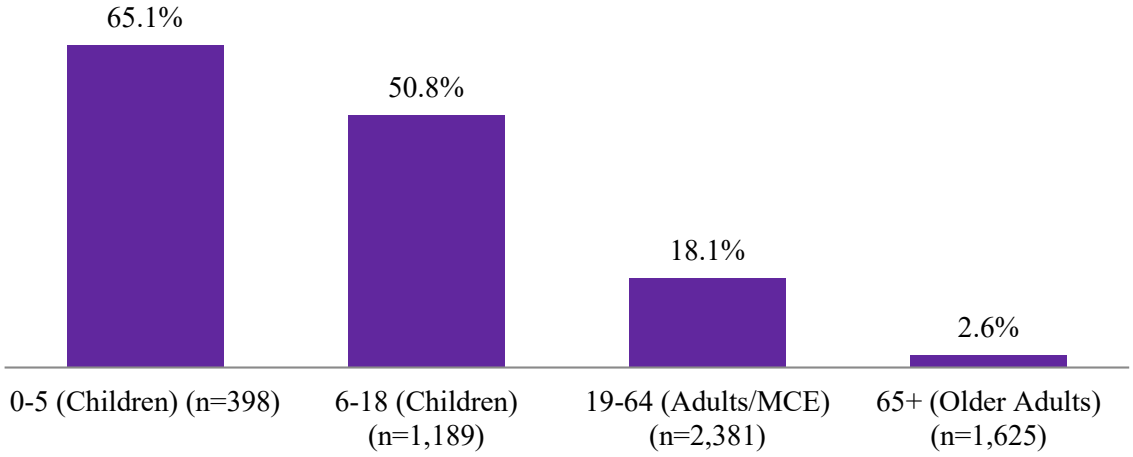
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

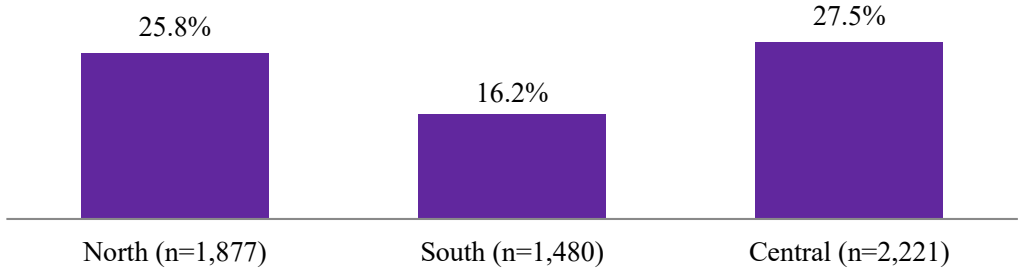
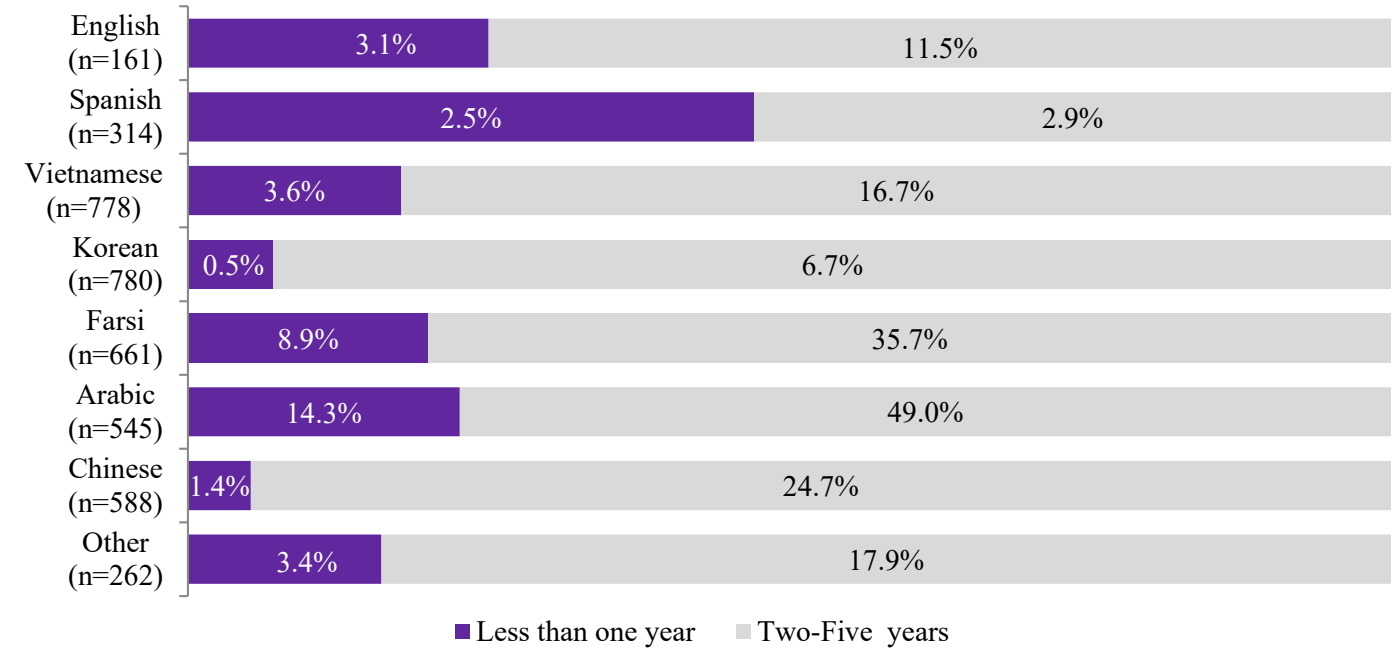
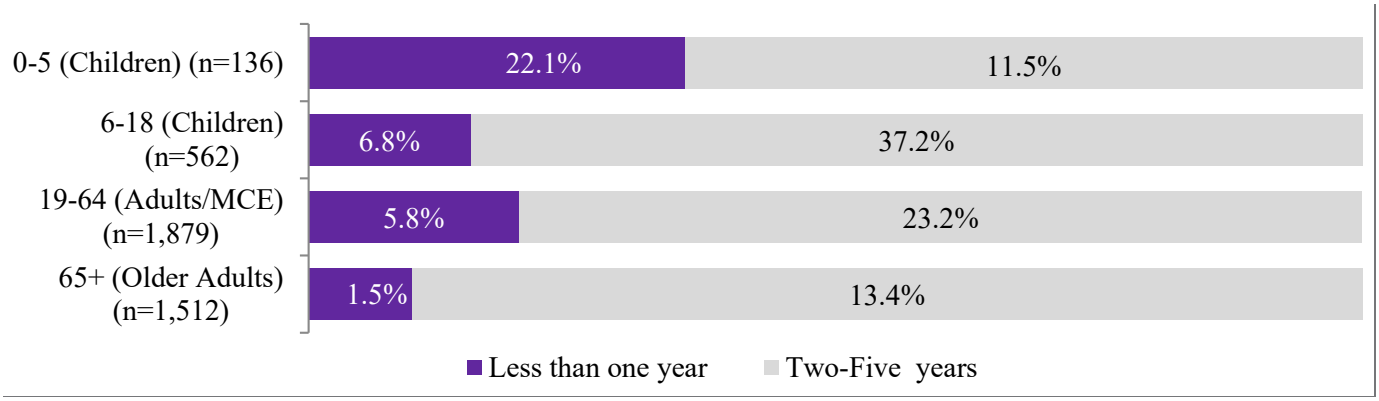


Exhibit 23. Length of time lived in the United States of those not born in the United States

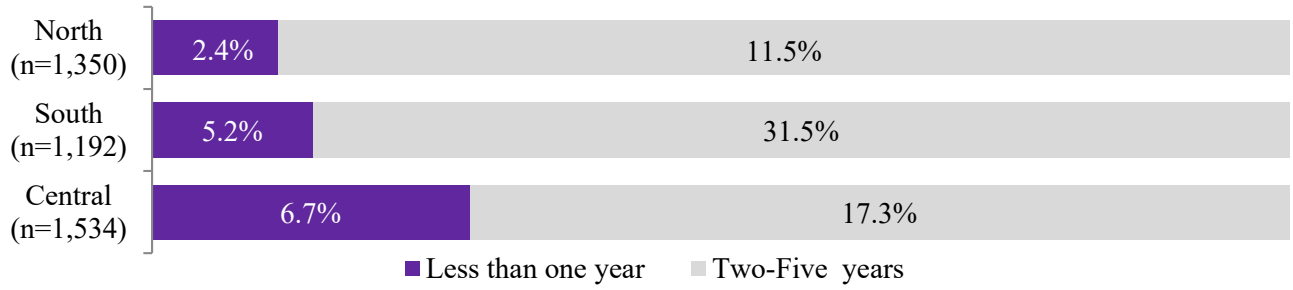
CalOptima language:



Age Category:



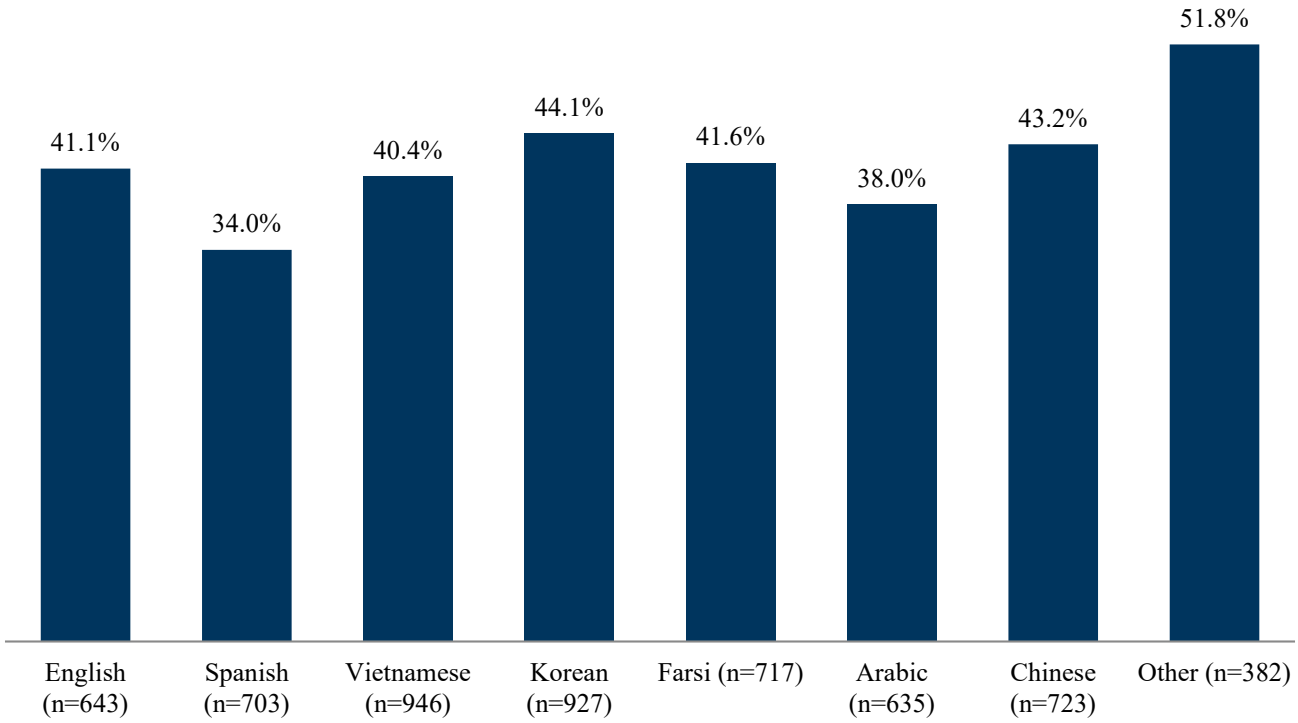
Region:



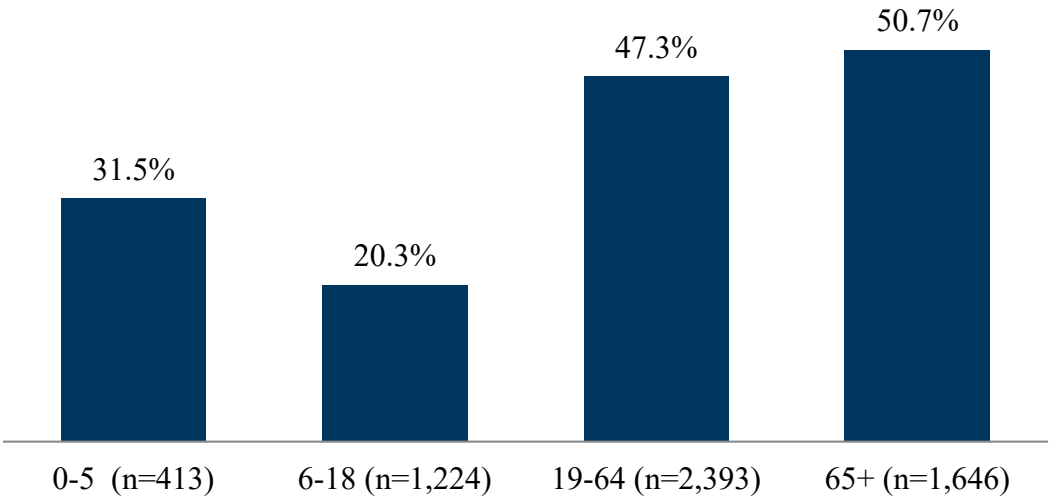
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

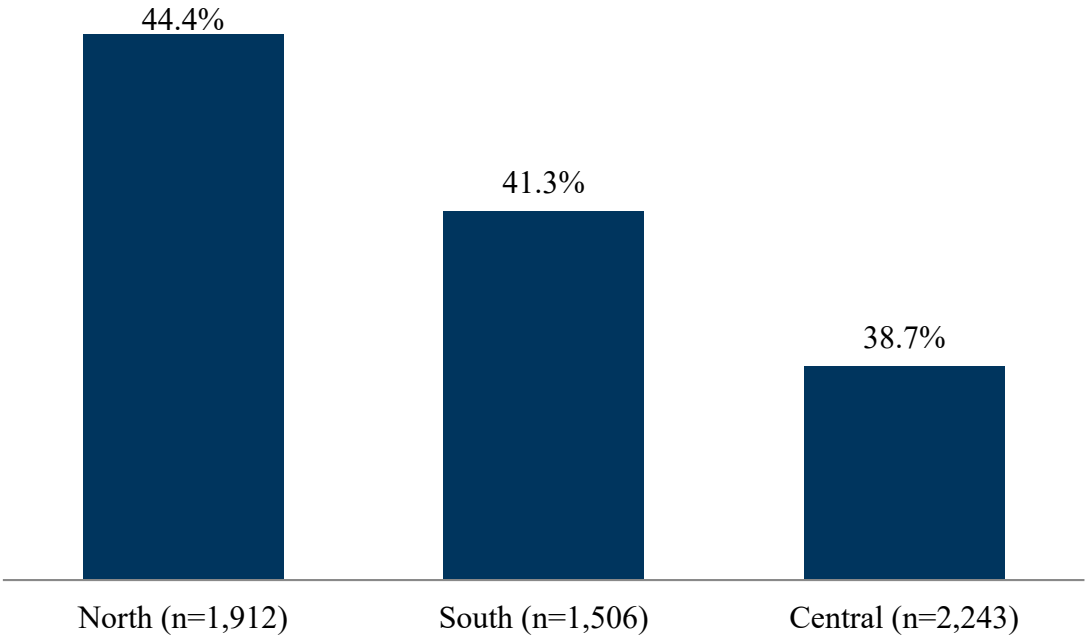


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

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)

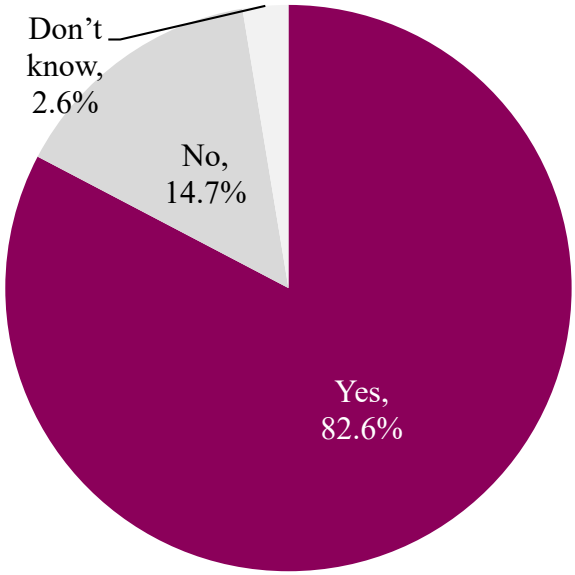


Exhibit 28. Where respondents go to see their doctor (n=5,743)

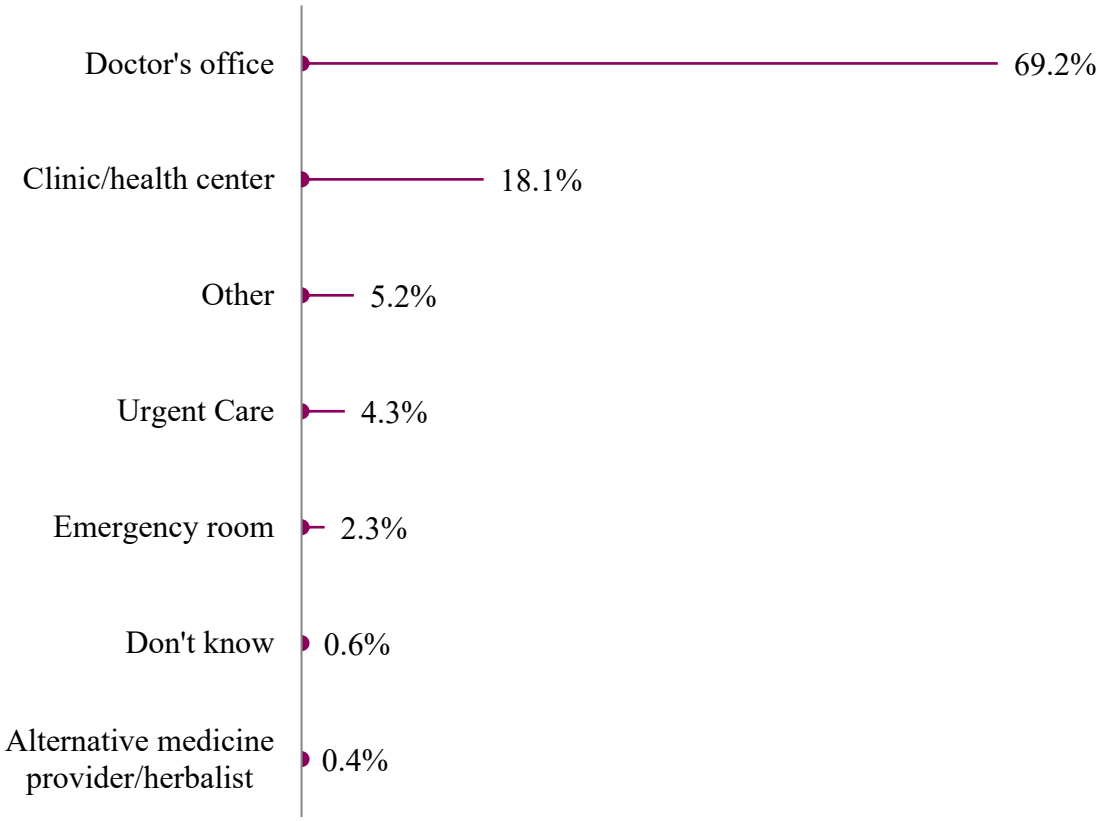


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

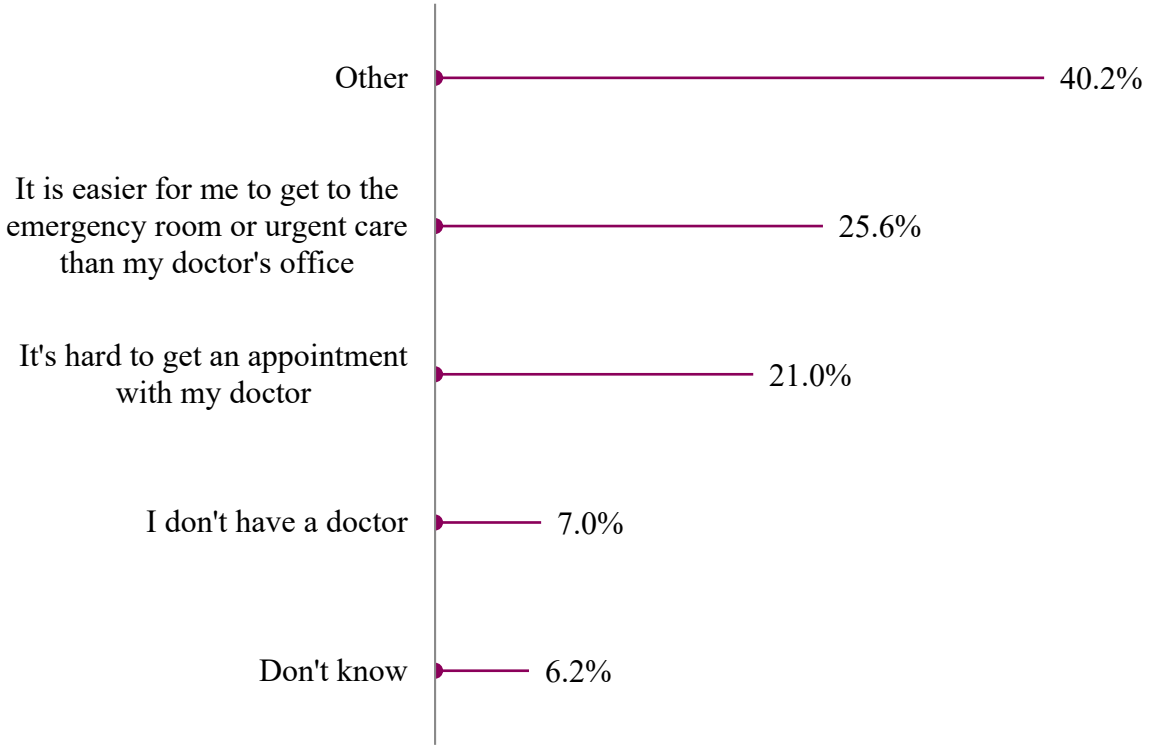


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

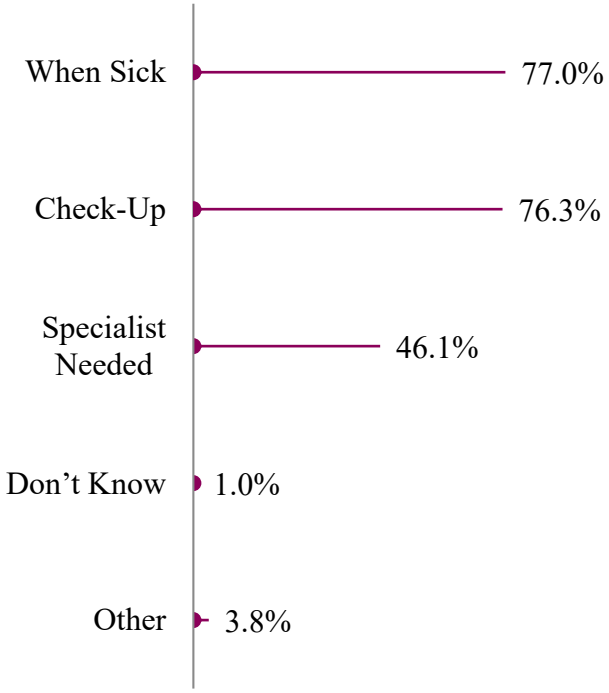
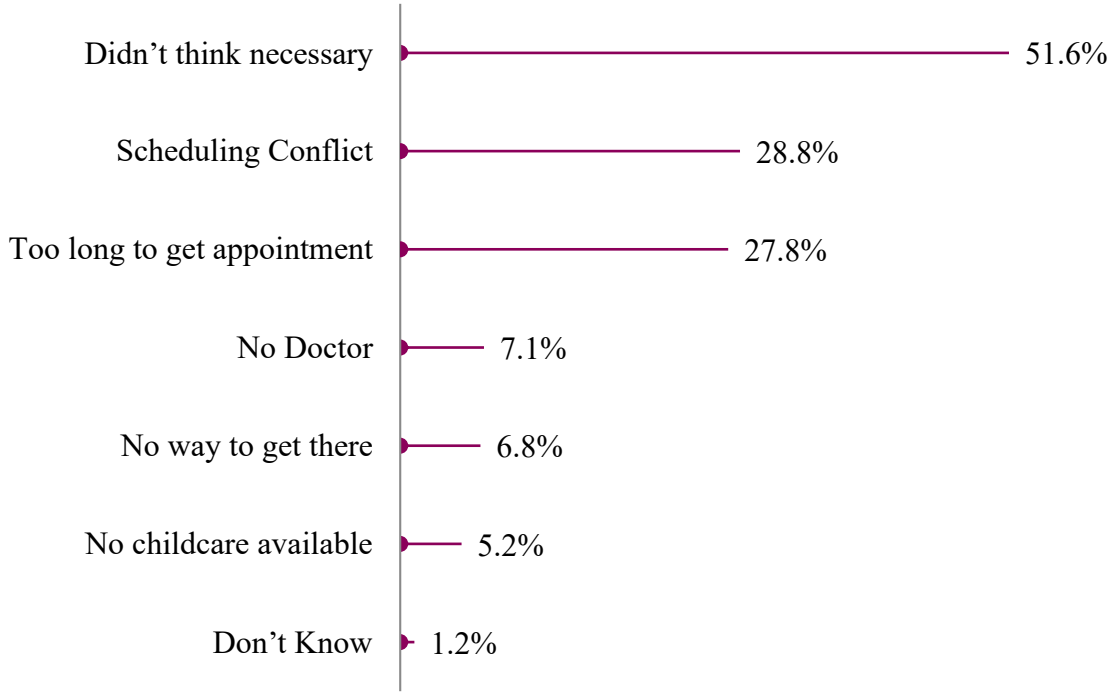


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[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]

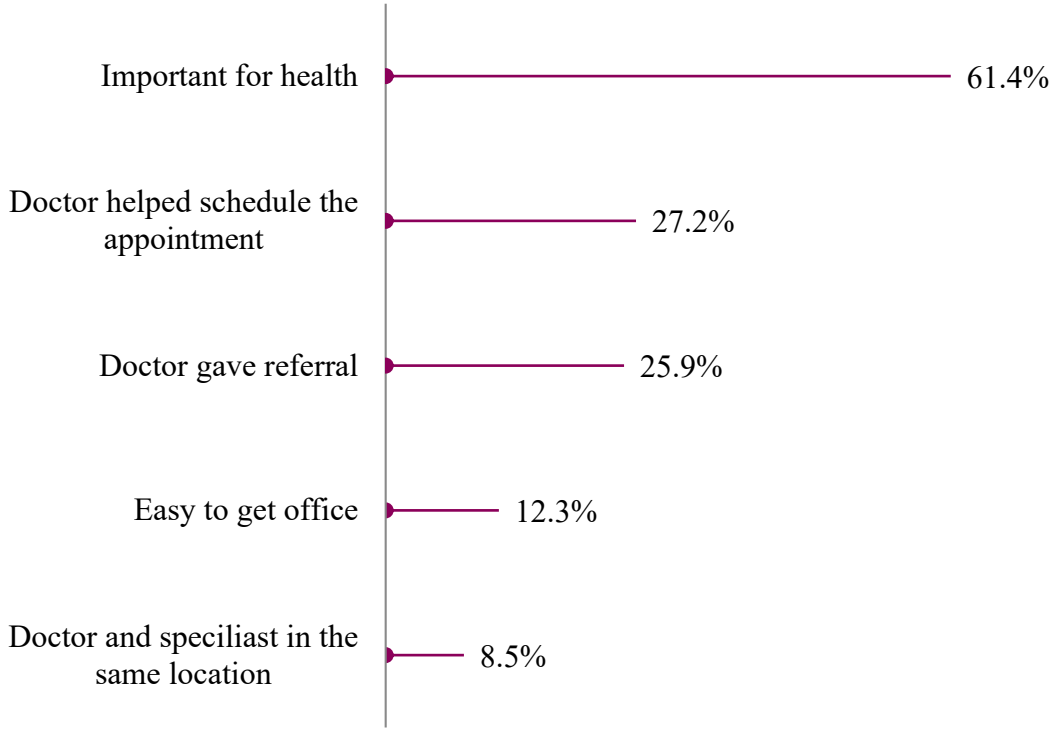
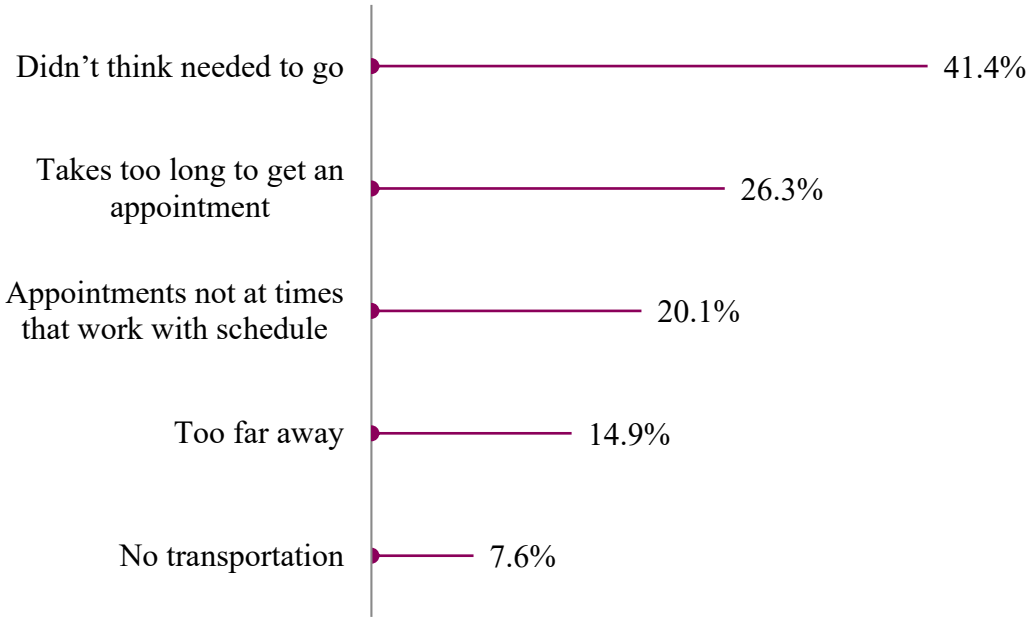
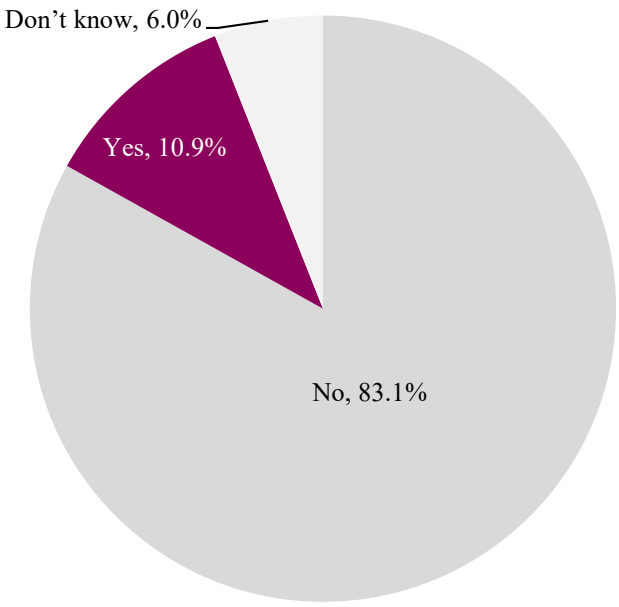


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[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)

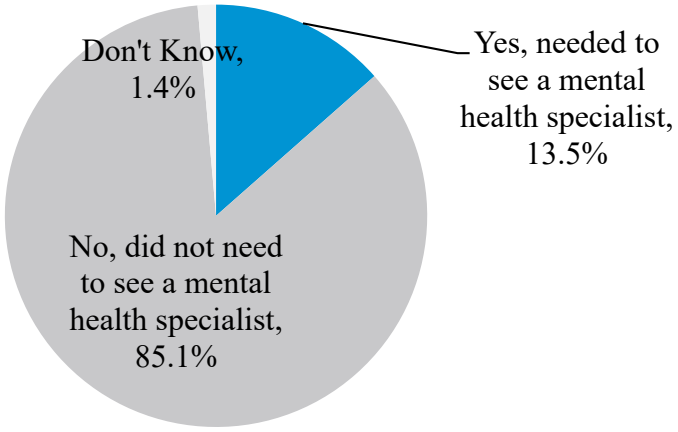


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

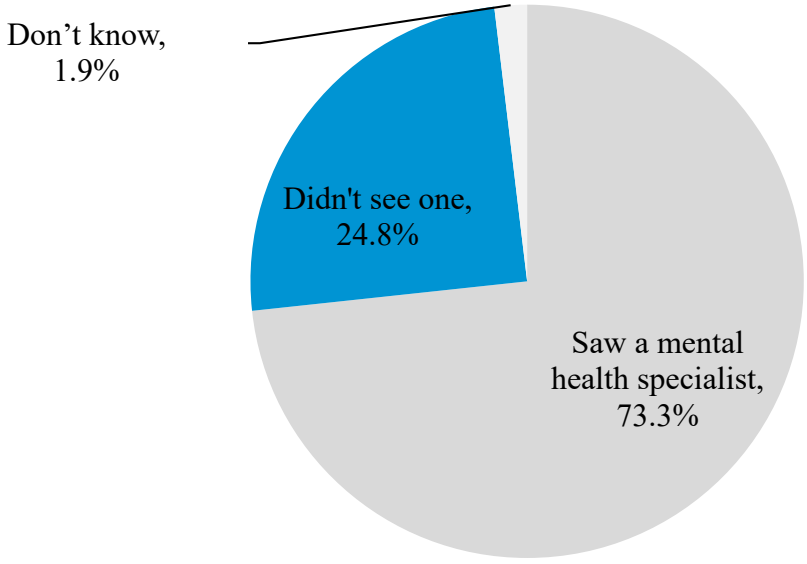


Exhibit 37. Reasons why members didn't see mental health specialist[24]

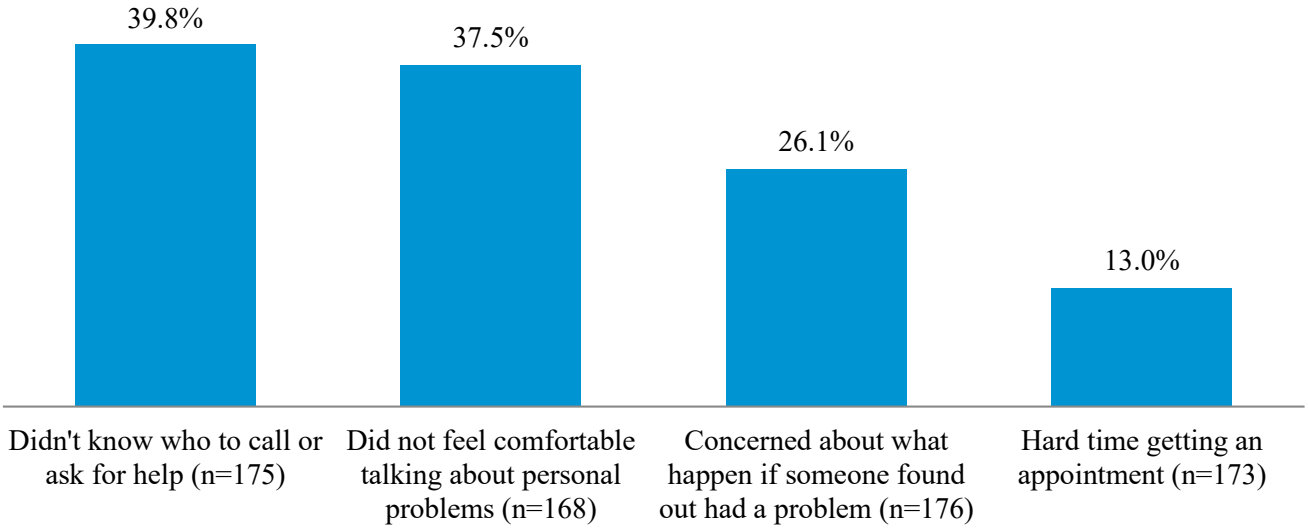
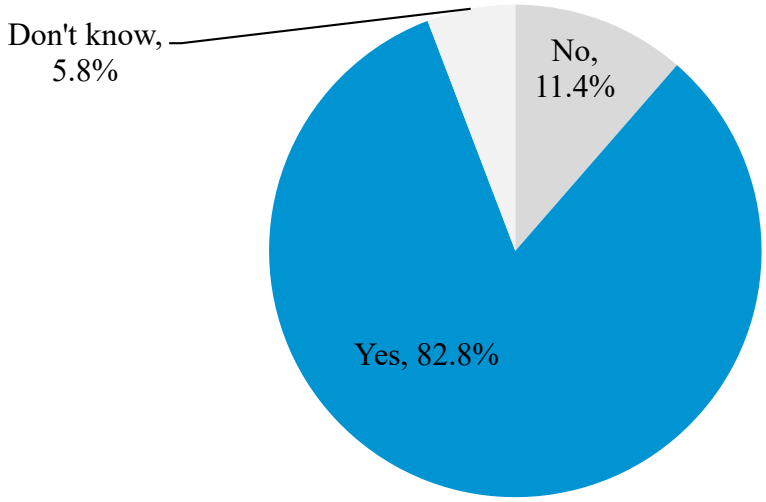


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[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:

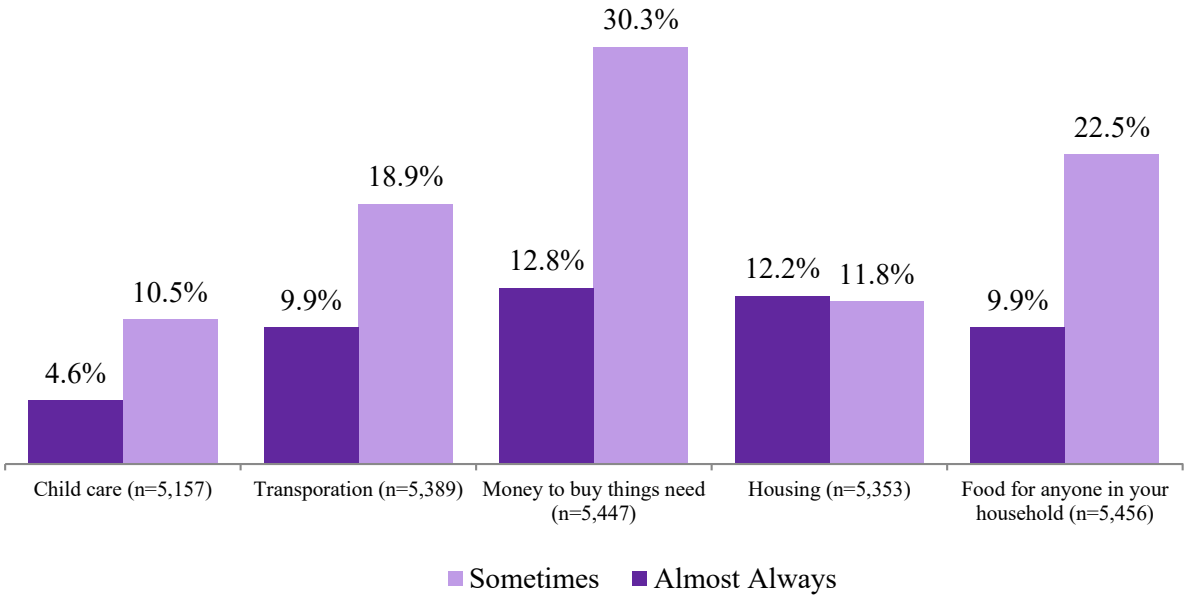


Exhibit 41. Percent of members who receive public benefits (n=5,117):

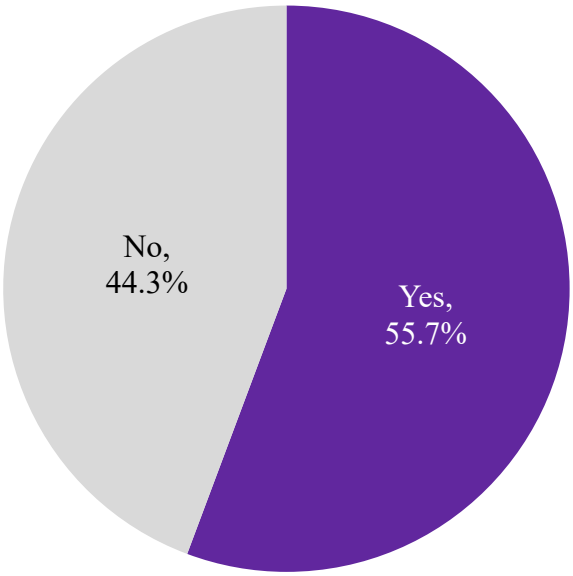
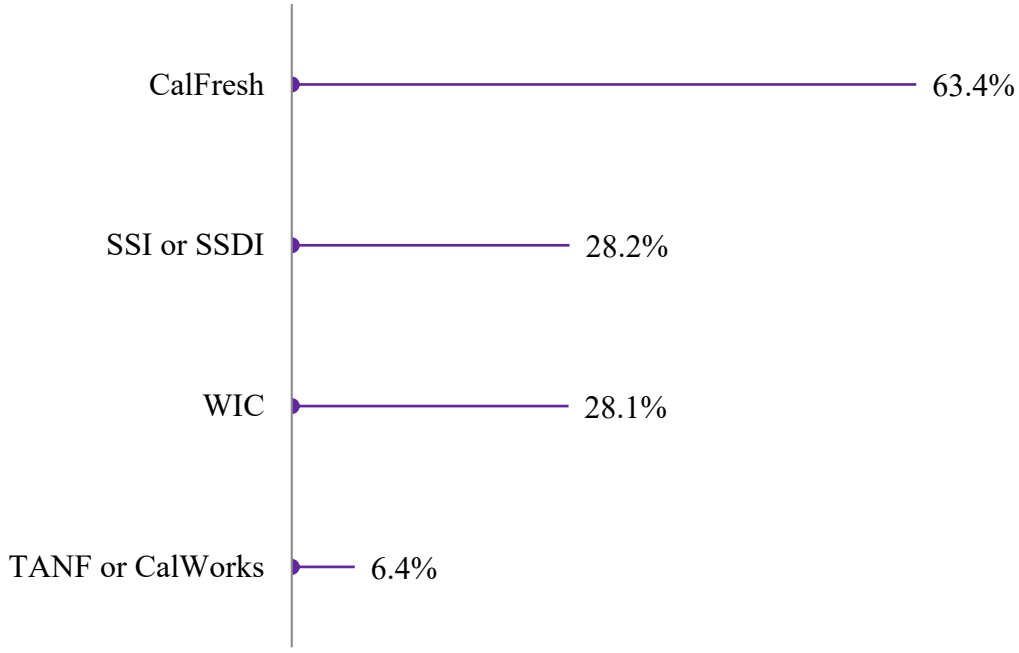


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

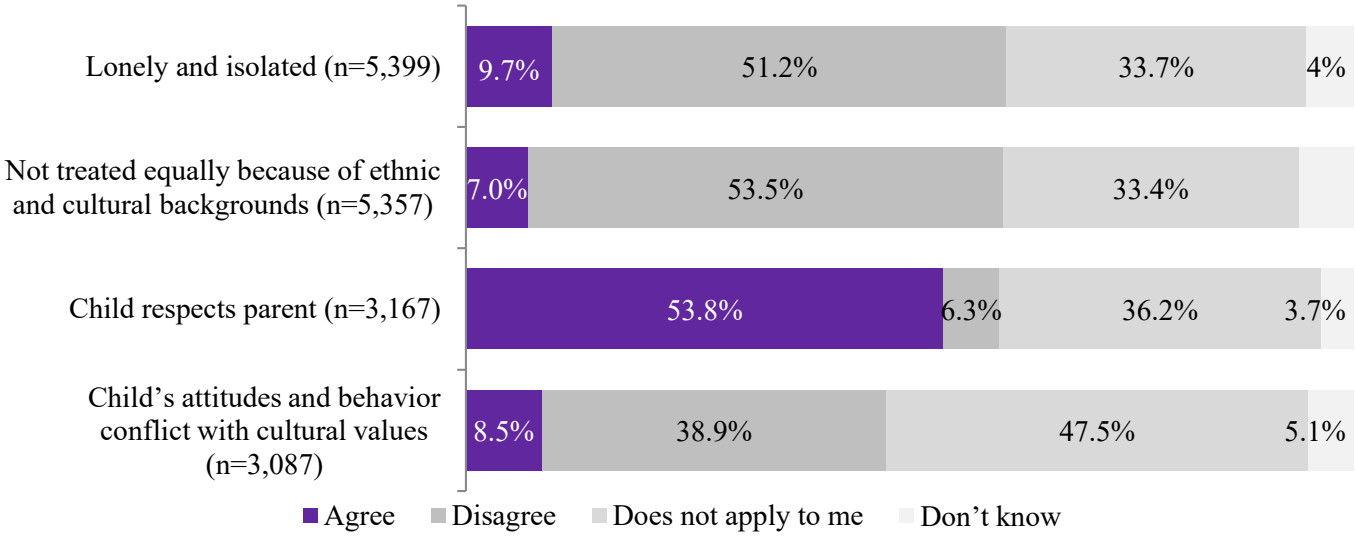


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

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%	
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)

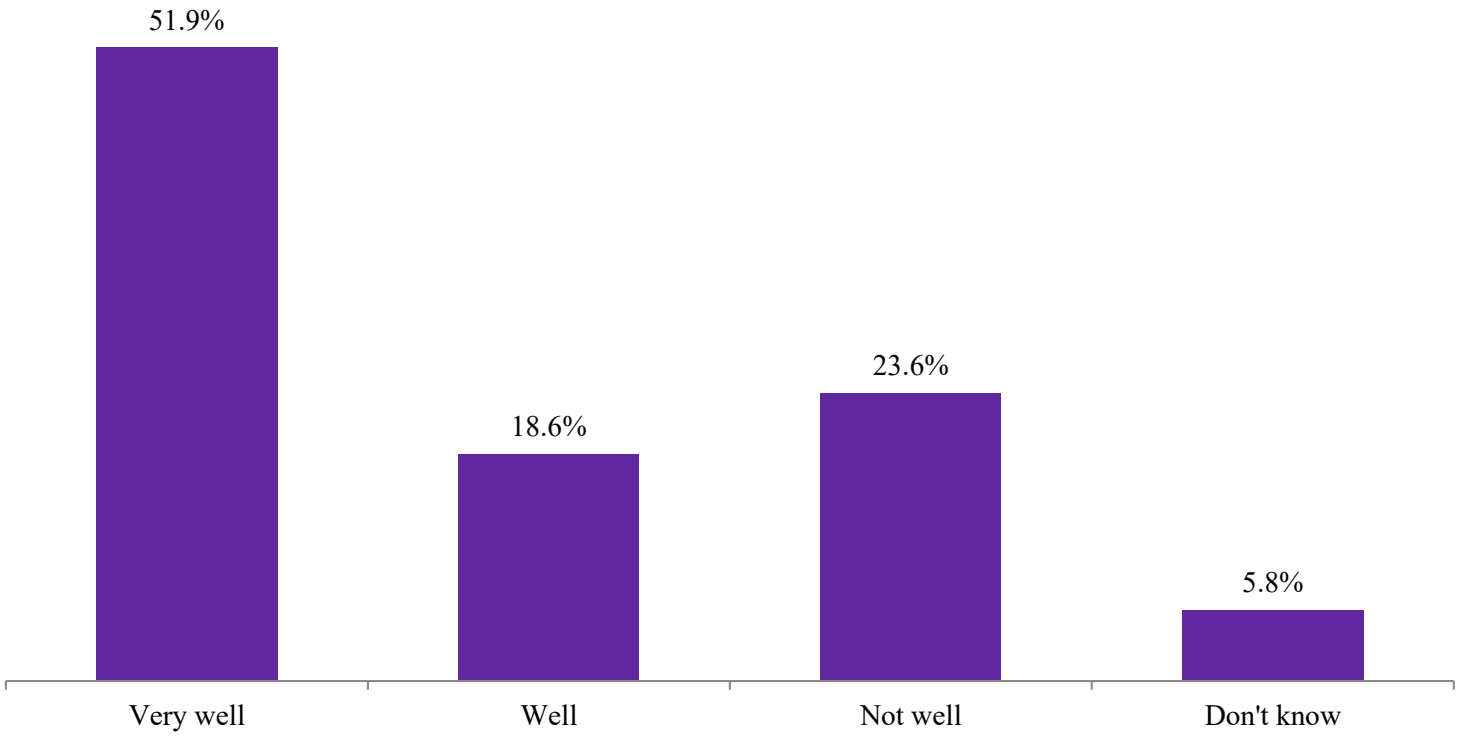


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

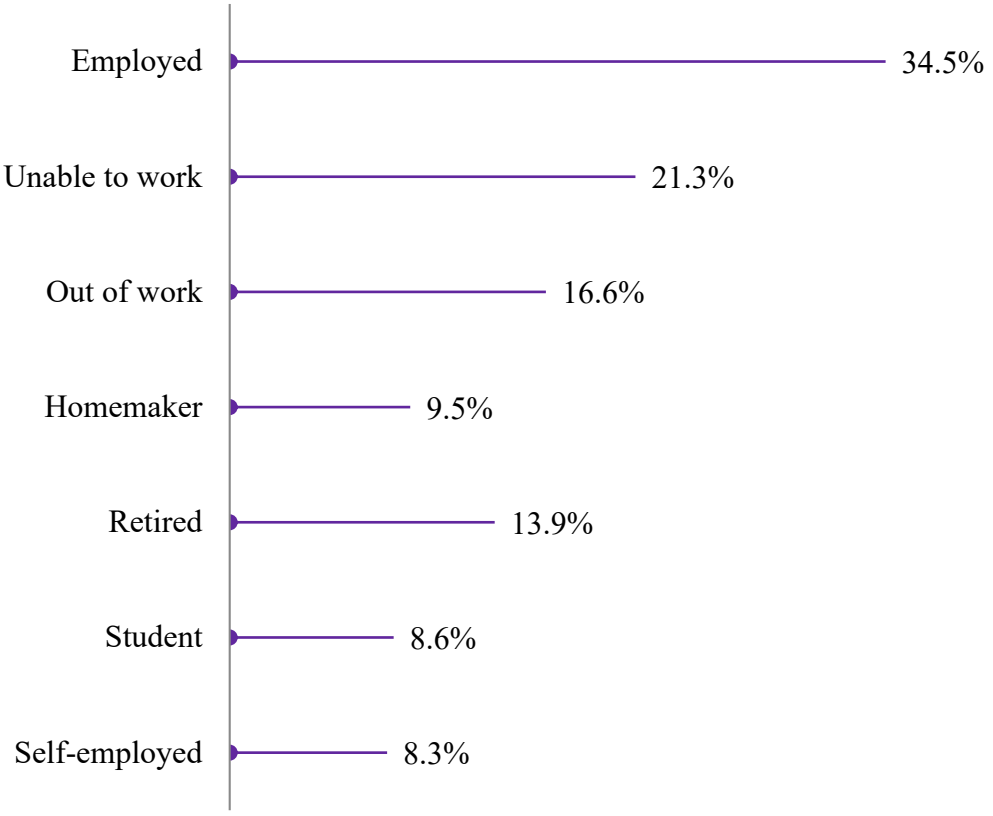
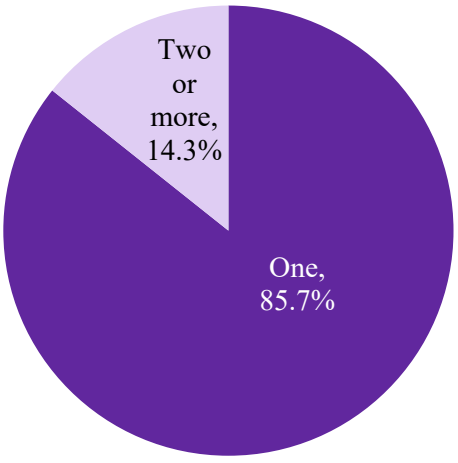
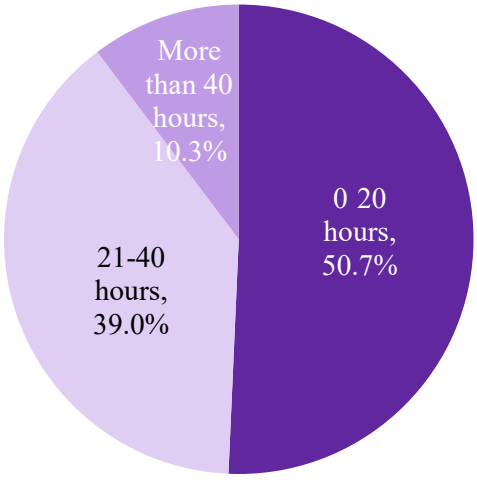


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

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)

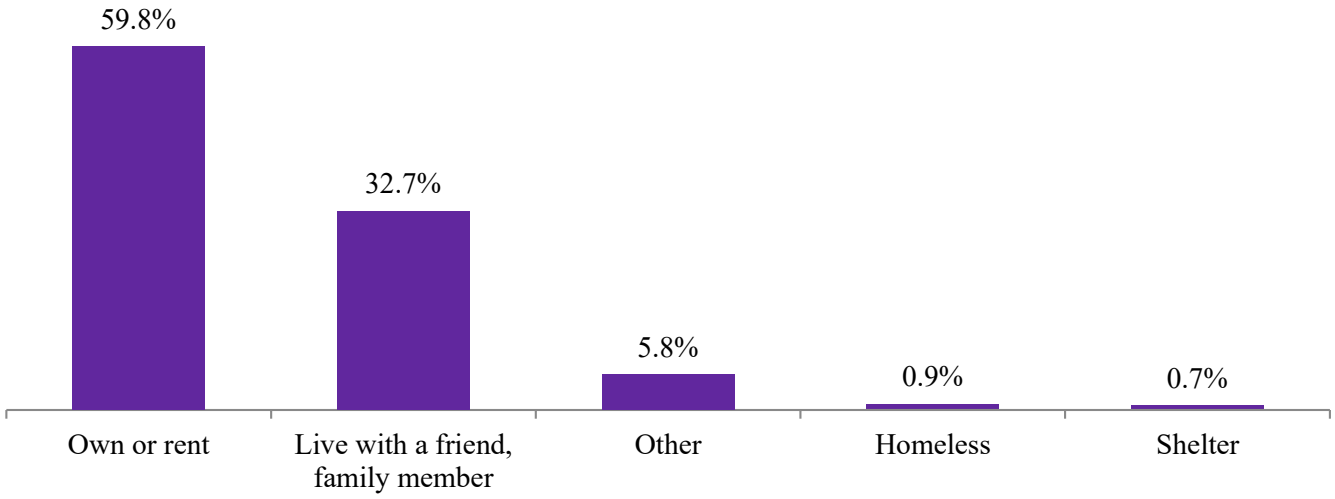
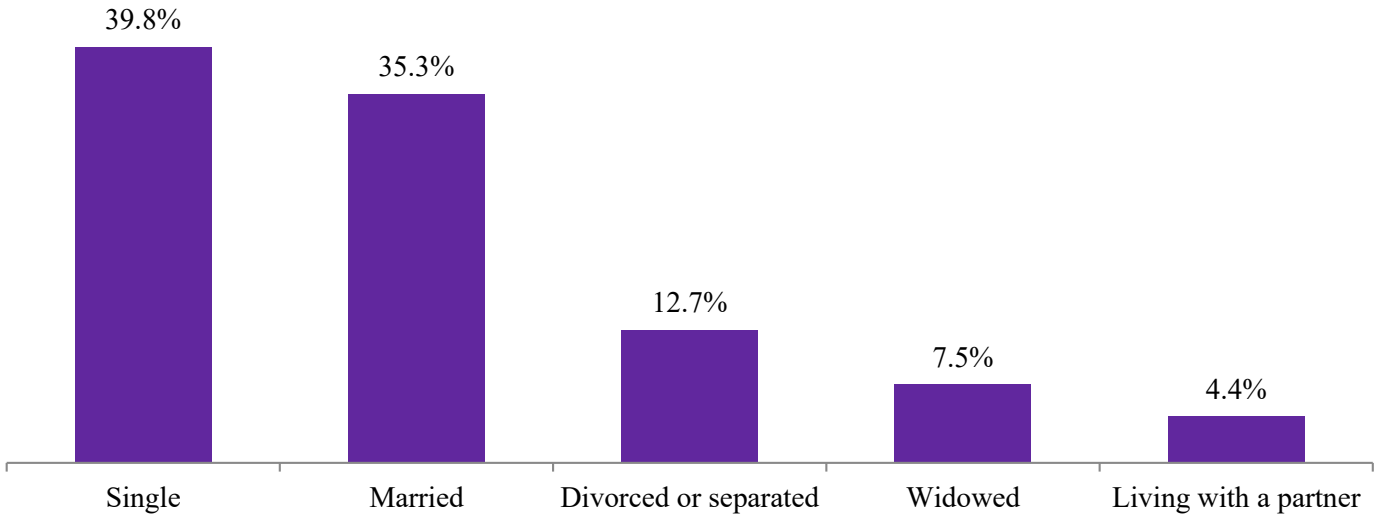


Exhibit 49. Marital status of members (n=3,271)[30]



[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)

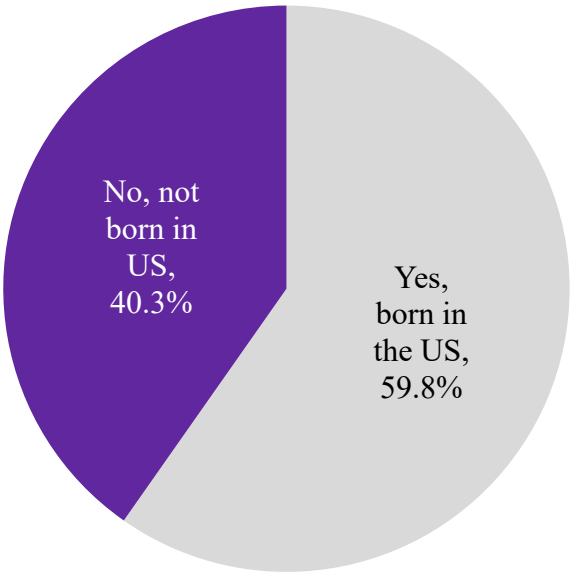
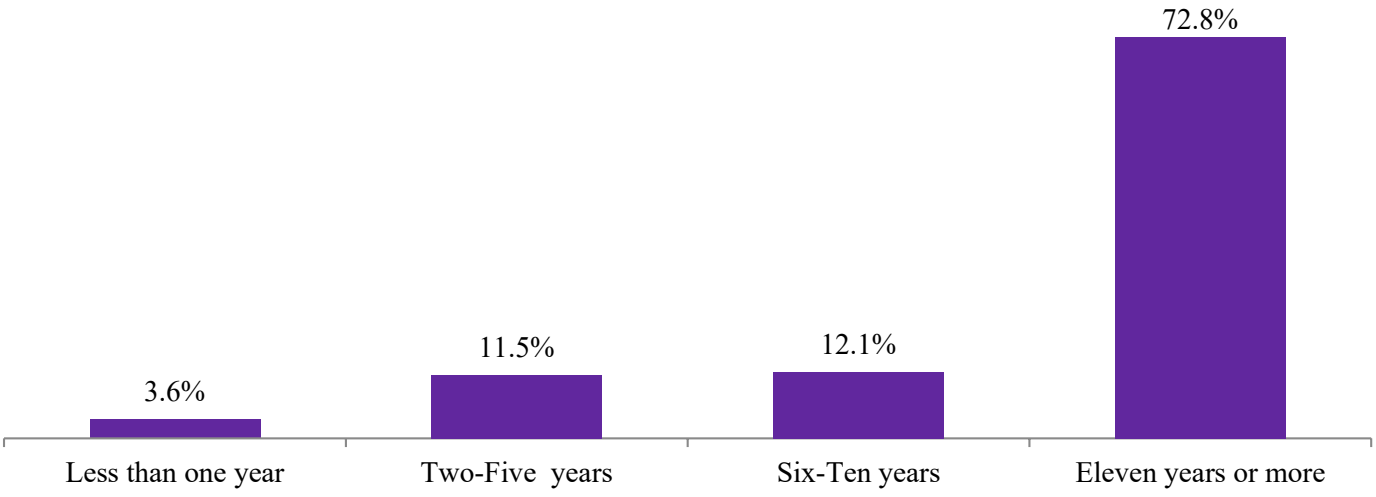


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

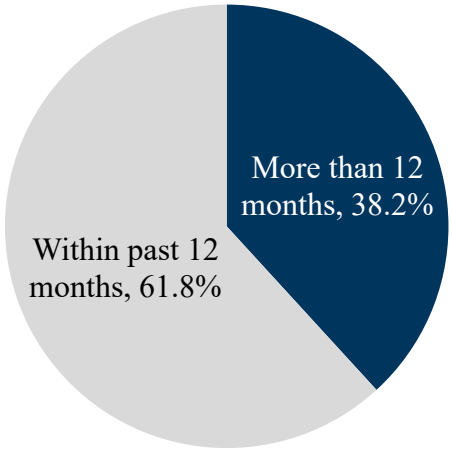
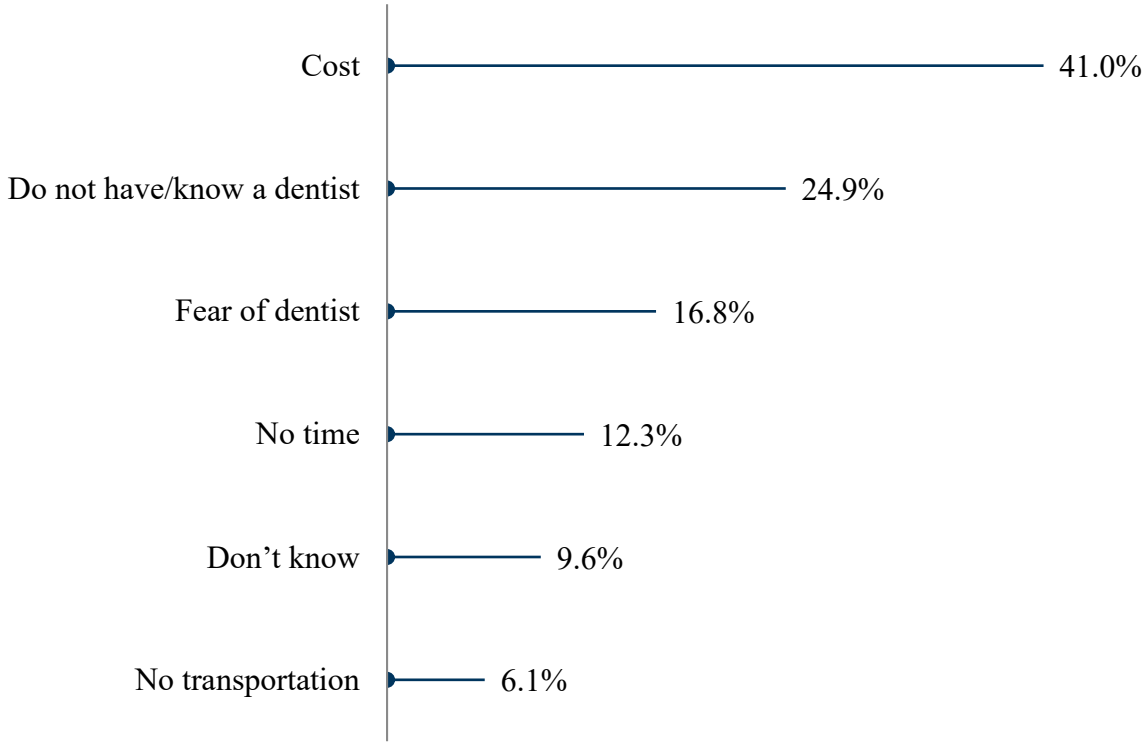
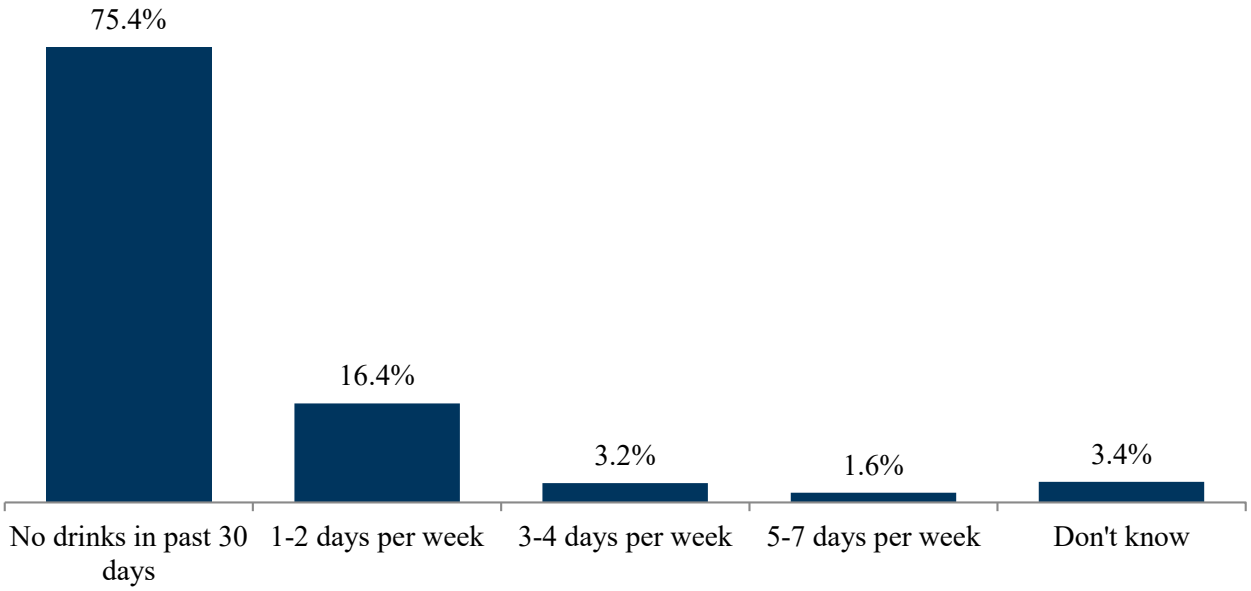


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[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:

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**

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 — *11/28/2018*
Authorized Signature — **Date**

Community Grant RFP Recommendations

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

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

CalOptima
A Public Agency
Better. Together.

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

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**

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
		$3.4 million

* Multiple awardees may be selected per RFP

CalOptima A Public Agency Better. Together.

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

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

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

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

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

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

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

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

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

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

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

GRANT REPORT TEMPLATE

GRANTEE INFORMATION

Name of Organization/Tax ID:	Healthy Smiles for Kids of Orange County XX-XXXXXXX
Address:	2101 E. Fourth St., Suite 220A, Santa Ana, CA 92705
Phone Number:	714-537-0700
Contact Name:	Tommie Servi (Ext. 7938) or 714-309-7485
Email:	tservi@healthysmilesoc.org
Is your 501(c)3 status current?	Yes ☒ No ☐ Not Applicable ☐
If no, explain	
Executive Director Name:	Ria Berger
Board Chair Name:	Richard Lee
Chief Financial Officer:	Kim Banco

GRANT INFORMATION

RFP 15-026 Orange County Public School-based Dental Services Grant	
Proposal Title: "Prevention Oral Health for School Aged Children"	

GRANT REPORT INFORMATION

Type of Grant Report

Annual Progress ☐ Final ☒

Report Due Date:	7/1/2017
Report Submission Date:	6/30/2017

Back to Agenda

EVALUATION CHART-FOR PROGRESS & FINAL REPORTS

Instructions: Please Submit an Updated Evaluation Chart with "Actuals" tied to Scope of Work in Attachment A

Objectives	Activities	Evaluation Indicators	Timeline
Establish site of dental care at high-need school	Yr 1 was focused on expansion. Healthy Smiles exceeded goals by doubling the number of schools visited; 5 new school districts and 56 new school sites were added; Yr 2 the focus was on improving participation rates in addition to continued expansion efforts. This was achieved by reviewing participation rates of schools in Yr 1 to exclude some of the low volume schools from our current year schedule and creation of a School Relations Coordinator position to work more closely with school staff to increase their engagement, get parent advocates involved and take advantage of communication options within the school system, such as email blasts, school newsletters, announcements at school events, banners in front of the school, etc. The average participation rate in Yr 1 was 23.7%. The participation rate for Yr 2 is 31.7%. Average for two years is 27.7%.	1. MOU's signed for five new school districts. 2. 16 new schools listed in Attachment G 3. 40 new schools not listed on Attachment G 4. 56 total new schools screened 5. Screenings from Expansion into New Schools: 7,468 6. Participation Rate: 27.7%	Jun 2015 – May 2017
Render oral health services and screening to 10,000-12,000 per year students at high-need	We are defining events as each day the mobile unit is at the school – one for each screening day and one for each sealant day depending on number of children to be seen and scheduling. We are collecting data on all schools	1. # of school events: 525 2. # of schools visited: 180 3. Children educated: 98,202	Jun 2015 – May 2017

Back to Agenda

schools	screened within the year though some related services may fall outside of the year (education/care coordination).	4. Parents/Teachers Educated: 4,694 5. Screenings: 29,753 6. Fluoride: 27,018 (90.8%) 7. Children Receiving Sealants: 10,470 (35.2%) 8. # of Sealants Applied: 31,698 9. # of children screened with visible decay: 16,125 or 54.2% 10. # of children screened with severe decay: 3.028 or 10.2%	
Connect children to a usual source of dental care	We have seen the number of children needing referral to a dental home decreasing due to increased dental insurance coverage for children and more families are connected to a dental provider. There are also a percentage of cases where we are unable to connect with the parent or they decline assistance.	1. % of children with visible decay who were linked to a dental home: 39% 2. % of children with visible decay who received referral for restorative care: 5.9%	Jun 2015 – May 2017
Track participation rates at schools and service utilization to inform CalOptima	In order to determine whether children identified as needing care have received treatment or completed treatment, care coordinators will need to contact parents subsequent to screening and may require more than one follow up call. Due to this, these numbers will take additional time to accumulate. There are also cases	1. % of parents who did not submit a consent form for their child's participation in the screening event: 72.5%	Jun 2015 – May 2017

Back to Agenda

	where care coordinators are unable to connect with the parent or the parent is uncooperative. As a result, we may not be able to identify all patients not receiving or completing treatment. This does not mean they are not getting treatment. Yr 2 %'s are provided but they will not include all outcomes from schools visited in the last quarter or from those parents that we were unable to contact or who refused to speak with us. Since there is a significant time lag in gathering this information, it will not be complete for reporting on quarterly reports. Note that 33.2% of parents declined care coordination. Of those who did not decline HSK care coordination, 29.2% HSK was unable to make a connection and 2.3% refused assistance.	2. % of children who did not ***receive*** treatment after being identified as needing care: In Yr 2 – 19.7% could be confirmed as receiving treatment (note this is based on the number of children whose parents accepted care coordination) 3. % of children who did not ***complete*** treatment after being identified as needing care: In Yr 2 – 14.6% could be confirmed as completing treatment (note this is based on the number of children whose parents accepted care coordination)	

Back to Agenda

QUESTIONAIRE TRACKING DATA- FOR ALL REPORTS	
1. Total number of events	525
2. Number of participating schools	180
3. For each school where services are rendered, please provide the following information: a) Name and address of the school b) Main contact person at the school who can verify that services were rendered c) Total number of students enrolled at the school and the percentage of students who received dental services d) Age range of children served (e.g. 5-11 years) at each school e) Number and percentage of children served who had visible decay f) Number of referrals for restorative care	See attached spreadsheet

Back to Agenda

FOR ANNUAL PROGRESS REPORTS (Due on annual basis)	YOUR ANSWERS
1. Please describe progress towards the performance target/milestones being reported on. If progress was not made, please describe why.	HSK exceeded targets in all areas.
2. Have you made any deviations from your original proposal? Explain how these deviations have, or will impact the project.	No, focus is the same. Addition of new FQHC allowed us to serve more schools.
3. Have you encountered any unexpected successes or challenges during this reporting period?	Have signed new FQHC contracts that will allow us to continue to expand services.
4. Are you requesting any changes to the project workplan or grant outcome? Please explain.	No
FOR FINAL REPORT (Due 30 days after completion of contract)	**YOUR ANSWERS**
1. Were you able to meet the desired outcomes of this grant? Please explain.	Yes, have exceeded goals.
2. What were the key variables contributing to your success or failure?	Strong relationships with FQHC's and school districts.
3. Please describe any unexpected successes or challenges you have experienced as a result of the grant. How have these items impacted the project and/or organization?	The grant allowed us to significantly expand. The first year of the grant, HSK doubled the number of schools served.
4. Please list any organizational or programmatic changes that will be made as a result of the grant experience.	HSK was able to implement processes that allow us to serve more schools each year. Our success will allow us to attract new school districts and FQHC partners.

Back to Agenda

5. Do you have any additional information about your project or the grant experience you would like to share with CalOptima?	We appreciate the support from CalOptima. For HSK, it's all about the kids. We were able to serve so many more children as a result of CalOptima support.

Back to Agenda

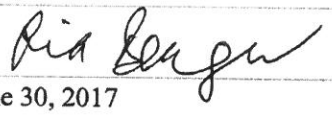
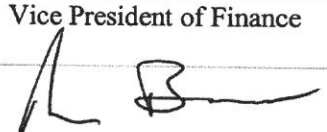
FINANCIALS FOR ANNUAL PROGRESS AND FINAL REPORTS			
COLUMN 1- PROJECTED EXPENSES	COLUMN 2- ACTUAL EXPENSES	COLUMN 3- DIFFERENCES BETWEEN PROJECTED AND ACTUAL EXPENSES	COLUMN 4- EXPLANATION OF DIFFERENCES
241,438	241,438	-0-	Staffing – hired additional staff due to change in program structure and to provide coverage for increase in services
96,668	96,668	-0-	Supplies – mobile unit expenses are higher due to unanticipated repairs. Dental supplies higher due to servicing more children than anticipated.
47,542	47,542	-0-	Facilities, Telephone, IT – lower allocation of space for Prevention team due to expansion of other programs that are picking up a larger portion
14,352	14,352	-0-	Other expenses – printing costs less than expected due to implementation of scanning processes. Cushion built into this category was not utilized.
400,000	400,000	-0-	Totals

Back to Agenda

QUESTIONS	ANSWERS
1. List the organization names and grant amounts of all sub-grantees and/or consultants indirectly receiving Foundation funds from this grant.	NA

***NOTE**-Please note that if there are any remaining funds from the grant, CalOptima will require you to document an appropriate use regarding how you intend to spend the funds.*

Back to Agenda

I hereby certify that this report, including any attachments, is accurate to the best of my knowledge, and that our organization, remains in full compliance with the terms of the Grant Contract. (Signatures are required for each position listed below)	
Primary Contact for Project	
Name:	Tommie Servi
Title:	Vice President of Operations
Signature:	
Date:	June 30, 2017
Executive Director or Board Chair	
Name:	Ria Berger
Title:	Chief Executive Officer
Signature:	
Date:	June 30, 2017
Chief Financial Officer	
Name:	Kim Banco
Title:	Vice President of Finance
Signature:	
Date:	June 30, 2017

Back to Agenda

CALOPTIMA TRACKING DATA - Final Years 1 & 2

Healthy Smiles for Kids of Orange County - RFP 15-026

1. Total number of events: 525

2. Number of participating schools: 89

NM	Newport Mesa
OV	Oceanview
SA	Santa Ana
SV	Savanna
TU	Tustin
WE	Westminster

*Includes parents and teachers

SCREENING DATE	SCHOOL DISTRICT	EVENTS	SCHOOL	ADDRESS	CITY/STATE	POSTAL CODE	CURRENT(CUR)/TARGET(TAR) /NEW(NEW)	SCHOOL POPULATION	CHILDREN SCREENED	EXPANSION	FLUORIDE	CHILDREN RECEIVING SEALANTS	# OF SEALANTS APPLIED	% WHO RECEIVED SERVICES	AGE RANGE	NUMBER OF CHILDREN WITH VISIBLE DECAY	% OF CHILDREN SERVED WITH VISIBLE DECAY	# OF CHILDREN WITH SEVERE DECAY (EMERGENCY)	ORAL HEALTH EDUCATION PROVIDED *	DECLINED CARE COORDINATION	LINKED TO DENTAL HOME	NUMBER OF REFERRALS FOR RESTORATIVE CARE	NOT CONNECTED	IN TREATMENT	TREATMENT COMPLETED	UNABLE TO CONFIRM TREATMENT	REFUSED TREATMENT
4/28/2016	NM	3	Adams Elementary	2850 Clubhouse Rd.	Costa Mesa, CA	92626	NEW	427	155	155	139	61	196	36.3%	5-12	74	47.7%	11	456	57	2		1				
1/25/2016	GG	2	Anthony Elementary	15320 Pickford St.	Westminister, CA	92683	NEW	467	146	146	134	51	167	42.7%	5-12	68	46.6%	19	490	39	32	3	15	3	14	8	1
11/9/2015	CY	2	Arnold Elementary	9281 Denni St.	Cypress, CA	90630	TAR	748	91	91	83	31	114	12.2%	5-12	34	37.4%	1	764	35	18	2	6	2	7	3	
2/25/2016	MA	2	Baden-Powell Elementary	2911 W. Stonybrook Dr.	Anaheim, CA	92804	NEW	734	60	60	53	25	61	8.2%	5-12	32	53.3%	8	708	24	11	2	11	1	3	1	2
12/14/2015	TU	3	Benson Elementary	12712 Elizabeth Way	Tustin, CA	92780	TAR	353	41	41	37	7	27	11.6%	5-12	20	48.8%	0	369	13	10	1	3		6		
11/3/2015	TU	4	Beswick Elementary	1362 Mitchell Ave.	Tustin, CA	92780	TAR	683	286	286	239	72	248	41.9%	5-12	139	48.6%	27	660	96	75	14	27	10	30	13	
4/4/2016	GG	3	Brookhurst Elementary	9821 Catherine Ave.	Garden Grove, CA	92841	CUR	514	180		165	69	289	35.0%	5-12	83	46.1%	15	532	66	43	2	15	3	3		2
2/29/2016	GG	2	Bryant Elementary	8371 Orangewood	Garden Grove, CA	92841	CUR	760	166		155	85	218	21.8%	5-12	99	59.6%	18	770	70	60	13	31	9	10	23	
10/5/2015	CE	2	Buena Terra Elementary	8299 Holder St.	Buena Park, CA	90620	CUR	508	70		65	27	100	13.8%	5-12	33	47.1%	5	542	30	16	4	5	1	7	4	1
9/24/2015	CE	3	Centralia Elementary	195 N. Western Ave.	Anaheim, CA	92801	CUR	582	170		157	60	139	29.2%	5-12	116	68.2%	5	561	61	51	7	31	3	21	18	
2/18/2016	SV	2	Cerritos Elementary	3731 Cerritos	Anaheim, CA	92804	NEW	502	67	67	62	31	81	13.3%	5-12	32	47.8%	8	550	18	20	3	5	3	9	5	
12/1/2015	GG	1	Clinton Corner Pre-School	13581 Clinton St.	Garden Grove, CA	92843	CUR	240	135		118	0	0	56.3%	3-5	74	54.8%	9	259	29	36	7	26	3	14		
3/29/2016	GG	2	Clinton Elementary	13641 Clinton St.	Garden Grove, CA	92843	NEW	695	171	171	133	49	187	24.6%	5-12	67	39.2%	9	718	64	20	2	28		2		2
10/13/2015	GG	2	Cook Elementary	9802 Woodbury Ave.	Garden Grove, CA	92844	CUR	389	89		83	38	128	22.9%	5-12	37	41.6%	3	369	32	17	3	9		8	5	1
8/25/2015	CE	3	Danbrook Elementary	320 Danbrook St.	Anaheim, CA	92804	CUR	672	262		235	45	155	39.0%	5-12	138	52.7%	10	662	101	69	14	31	21	33	13	
1/11/2016	SA	1	Davis Elementary	1405 French St	Santa Ana, CA	92701	CUR	747	140		127	42	133	18.7%	5-12	89	63.6%	15	680	42	53	7	16	9	18	6	3
&	SA	2	Diamond Elementary	1450 S. Center St.	Santa Ana, CA	92704	CUR	600	311		277	131	381	51.8%	5-12	179	57.6%	71	598	48	85	23	36	14	30	13	1
4/26/2016	MA	2	Disney Elementary	2323 W. Orange Ave.	Anaheim, CA	92804	NEW	671	147	147	130	51	180	21.9%	5-12	67	45.6%	9	705	72	1		1		1		1
9/15/2015	CE	2	Dysinger Elementary	7770 Camellia Dr.	Buena Park, CA	90620	CUR	534	97		94	32	111	18.2%	5-12	34	35.1%	5	531	38	12	4	10	1	3	5	
&	AN	4	Edison Elementary	1526 E. Romneya	Anaheim, CA	92805	CUR	1002	219		200	81	246	21.9%	5-12	94	42.9%	9	928	90	55	12	19	11	25	8	4
6/2/2015	SA	3	El Sol Elementary	1010 N. Broadway St.	Santa Ana, CA	92701	CUR	800	175		162	57	203	21.9%	5-12	68	38.9%	10	591	79	28	9	11		15	3	
12/15/2016	TU	2	Estock Elementary	14741 North B Street	Tustin, CA	92780	TAR	384	92	92	81	28	97	24.0%	5-12	54	58.7%	9	389	32	27	9	11		5		
6/1/2015	GG	3	Faylane Elementary	11731 Morrie Ln.	Garden Grove, CA	92840	CUR	628	83		79	50	184	13.2%	5-12	47	56.6%	8	488	22		1					
3/22/2016	GG	2	Faylane Elementary	11731 Morrie Ln.	Garden Grove, CA	92840	CUR	610	121		113	44	163	19.8%	5-12	57	47.1%	12	479	34	29	4	14	5	6		
11/17/2015	TU	2	Foss Elementary	18492 Vanderlip Ave.	Santa Ana, CA	92705	NEW	452	43	43	41	17	57	9.5%	5-12	14	32.6%	0	401	21	7	2	1		1	1	
10/19/2015	AN	3	Franklin Elementary (Anaheim)	521 W. Water St.	Anaheim, CA	92805	CUR	879	128		122	49	172	14.6%	5-12	65	50.8%	11	895	49	29	4	16	3	16	8	1
10/20/15	SA	5	Franklin Elementary (Santa Ana)	210 W. Cubbon St.	Santa Ana, CA	92701	CUR	489	193		176	60	245	39.5%	5-12	110	57.0%	11	469	67	48	9	24	9	14	11	2
3/10/2016	GG	2	Gilbert Elementary	9551 Orangewood Ave.	Garden Grove, CA	92841	NEW	530	96	96	89	38	106	18.1%	5-12	60	62.5%	6	539	25	27	3	19	3	2		
2/1/2016	SV	2	Hansen Elementary	1300 South Knott	Anaheim, CA	92804	NEW	690	126	126	117	51	155	18.3%	5-12	60	47.6%	9	719	46	23	5	15	3	3	9	
4/14/2016	SA	3	Harvey Elementary	1635 S. Center St.	Santa Ana, CA	92704	CUR	447	168		147	81	220	37.6%	5-12	79	47.0%	20	479	61	41	9	14	3	1		1
10/12/2015	GG	3	Hazard Elementary	4218 West Hazard Ave.	Santa Ana, Ca	92703	NEW	630	153	153	140	50	217	24.3%	5-12	64	41.8%	8	630	40	36	9	21	3			1
1/19/2016	TU	3	Heideman Elementary	15571 William St	Tustin, CA	92780	TAR	630	214	214	192	89	311	34.0%	5-12	107	50.0%	14	655	64	55	12	22	9	28	7	
10/27/2015	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	600	157		139	57	196	26.2%	5-12	63	40.1%	3	573	71	30	5	7	1	9	6	2
3/1/2016	GG	2	Hill Elementary	9681 11th St.	Garden Grove, CA	92844	NEW	370	88	88	84	39	133	23.8%	5-12	35	39.8%	10	383	22	17	3	11	3			
2/11/2016	SV	2	Holder Elementary	9550 Holder St.	Buena Park, CA	90620	NEW	560	87	87	80	31	109	19.6%	5-12	40	46.0%	6	557	33	16	4	12	1	3	7	2
6/9/2015	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	1126	154		132	48	174	13.7%	5-12	60	39.0%	5	1046	39		1	12	9	9		
11/5/2015	SA	3	Jefferson Elementary	1522 W. Adams St.	Santa Ana, CA	92704	CUR	897	147		137	51	148	16.4%	5-12	79	53.7%	30	814	43	49	13	14	3	14	12	1
11/2/2015	CY	2	King Elementary	8710 Moody St.	Cypress, CA	90630	TAR	585	65	65	62	27	100	11.1%	5-12	19	29.2%	3	584	27	7		4	1	4		1
11/13/2015	TU	3	Lambert Elementary	1151 San Juan St.	Tustin, CA	92780	TAR	523	169	169	156	65	243	32.3%	5-12	71	42.0%	8	435	55	41	10	21	4	13	14	
8/19/2015	CY	3	Landell Elementary	9739 Denni St.	Cypress, CA	90630	TAR	750	63	63	52	20	68	8.4%	5-12	29	46.0%	4	737	33	12	1	3		7	1	4
9/14/2015	CE	2	Los Coyotes Elementary	8122 Moody St.	La Palma, CA	90623	CUR	529	90		79	41	148	17.0%	5-12	34	37.8%	4	575	41	16	2	7	1	6	2	4
2/22/2016	MA	2	Low Elementary	215 N. Ventura St.	Anaheim, CA	92801	NEW	704	101	101	91	48	93	14.3%	5-12	49	48.5%	10	729	28	25		7	3	10	4	
1/21/2016	SA	5	Lowell Elementary	700 S Flower St	Satna Ana, CA	92703	CUR	900	307		292	135	342	34.1%	5-12	164	53.4%	38	947	91	82	20	32	7	33	14	3
10/26/2015	CY	2	Luther Elementary	4631 La Palma Ave.	La Palma, CA	90623	TAR	515	59	59	53	20	71	11.5%	5-12	19	32.2%	0	535	20	9	1	10		1	1	
8/3/2015	AN	3	Mann Elementary (Tracks BC)	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	668	125		118	53	188	18.7%	5-12	64	51.2%	9	609	47	41	16	8	7	14	4	1
12/7/2015	GG	3	Marshall Elementary	15791 Bushard St.	Westminister, CA	92683	TAR	456	109	109	96	48	150	23.9%	5-12	58	53.2%	6	472	33	28	28	20		5		
3/15/2016	MA	2	Marshall Elementary	2627 Crescent Ave.	Anaheim, CA	92801	NEW	657	56	56	49	12	47	8.5%	5-12	35	62.5%	4	707	7	10	3	8	1	19		
10/22/2015	SA	5	Martin Elementary	939 W. Wilshire Ave.	Santa Ana, CA	92707	CUR	750	285		262	119	303	38.0%	5-12	129	45.3%	62	767	86	70	16	31	3	24	12	

Back to Agenda

4/25/2016	MA	3	Maxwell Elementary	2613 W. Orange Ave.	Anaheim, CA	92804	NEW	802	206	206	177	70	182	25.7%	5-12	108	52.4%	12	871	63	14	2			1			
9/8/2015	CE	2	Miller Elementary	7751 Furman Rd.	La Palma, CA	90623	CUR	579	62		52	29	113	10.7%	5-12	25	40.3%	4	612	29	10	3	5	2	5	3	1
3/24/2016	GG	3	Mitchell Elementary	13451 Taft Ave.	Garden Grove, CA	92843	CUR	469	153		137	70	189	32.6%	5-12	80	52.3%	21	463	63	22	2	29		1		
11/16/2015	CY	2	Morris Elementary	9952 Graham St.	Cypress, CA	90630	TAR	737	62	62	52	18	67	8.4%	5-12	26	41.9%	4	763	24	8		8		2	2	
11/19/2015	TU	2	Nelson Elementary	14392 Browning Ave.	Tustin, CA	92780	TAR	620	60	60	52	12	29	9.7%	5-12	38	63.3%	13	649	21	17	7	8	2	6	3	
3/10/2016	GG	1	Newhope Elementary	4419 West Regent Dr.	Santa Ana, CA	92704	NEW	431	63	63	63	2	3	14.6%	5-12	33	52.4%	4	416	24	16	7	5		1		1
3/3/2016	OV	3	Oakview Elementary	17241 Oak Lane	Huntington Beach, CA	92647	CUR	709	201		182	82	193	28.3%	5-12	96	47.8%	20	689	77	41	2	16	1	1		1
11/10/2015		1	Oakview Pre-School	17241 Oak Lane	Huntington Bch, CA	92647	CUR	320	81		75	0	0	25.3%	3-5	38	46.9%	2	281	23	19	3	9	2	9	9	1
1/12/2016	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	500	81		80	45	161	16.5%	5-12	35	43.2%	5	574	25	19	7	10		11		
4/12/2016	NM	2	Paularino Elementary	1060 Paularino Ave.	Costa Mesa, CA	92626	NEW	485	130	130	117	48	166	26.8%	5-12	47	36.2%	10	445	46	24	5	10	2			1
4/5/2016	GG	2	Peters Elementary K-2	13162 Newhope St.	Garden Grove, CA	92843	CUR	1180	172		164	67	211	9.7%	5-12	109	70.2%	150	1262	53	59	14	20	6	18	9	2
11/12/2015	SA	3	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	634	155		145	20	134	24.4%	5-12	85	54.8%	29	635	46	38	9	25	6	14	7	1
&8/24/2015	AN	3	Ponderosa Elementary	2135 S. Mountain View Avenue	Anaheim, CA	92802	CUR	1032	324		291	123	441	31.4%	5-12	159	49.1%	35	1041	99	84	17	60	16	40	20	4
3/17/2016	MA	3	Pyles Elementary	10411 S. Dale Ave.	Stanton, CA	90680	NEW	721	142	142	117	61	157	19.7%	5-12	71	50.0%	19	791	56	66	8	19	2	3		2
5/16/2016	NM	4	Rea Elementary	661 Hamilton St.	Costa Mesa, CA	92627	NEW	502	192	192	177	64	195	38.2%	5-12	118	61.5%	23	502	43	4						
2/2/2016	SV	3	Reid Elementary	720 S. Western Ave.	Anaheim, CA	92804	NEW	657	147	147	138	67	263	22.4%	5-12	66	44.9%	17	706	49	35	3	13	1	11	11	2
6/8/2015	SA	4	Remington Elementary	1325 E. Fourth St.	Santa Ana, CA	92701	TAR	339	87	87	83	72	247	25.7%	5-12	36	41.4%	5	331	30	32	3					
11/30/2015	SA	2	Remington Elementary	1325 E. Fourth St.	Santa Ana, CA	92701	CUR	319	69	69	64	22	76	21.6%	5-12	43	62.3%	9	363	9	28	2	13	6	10	12	
5/3/2016	AN	5	Revere Elementary	140 W. Guinida Lane	Anaheim, CA	92805	CUR	921	314		285	130	480	34.1%	5-12	181	57.6%	21	955	118	5	1					
5/10/2016	GG	3	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	553	164		158	65	227	29.7%	5-12	72	43.9%	13	585	57	2						
2/23/2016	GG	3	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	569	184		173	76	204	32.3%	5-12	89	48.4%	15	535	67	48	4	15	6	13	16	2
4/21/2016	AN	3	Ross Elementary	535 S. Walnut St.	Anaheim, CA	92802	CUR	1005	176		163	88	201	17.5%	5-12	83	47.2%	12	1008	58	28	3	3	1	5		2
9/28/2015	GG	3	Russell Elementary	600 S. Jackson	Santa Ana, CA	92704	NEW	719	291	291	260	91	336	40.5%	5-12	123	42.3%	24	704	94	62	7	29	9	27	19	4
4/19/2016	MA	2	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	NEW	849	85	85	80	31	116	10.0%	5-12	43	50.6%	5	865	28	19	2	9	2			
9/29/2015	CE	3	San Marino Elementary	6215 San Rolando Way	Buena Park, CA	90620	CUR	583	121		114	41	139	20.8%	5-12	48	39.7%	8	635	48	25	3	18	2	10	8	1
3/8/2016	MA	2	Schweitzer Elementary	229 S. Dale Ave.	Anaheim, CA	92804	NEW	635	64	64	60	21	48	10.1%	5-12	38	59.4%	9	677	21	22	6	5	1	1		2
10/8/2015	SA	3	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	NEW	482	120	120	97	40	105	24.9%	5-12	86	71.7%	27	487	34	45	7	20	3	18	16	1
5/2/2016	NM	4	Sonora Elementary	966 Sonora Rd.	Costa Mesa, CA	92626	NEW	527	164	164	142	59	185	31.1%	5-12	79	48.2%	9	527	48	3	2	1				
9/1 & 9/8/15	AN	5	Sunkist Elementary	500 N. Sunkist St.	Anaheim, CA	92806	CUR	875	288		277	123	380	32.9%	5-12	138	47.9%	15	945	97	69	9	32	8	28	13	
5/12/2016	GG	4	Sunnyside Elementary	9972 East Russell Ave.	Garden Grove, CA	92844	NEW	698	266	266	204	85	257	38.1%	5-12	152	57.1%	26	699	130	1				1		
9/21/2015	CE	2	Temple Elementary	7800 Holder St.	Buena Park, CA	90620	CUR	504	113		106	32	107	22.4%	5-12	39	34.5%	4	532	42	13	6	13		4	2	
1/28/2016	TU	1	Thorman Elementary	1402 Sycamore Ave	Tustin, CA	92780	TAR	572	162	162	145	72	189	28.3%	5-12	89	54.9%	23	591	41	56	6	18	8	23	8	2
2/16/2016	TU	2	Tustin Ranch Elementary	12950 Robinson Dr.	Tustin, CA	92782	NEW	655	83	83	68	30	111	12.7%	5-12	33	39.8%	2	668	34	17	1	9	2	9	4	1
& 12/9/15	TU	1	Veeh Elementary	300 South C St.	Tustin, CA	92780	TAR	429	134	134	115	48	166	31.2%	5-12	65	48.5%	12	403	37	32	9	19	5	12	5	3
11/9/2015	CY	2	Vessels Elementary	5900 Cathy Ave.	Cypress, CA	90630	TAR	685	43	43	37	0	0	6.3%	5-12	18	41.9%	0	708	22	7	2		2	1	3	
5/9/2016	NM	2	Victoria Elementary	1025 Victoria St.	Costa Mesa, CA	92627	NEW	363	82	82	73	25	97	22.6%	5-12	47	57.3%	6	388	30	3						
3/31/2016	GG	3	Violette Elementary	12091 Lampson Ave.	Garden Grove, CA	92840	CUR	562	274		254	111	308	48.8%	5-12	91	33.2%	25	542	101	76	10	35	6	5		2
1/14/2016	GG	2	Wakeham Elementary	7772 Chapman Ave	Garden Grove, CA	92840	CUR	354	87		81	39	102	24.6%	5-12	45	51.7%	8	368	33	24	6	6	4	9	1	
4/18/2016	MA	2	Walter Elementary	10802 Rustic Ln.	Anaheim, CA	92804	NEW	607	172	172	138	54	202	28.3%	5-12	64	37.2%	14	669	52	35	9	13	3			
5/5/2016	GG	4	Warren Elementary	12871 Estock Dr.	Garden Grove, CA	92840	NEW	469	246	246	232	112	366	52.5%	5-12	140	56.9%	17	531	95	5						
1/7/2016	WE	2	Webber Elementary	14142 Hoover St	Westminister, CA	92683	CUR	362	114		105	53	142	31.5%	5-12	62	54.4%	17	371	45	25	3	14	5	11	4	1
2/4/2016	OV	3	Westmont/Lake View Elementa	8251 Heil Ave.	Westminister, CA	92801	CUR	912	149		131	59	148	16.3%	5-12	76	51.0%	14	628	59	39	1	19	5	14	11	1
& 4/11/16	NM	5	Whittier Elementary	1800 Whittier Ave.	Costa Mesa, CA	92627	NEW	715	345	345	280	127	371	48.3%	5-12	177	51.3%	27	744	88	99	9	44	7	7		4
5/31/2016	NM	3	Wilson Elementary	801 W. Wilson St.	Costa Mesa, CA	92627	NEW	477	89	89	80	67	176	18.7%	5-12	52	58.4%	7	486	24							
3/21/2016	GG	2	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	NEW	427	162	162	144	63	215	37.9%	5-12	81	50.0%	18	477	50	35	4	27				
10/31/2016	GG	2	Anthony Elementary	15320 Pickford St.	Westminster, CA	92683	CUR	418	98		82	22	71	22.4%	5-12	48	49.0%	14	440	68	23	2	19	1	6		3
12/2/2016	GG	3	Anthony Elementary	15320 Pickford St.	Westminster, CA	92683	CUR	475	77		67	38	94	49.4%	5-12	45	58.4%	5									
& 11/1/2016	MA	4	Baden Powell Elementary	2911 W. Stonnybrook Dr.	Anaheim, CA	92804	CUR	661	207		186	66	209	31.9%	5-12	125	60.4%	31	721	84	46	8	25	2	4	2	5
10/27/2016	TU	2	Benson Elementary	12712 Elizabeth Way	Tustin, CA	92780	CUR	380	126		85	37	105	29.4%	5-12	70	55.6%	17	393	58	42	11	3	5		4	
10/6/16 & 10/10/16	TU	5	Beswick Elementary	1362 Mitchell Ave.	Tustin, CA	92780	CUR	600	303		262	118	352	38.9%	5-12	183	60.4%	39	612	102	78	13	53	6	8	1	7
5/8,9 & 11/2017	AN	3	Betsy Ross Elementary	535 S. Walnut St.	Anaheim, CA	92802	CUR	928	179		166	60	159	33.5%	5-12	100	55.9%	12	1103	58	29	10	24	4	6		3
1/9/2017	GG	2	Brookhurst Elementary	9821 Catherine Ave.	Garden Grove, CA	92841	CUR	532	156		149	33	96	21.2%	5-12	100	64.1%	21	500	48	23	6	23	3	7	1	2
4/17&18 & 5/2,30/2017	GG	4	Bryant Elementary	8371 Orangewood	Garden Grove, CA	92841	CUR	700	323		299	103	283	31.9%	5-12	207	64.1%	23	733	126	72	7	42	11	22		2
5/16 & 5/22/2017	CE	2	Buena Terra Elementary	8299 Holder St.	Buena Park, CA	90620	CUR	530	137		120	18	70	13.1%	5-12	62	45.3%	7	544	4	2	1		1			
3/7,9,10, & 13/2017	GG	4	Clinton Elementary	13641 Clinton St.	Garden Grove, CA	92843	CUR	651	215		185	50	149	23.3%	5-12	115	53.5%	16	684	77	50	1	35	6	12		2
6/2/2016	NM	2	College Park Elementary	2380 Notre Dame Rd.	Costa Mesa, CA	92626	NEW	575	87	87	78	34	79	39.1%	5-12	52	59.8%	8	546	29	25	2	10	4	3	1	1
9/29/2016	GG	3	Cook Elementary	9802 Woodbury Ave.	Garden Grove, CA	92844	CUR	353	178		167	82	221	46.1%	5-12	98	55.1%	16	367	101	30	2	13	1	5		
4/10,11,14/2017	SA	3	Davis Elementary	1405 French St.	Santa Ana, CA	92701	CUR	639	203		182	66	170	32.5%	5-12	159	78.3%	28	557	110	1	1	41	6	18		

Back to Agenda

2/6/17 & 2/7/17	SA	3	Diamond Elementary	1450 S. Center St.	Santa Ana, CA	92704	CUR	542	238		218	45	153	18.9%	5-12	166	69.7%	31	547	35	45	5	19	9	20		
12/12/16 & 2/3/17	MA	4	Disney Elementary	2323 W. Orange Ave.	Anaheim, CA	92804	CUR	659	138		224	75	246	54.3%	5-12	138	100.0%	21	666	128	15	4	18	2	5	1	1
5/15/2017	CE	1	Dysinger Elementary	7770 Camellia Dr.	Buena Park, CA	90620	CUR	480	181		173	14	47	7.7%	5-12	105	58.0%	11	491	44	27	7	2	1	9		4
8/23/2016	AN	2	Edison Elementary - Tracks A&B	1526 E. Romneya	Anaheim, CA	92805	CUR	494	117		111	38	83	32.5%	5-12	74	63.2%	17	250								
9/20/2016	AN	2	Edison Elementary (Tracks C&D)	1526 E. Romneya	Anaheim, CA	92805	CUR	414	101		94	25	83	24.8%	5-12	71	70.3%	11	265	62	91	8	20	4	10	8	3
11/3/16 & 11/4/16	TU	4	Estock Elementary	14741 North B Street	Tustin, CA	92780	CUR	640	289		259	76	192	26.3%	5-12	179	61.9%	27	673	119	81	8	28	4	13	1	4
12/15/2016	TU	1	Estock Elementary (Add'l Sealant Day)	14741 North B St.	Tustin, CA	92780	CUR					44	94	#DIV/0!	5-12		#DIV/0!										
1/10/2017	GG	3	Faylane Elementary	11731 Morrie Lane	Garden Grove, CA	92840	CUR	610	172		157	55	186	32.0%	5-12	104	60.5%	18	550	64	11	6	18	2	1		2
11/17/2016	TU	2	Foss Elementary	18492 Vanderlip Ave.	Santa Ana, CA	92705	CUR	460	131		120	43	121	32.8%	5-12	78	59.5%	11	476	65	31	2	10		2	2	1
9/15/16 & 9/20/16	AN	4	Franklin Elementary (Anaheim)	521 W. Water St.	Anaheim, CA	92805	CUR	855	316		291	121	325	38.3%	5-12	186	58.9%	38	862	121	89	13	33	2	5	3	8
10/20/15 & 10/25/16	SA	5	Franklin Elementary (Santa Ana)	210 W. Cubbon St.	Santa Ana, CA	92701	CUR	450	205		186	92	244	44.9%	5-12	131	63.9%	27		61	70	9	19	1	3	2	1
1/23 & 26/2017	GG	2	Gilbert Elementary	9551 Orangewood Ave.	Garden Grove, CA	92841	CUR	543	146		138	30	91	20.5%	5-12	99	67.8%	18	580	73	11	2	13	1	3		1
3/13,14,16 & 4/11/2017	SA	4	Glenn Martin Elementary	939 W. Wilshire Ave.	Santa Ana, CA	92707	CUR	698	311		297	142	311	45.7%	5-12	191	61.4%	34	673	125	69	4	31	3	16		3
3/27,28,31/ 2017	SA	3	Harvey Elementary	1635 S. Center St.	Santa Ana, CA	92704	CUR	455	158		146	35	104	22.2%	5-12	121	76.6%	19	469	75	54	6	31	2	14		1
10/24/16 & 10/27/16	GG	4	Hazard Elementary	4218 W. Hazard Ave.	Santa Ana, CA	92703	CUR	545	238		217	71	227	29.8%	5-12	140	58.8%	32	567	142	63	10	21	2	4	2	1
11/8/16, 11/14/16 & 11/15/16	TU	5	Heideman Elementary	15571 Williams St.	Tustin, CA	92780	CUR	650	326		292	56	172	17.2%	5-12	177	54.3%	32	620	105	85	7	22	2	11	1	6
1/6/2017	TU	1	Heideman Elementary (Add'l Sealant Day)	15571 Williams St.	Tustin, CA	92780	CUR					45	132	#DIV/0!	5-12		#DIV/0!										
2/9/2017	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	541	134		124	79	189	59.0%	5-12	81	60.4%	7	585	98	32		24	3	16		2
4/20 & 24/2017	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	541	130		118	63	160	48.5%	5-12	50	38.5%	10									
11/15/16 & 11/18/16	GG	2	Hill Elementary	9681 11th St.	Garden Grove, CA	92844	CUR	370	137		116	34	83	60.6%	5-12	80	58.4%	16	375	18	25	2	22		6	3	
6/7/2016	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	990	269		258	93	296	34.6%	5-12	187	69.5%	23	851	79	170	28	70	20	37	13	6
4/24,25,27/ 2017	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	925	243		218	88	235	36.2%	5-12	152	62.6%	25	933								
10/18/16 & 10/20/16	GG	3	Lawrence Elementary	12521 Monroe	Garden Grove, CA	92841	NEW	600	188	188	162	52	180	27.7%	5-12	137	72.9%	29	599	80	62	5	17		7		2
4/6/2017	CE	2	Los Coyotes Elementary	8122 Moody St.	La Palma, CA	90623	CUR	535	262		236	47	157	17.9%	5-12	43	16.4%	4	540	49	21		33	1	8		2
1/12/17 & 1/17/17	MA	4	Low Elementary	215 N. Ventura St.	Anaheim, CA	92801	CUR	635	188		178	85	231	45.2%	5-12	96	51.1%	26	634	61	29	10	16	5	9	3	3
4/13,14,18, 21 & 9/8/16	SA	5	Lowell Elementary	700 S. Flower St.	Santa Ana, CA	92703	CUR	844	319		286	145	431	45.5%	5-12	165	51.7%	46	861	126	70	8	36	2	16		4
9/22/16	AN	4	Mann Elementary	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	876	133		124	53	142	39.8%	5-12	90	67.7%	18		83	72	6	27	3	5	6	3
8/25/2016	AN	2	Mann Elementary - Tracks A&B	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	438	100		83	19	43	19.0%	5-12	68	68.0%	14	727								
10/17/2016 & 11/8/16	MA	4	Marshall Elementary	2627 Crescent Ave.	Anaheim, CA	92801	CUR	700	251		226	77	218	30.7%	5-12	139	55.4%	23	736	130	61	5	13	4	11	2	2
1/17/2017	GG	2	Marshall Elementary	15791 Bushard Ave.	Westminster, CA	92683	CUR	414	169		158	31	109	18.3%	5-12	117	69.2%	23	423	61	23	4	11	2	4	2	1
12/1/16 & 12/9/16	MA	5	Maxwell Elementary	2613 W. Orange Ave.	Anaheim, CA	92804	CUR	822	228		213	66	183	28.9%	5-12	142	62.3%	29	857	70	28	4	32	2	10	2	1
5/1,4, & 5/2017	CE	3	Miller Elementary	7751 Furman Rd.	La Palma, CA	90623	CUR	578	146		134	57	155	39.0%	5-12	51	34.9%	1	614	36	18	3	20		6		4
1/19/17 & 1/31/17	GG	4	Mitchell Elementary	13451 Taft Ave.	Garden Grove, CA	92843	CUR	453	181		170	30	71	16.6%	5-12	122	67.4%	23	471	87	14	6	18		3	2	
11/7/2016	TU	2	Nelson Elementary	14392 Browning Ave.	Tustin, CA	92780	CUR	545	155		137	35	112	22.6%	5-12	74	47.7%	14	562	53	29	3	19		4	1	3
1/27/2017	GG	3	Newhope Elementary	4419 West Regent Dr.	Santa Ana, CA	92704	CUR	411	123		113	51	168	41.5%	5-12	41	33.3%	6	420	33	4	3	6	1		1	1
10/25/2016	AN	2	Orange Grove Elementary	1000 S. Harbor Blvd.	Anaheim, CA	92805	NEW	690	120	120	108	23	65	19.2%	5-12	67	55.8%	18	681	33	38	8	15	1	3	3	3
2/14/2017	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	520	119		115	15	60	12.6%	5-12	78	65.5%	7	549	11	47	3	27	4	25		1
3/24 & 29/2017	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	500	106		93	38	98	35.8%	5-12	58	54.7%	6									

Back to Agenda

3/20,21,23, 30,31/2017; 4/3,4,20/20 17	GG	8	Peters Elementary	13162 Newhope St.	Garden Grove, CA	92843	CUR	1290	559		509	164	464	29.3%	5-12	324	58.0%	40	1302	199	125	8	94	14	44		5
2/27/17 & 2/28/17	SA	3	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	600	237		226	50	163	21.1%	5-12	173	73.0%	29	618	8	74	4	36	4	32	2	2
3/2/2017	SA	1	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	600				50	167	21.1%	5-12		#DIV/0!										
6/13/2016	NM	3	Pomona Elementary	2051 Pomona Ave.	Costa Mesa, CA	92627	CUR	512	265		212	67	206	25.3%	5-12	139	52.5%	15	523	90	70	7	29	5	18	1	1
9/1/16 & 9/19/16	AN	5	Ponderosa (Tracks C&D)	2135 S. Mountain View Ave.	Anaheim, CA	92802	CUR	530	313		279	125	338	39.9%	5-12	203	64.9%	39	552	148	152	29	71	15	13	9	5
8/26/2016	AN	2	Ponderosa Elementary - A&B	2135 S. Mountain View Ave.	Anaheim, CA	92802	CUR	530	177		162	57	129	32.2%	5-12	116	65.5%	28	530								
6/6/2016	GG	4	Post Elementary	14641 Ward Street	Westminster, CA	92683	NEW	536	236	236	220	88	330	37.3%	5-12	127	53.8%	24	562	214	58	7	58	4	15		4
2/16/17 & 2/17/17	GG	4	Post Elementary	14641 Ward St.	Westminster, CA	92683	CUR	520	224		201	76	217	33.9%	5-12	130	58.0%	16	526								
11/14/16 & 11/18/16	MA	3	Pyles Elementary	10411 S. Dale St.	Stanton, CA	90680	CUR	742	229		197	32	97	14.0%	5-12	117	51.1%	31	785	85	53	11	19		8	3	4
1/25/2017	MA	1	Pyles Elementary (Add'l Sealant Day)	10411 S. Dale St.	Stanton, CA	90680	CUR					21	77	#DIV/0!	5-12		#DIV/0!										
5/11,12 & 16/2017	CE	3	Raymond Temple Elementary	7800 Holder St.	Buena Park, CA	90620	CUR	540	198		174	44	139	22.2%	5-12	89	44.9%	18	569	22	12	4	8	3	2		3
22 & 24/2017	AN	5	Revere Elementary	140 W. Guinida Lane	Anaheim, CA	92805	CUR	871	299		278	138	397	46.2%	5-12	140	46.8%	21	941	98	54	2	40	4	21		5
2/21/17 & 2/24/17	GG	4	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	580	266		238	51	164	19.2%	5-12	174	65.4%	23	588	37	50	8	71	3	15		4
3/15/2017	GG	4	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	550				30	90	11.3%	5-12		#DIV/0!										
2/23/17 & 2/24/17	GG	5	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	500	231		214	68	354	29.4%	5-12	142	61.5%	25	522	11	59	8	46	3	23	2	1
3/1/2017 & 3/21/17	GG	2	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	500				69	205	29.9%	5-12		#DIV/0!										
9/26/16 & 9/27/16	GG	5	Russell Elementary	600 S. Jackson St.	Santa Ana, CA	92704	CUR	690	301		281	102	329	33.9%	5-12	209	69.4%	51	628	112	114	7	22	6	9	11	3
11/29/16 & 12/1/16	MA	1	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	CUR	800	119		109			0.0%	5-12	67	56.3%	16	838	78	41	4	19		8	1	3
12/1/2016	MA	2	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	CUR	849	85		81	66	195	77.6%	5-12	33	38.8%	7									
5/22 & 23/2017	CE	2	San Marino Elementary	6215 San Rolando Way	Buena Park, CA	90620	CUR	580	218		198	31	109	14.2%	5-12	105	48.2%	11	586								
10/1/2016	MA	2	Schweitzer Elementary	229 S. Dale Ave.	Anaheim, CA	92804	CUR	635	159		147	42	121	26.4%	5-12	124	78.0%	20	665	73	49	4	14	2	3	7	3
2/2/17 & 2/7/17	SA	3	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	CUR	415	188		168	48	111	25.5%	5-12	109	58.0%	24	424	59	22	6	17	1	4		1
3/1 & 3/2/2017	SA	1	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	CUR	415				19	46	10.1%	5-12		#DIV/0!										
3/6, 3/9 & 3/10/17 & 4/7/17	GG	4	Simmons Elementary	11602 Steele Dr.	Garden Grove, CA	92841	NEW	453	222	222	206	57	182	25.7%	5-12	146	65.8%	25	445	103	59	2	38	4	25		
9/13/16, & 5/18,19,23 & 26/2017	AN	4	Sunkist Elementary	500 N. Sunkist St.	Anaheim, CA	92806	CUR	864	365		343	137	386	37.5%	5-12	230	63.0%	44	899	83	97	5	55	7	10	4	7
	GG	4	Sunnyside Elementary	9972 E. Russell Ave.	Garden Grove, CA	92844	CUR	665	227		199	74	219	32.6%	5-12	101	44.5%	21	683	8	5	2	2	1			
12/1/16 & 1/5/17	TU	6	Thorman Elementary	1402 Sycamore Ave.	Tustin, CA	92780	CUR	573	281		263	105	298	37.4%	5-12	179	63.7%	39	601	71	44	15	28	7	13	3	5
12/13/2016	TU	2	Tustin Ranch Elementary	12950 Robinson Dr.	Tustin, CA	92782	CUR	646	150		132	19	71	12.7%	5-12	63	42.0%	11	638	88	10	4	14		3		
12/8/16 & 1/30/17	TU	4	Veeh Elementary	300 South C St.	Tustin, CA	92780	CUR	432	170		164	63	181	37.1%	5-12	103	60.6%	17	451	58	21	9	24	2	3	2	2
4/3,4,25, & 27/2017	GG	4	Violette Elementary	12091 Lampson Ave.	Garden Grove, CA	92840	CUR	500	224		209	102	262	45.5%	5-12	125	55.8%	15	504	93	49	3	31	5	18		2
10/4/2016	GG	2	Wakeham Elementary	7772 Chapman Ave.	Garden Grove, CA	92840	CUR	344	100		79	33	110	33.0%	5-12	85	85.0%	22	343	43	38	6	9	2	3	2	1
12/6/16 & 1/10/17	MA	4	Walter Elementary	10802 Rustic Lane	Anaheim, CA	92804	CUR	624	161		144	47	125	29.2%	5-12	105	65.2%	15	658	70	24	2	11	5	7	1	
3/2,6,7 & 4/3/17	GG	5	Warren Elementary	12871 Estock Dr.	Garden Grove, CA	92840	CUR	488	212		203	99	270	46.7%	5-12	111	52.4%	18	530	72	154	3	36	2	27		
5/25,26 & 30/2017	SA	3	Washington Elementary	910 W. Anahurst Pl.	Santa Ana, CA	92704	NEW	823	153	153	128	58	174	37.9%	5-12	84	54.9%	12	825								
6/3/2016	NM	3	Wilson Elementary	801 W. Wilson St.	Costa Mesa, CA	92627	NEW	477	111	111	100	67	176	60.4%	5-12	12	10.8%	10	486	32	36	4	18	3	16	4	1
6/9/2016	SA	4	Wilson Elementary	1317 N. Baker St.	Santa Ana, CA	92706	CUR	720	294		266	133	266	45.2%	5-12	150	51.0%	33	749	88	73	8	39	4	16	14	1
1/26/2017	GG	2	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	CUR	410	92		84	26	68	28.3%	5-12	41	44.6%	5	440	64	17	2	23	3	5		

Back to Agenda

3/12,27,30/ 2017	GG	3	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	CUR	410	94		88	67	198	71.3%	5-12	41	43.6%	14																			
		##						108,211	29,753	7,468	27,018	10,470	31,698	27.5%		16,125	54.2%	3,028	102,896	9,873	6,286	953	3,151	543	1,575	560	245										
		##							27.5%	25.1%	90.8%	35.2%				54.2%		10.2%		33.2%	39.0%	5.9%	19.5%	3.4%	9.8%	3.5%	1.5%										
																				5,351			29.2%	5.0%	14.6%	5.2%	2.3%										
																				10,774																	
																										24.5%										
																										13.1%										

[Back to Agenda]

CC	225	34			Target	New	Screenings
DI	569	29					
MA	448	24		1st	2	0	1492
BE	349	20		2nd	10	4	4023
ES	361	28		3rd	5	8	3091
WE	358	13		4th			
DA	642	38					
PA	538	36					
WA	347	21					
HE	632	23					
LO	911	36					
AN	466	24					
TH	570	21			17	12	8606
HA	679	40					
RE	678	28					
WES	594	34					
PE	1238	24					
HO	533	24					
TR	643	25					
CE	522	28					
LO	703	26					
RO	510	25					
BP	676	32					
BR	744	26					
	13936	659	14595				

Back to Agenda

IGT 5 Requests for Proposal
1. Access to Children's Dental Services

Appl. ID #	Organization Name	Request ($)	Project Title	Proposed Partners	Project Description	Additional CalOptima Members Served	Initial Assessment	Site Visit	Financial Assessment	Comments
198	Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	• Families Together of Orange County (FQHC Look-Alike in Tustin and expanding to Anaheim) • Korean Community Services (FQHC Look-Alike in Buena Park) • North Orange County Regional Health Foundation (FQHC Look-Alike in Fullerton) • Serve the People (FQHC in Santa Ana) • Southland Integrated Services (FQHC in Garden Grove) • Anaheim Union High School District • Boys and Girls Clubs • Buena Park School District • Centralia School District • Fullerton School District • Hands Together • KidWorks • Lighthouse Community Centers • Project Access • Rancho Santiago Community College District • Santa Ana Unified School District • The Cambodian Family • Tustin Unified School District	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	4.87	Yes	Yes	• The project will expand pediatric dental services with preventative and restorative dental care • There is no mention of the Dental Transformation Initiative (DTI) in the proposal and whether the propose project will be different from DTI or a continuation of DTI • Unsure of how safety net clinic/co-lead would maintain staffing <u>Site Visit:</u> • The collaborative clinics are very passionate of the work • One of the five clinics currently does no have a fixed site dental program, they will need to build out a program • For all sites a mobile unit will need to be built out to implemented the mobile dental program • Not entirely clear on the implementation of the program
191	Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	• Smile Center in Garden Grove • Smile Clinic at CHOC Children's • Garden Grove Unified School District • Santa Ana Unified School District • Westminster Unified School District • Anaheim Unified School District • Buena Park Unified School District • La Palma Unified School District • Tustin Unified School District • Fountain Valley Unified School District • Stanton Unified School District • Placentia Unified School District • Fullerton Unified School District • USC's Herman Ostrow School of 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	4.65	Yes	Yes	• Project will expand services and ramp-up of mobile restorative program for all four mobile and a new mini clinic • Organization has deep knowledge and experience providing comprehensive dental services and link member back to a dental home • Mobile unit can be up and running in three months for immediate impact <u>Site Visit:</u> • Well established organization and supportive leadership • Presentation was well organized • Goals and objective are well understood

Summary: Provided to IGT 5 Board Ad Hoc Committee

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Authorizing Supplemental Payments to Health Networks for Specific Home Health Agency Services

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

Recommended Actions
1. Authorize the Chief Executive Officer (CEO) to make supplemental payments for specific home health agency services to health networks from July 1, 2018, through June 30, 2019;
2. Approve disbursement methodology for these supplemental payments;
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
4. Authorize the CEO to execute agreements and/or contract amendments as necessary for implementation.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) increased the excise tax rate on cigarettes and tobacco products to fund specified expenditures. Senate Bill (SB) 856 appropriated Proposition 56 funds in the 2018-19 state fiscal year (SFY) for defined DHCS supplemental payment expenditures.

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the one percent (1%) payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency and certain Pediatric Day Health Care services by fifty percent (50%) effective July 1, 2018. The following procedure codes (or their HIPAA compliant equivalent) provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These procedure codes mainly apply to pediatric Medi-Cal members. As such, implementing the new rates will directly affect the Whole Child Model (WCM) population.

Procedure Code	Medi-Cal Rate		Procedure Code	Medi-Cal Rate
Z5804	$47.91		Z5834	$44.12
Z5805	$52.70		Z5835	$48.53
Z5806	$36.63		Z5836	$68.15
Z5807	$40.29		Z5838	$28.35
Z5832	$60.86		Z5840	$53.66
Z5833	$66.95		Z5868	$44.12

DHCS noted that providers in the Medi-Cal fee-for-service (FFS) delivery systems and impacted Home and Community-based Services (HCBS) waivers will receive the rate increases.

Back to Agenda

Discussion

Staff updated internal systems to reflect the increased rates for certain home health agency services on August 28, 2018. Providers contracted directly with CalOptima (i.e., CalOptima Direct, CalOptima Care Network) received a retroactive true-up payment (effective July 1, 2018) and began receiving updated rates in September 2018.

With no additional funding anticipated from DHCS, Staff assumes that costs and trends for the increased rates for home health agency services will be incorporated in a future Rate Development Template (RDT). In general, a unit cost change imposed by DHCS will not result in a supplemental payment beyond CalOptima's primary capitation to health networks. These cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions.

However, given the 50% unit cost trend applied by DHCS and the corresponding negative fiscal impact to health networks, Management recommends the provision of a supplemental payment for the period of July 1, 2018, through June 30, 2019. Beginning July 1, 2019, with the implementation of the WCM program, the majority (approximately 80% to 85%) of home health agency services will be incorporated into the health networks' WCM all-inclusive capitation rate. As such, the end-date for the supplemental payment methodology is June 30, 2019.

Proposed Payment Methodology

Health Networks will submit encounter data evidencing the Health Networks' reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019, to CalOptima. If a Health Network has made payments at the increased rate, CalOptima will reimburse the Health Network for the increased unit cost expense. CalOptima staff will evaluate the encounter data in October 2019 and perform a final reconciliation in April 2020 to confirm that Health Networks have made payments at the higher rates. CalOptima will incorporate the home health unit cost adjustment in the HMO/PHC hospital capitation benchmark for the shared risk pool calculation for Fiscal Year (FY) 2018-19.

Fiscal Impact

The annual delegated volume for certain home health agency services from July 1, 2018, through June 30, 2019, is approximately $4.3 million. The net fiscal impact to CalOptima, assuming a 50% unit cost trend, is approximately $2.15 million. Staff anticipates that the forecasted expense trend included in the Board-approved FY 2019-20 Medi-Cal Operating Budget is sufficient to cover the anticipated costs related to the recommended action, inclusive of the resulting increase to the shared risk pool payout.

Rationale for Recommendation

The recommended action will ensure that CalOptima's delegated entities are appropriately funded for home health agency services in order to pay providers at the increased rates.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action ~~None~~

Rev. 10/3/19

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

Attachment to the October 3, 2019 Board of Directors Meeting – Agenda Item 13

Rev. 10/3/19

Health Network	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
Family Choice Medical Group	15821 Ventura Blvd.m #600	Encino	CA	91436
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
ARTA Western California Inc.	3390 Harbor Blvd	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite	Orange	CA	92868
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, P.C.	3390 Harbor Blvd	Costa Mesa	CA	92626
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 October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to:
   a. Amend the CalOptima Medi-Cal Health Network Contracts, except those associated with AltaMed Health Services Corporation, to provide Health Homes Program (HHP) services, including responsibilities as Community Based-Care Management Entities (CB-CMEs), as well as include all subcontracting requirements of the California Department of Health Care Services (DHCS);
   b. Amend the Business Associate Agreements, as necessary, for network data sharing; and
2. Ratify the Behavioral Health Memorandum of Understanding (MOU) amendment with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in the Health Homes Program, effective October 1, 2019.

Background/Discussion

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option, which is intended to improve member outcomes and reduce health care costs 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).

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 30,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. HHP eligible members who are currently in Whole Person Care Pilot program can also elect to enroll in HHP, however services provided under both programs cannot be duplicated. CalOptima's dually eligible

Back to Agenda

members can be referred to participate in HHP by community providers if members meet HHP eligibility criteria.

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 can leverage existing infrastructure to incorporate the new HHP services.

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 Contracts
In order to implement HHP, CalOptima health network contracts will need to be amended, effective January 1, 2020, to include providing HHP services, expectations of CB-CME responsibilities, guidelines for information and data sharing, as well as HHP training. 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.

Amendment to County Behavioral Health MOU
Pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding (MOU) 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. The Behavioral Health MOU between CalOptima and the County of Orange has been amended to reflect that CalOptima and the County agree to coordinate appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

Back to Agenda

Implementation Efforts
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and adjust 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. Currently, CalOptima's policies impacted by HHP requirements have been submitted to DHCS as part of the HHP regulatory submission requirements. Once CalOptima receives the feedback from DHCS, CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

Additionally, CalOptima staff will continue to collaborate with Orange County HCA, Health Networks, and other stakeholders for Phase II of the Health Homes Program for SUD, SMI, and homelessness consistent with requirements as specified by DHCS.

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. 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

Back to Agenda

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 *9/25/2019*
Authorized Signature **Date**

Back to Agenda

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 14

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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 — *5/30/2018*

Authorized Signature — **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

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

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

Medi-Cal Health Homes Program
Program Guide
7/01/19

Back to Agenda

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;

Back to Agenda

- 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.

SAMPLE

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,

Back to Agenda

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.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Associated with AltaMed Health Services Corporation to include language for the Health Homes Program

Contact

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

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to Amend the CalOptima Medi-Cal Health Network Contracts associated with AltaMed Health Services Corporation to provide Health Homes Program (HHP) services including responsibilities as Community Based-Care Management Entities (CB-CMEs)

Background/Discussion

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option, which is intended to improve member outcomes and reduce health care costs 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).

Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. 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.

In order to implement HHP, staff seeks approval to amend CalOptima's health network contract associated with AltaMed Health Services Corporation to include expectations of CB-CME responsibilities to provide HHP services effective 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.

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

Back to Agenda

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. 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 above 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. 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
2. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
3. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
4. Contracted Entities Covered by this Recommended Board Action | *Rev. 10/3/19*

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

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 — *5/30/2018*

Authorized Signature — **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

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;

Back to Agenda

- 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.

SAMPLE

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,

Back to Agenda

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

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

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

Health Network	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services

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. Approve recommended vendor Illumination Foundation for HHP select services for accompaniment and housing related services;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with the recommended vendor, effective January 1, 2020; and
3. In the event CalOptima and Illumination Foundation are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Maxim Healthcare Services, for HHP select services for accompaniment and housing related services.

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 (Board) 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, the funding returns to the standard Medicaid funding (Federal 50%/State 50%).

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

Back to Agenda

and Community-Based Care Management Entities (CB-CMEs). Per the DHCS requirements, HHP services are to be provided and coordinated through the network of CB-CMEs. In addition, 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 Supports

Under HHP, members will be eligible for new services, including housing navigation, housing tenancy sustainability, and accompaniment to clinical appointments. CalOptima plans to contract with a vendor for these HHP select services.

Discussion

New HHP services include accompaniment to clinical appointments, housing transition services and tenancy sustaining services. Following CalOptima's standard RFP process in accordance with CalOptima Policy GA.5002: Purchasing, CalOptima staff conducted a Request For Proposal (RFP) processes to procure vendors for these new HHP select services beginning January 1, 2020. The new HHP select services are provided in-person and do not include direct medical care services. An HHP select services vendor is not required to be registered with the Medi-Cal program. Health networks, as CB-CMEs, will have the ability to contract with the selected vendor(s).

In response to the RFP, CalOptima received responses from:

- American Family Housing
- Illumination Foundation
- Maxim Healthcare Services

The submitted proposals were reviewed by an internal evaluation team consisting of representatives from Business Integration, Medical Affairs, Strategic Development, Network Management, Contracting, Vendor Management, Operations, Finance, Behavioral Health and Information Services.

The recommended vendor will provide the HHP select services in-person and participate in the member's care team meetings. The vendor is expected to capture, track, and report all services and coordinated efforts to CalOptima and care team members as appropriate. Additionally, the vendor will make the same HHP select services available to the health networks either through CalOptima's contract or a separate contract with the individual health network.

Vendor	Final Weighted Score
American Family Housing	11.00
Illumination Foundation	22.35
Maxim Healthcare Services	16.60

Back to Agenda

Based on the final weighed scores, staff recommends contracting with the Illumination Foundation for select HHP services.

Founded in 2008, Illumination Foundation is a 501 (c)(3) non-profit organization dedicated to the mission of providing targeted and interdisciplinary services. Illumination Foundation has experience working with similar populations as HHP eligible members. They believe that every person has an intrinsic right to home, health, and dignity. Their direct client care staff includes case managers, housing navigators, behavioral health therapists, substance use counselors, and a variety of healthcare workers (LVNS, RNs, nurse practitioners) who follow clients as they access emergency shelter, recuperative care, and housing related services with the overall goal to achieve longer-term health and housing outcomes. The agency has served more than 52,825 individuals since its inception.

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. 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

Back to Agenda

Attachments

1. 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
5. HHP Select Services RFP

/s/ Michael Schrader *9/25/2019*

Authorized Signature **Date**

Back to Agenda

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 16

Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip
American Family Housing	15161 Jackson Street	Midway City	CA	92655
Illumination Foundation	1091 N. Batavia St.	Orange	CA	92867
Maxim Healthcare Services	7227 Lee Deforest Drive	Columbia	MD	21046

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 — *5/30/2018*

Authorized Signature — **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

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;

Back to Agenda

- 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.

SAMPLE

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,

Back to Agenda

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

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

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

June 06, 2019

NOTICE OF REQUEST FOR PROPOSALS (RFP)

#19-021A

GENERAL CONDITIONS AND INSTRUCTIONS TO OFFERORS

For

Health Homes Program Select Services – Revised

Key RFP Dates

Written Questions Due: June 24, 2019, 2:00, PM Pacific Time
Proposal Submittal Date: July 11, 2019, 2:00 PM Pacific Time

Back to Agenda

Inviting Request for Proposals (RFP) 19-021A for Health Homes Program Select Services - Revised

CalOptima invites Proposals from qualified Offerors to provide Health Homes Program Select Services - Revised. Proposals shall be prepared and submitted in accordance with the requirements set forth in this RFP #19-021A. **Proposals must be submitted via BidSync no later than 2:00 PM Pacific Time, July 11, 2019.**

Proposals, and amendments to Proposals received after the date and time specified above will be rejected by the BidSync program and will not be delivered to CalOptima.

CalOptima's Basic Philosophy: Contracting for Results

CalOptima's fundamental commitment is to contract for results. CalOptima defines a successful result as a generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support CalOptima's mission and objectives. This RFP 19-021A describes what is required of the successful Offeror in terms of services, deliverables, performance measures and outcomes, and unless otherwise noted in this RFP, places the responsibility for how they are accomplished on the successful Offeror.

Contract Elements

The term "contract" means the contract awarded as a result of this RFP 19-021A and all exhibits thereto. (See RFP Attachment 4: CalOptima Sample Contract). The successful Offeror/s will be required to accept a written contract in accordance with and included as a part thereof, this Request for Proposal, including all requirements, conditions and specifications contained therein. The Proposal, including all attachments and information on services, and associated pricing shall be binding and shall be incorporated into the written contract. At a minimum, the following documents will be incorporated into the contract:

- This RFP 19-021A and all attachments and exhibits.
- Any modifications, addendum or amendments issued in conjunction with this RFP 19-021A.
- The successful Offeror's Proposal.

Should there be any conflict between RFP 19-021A and the contract, the terms and conditions of the contract shall prevail.

It should be noted that as a public agency, CalOptima is mandated by various government entities to incorporate many of the terms and conditions listed within the entities Contract and BAA, and is unable to modify them in any way.

CalOptima is permitting each Offeror to identify the terms of the Contract and BAA it would like to negotiate. Using Attachment 5 entitled "Request to Negotiate Contract/BAA Terms," Offerors must identify the Current Language, Proposed Language, and Rationale for the

Back to Agenda

Request. Note that any request to negotiate contract terms without a rationale will not be considered for negotiation. CalOptima will evaluate all requests and render a decision on each Contract/BAA term identified.

If a "Request to Negotiate Contract/BAA Terms" form is not submitted with the proposal, the terms submitted in the Sample Contract will be in force. CalOptima will not review any changes marked on the Contract/BAA PDFs that are not included on the "Request to Negotiate Contract/BAA Terms" form. CalOptima will also not review any additional terms & conditions submitted by Vendor on Vendor paper. Even if you currently have an existing contract/BAA with CalOptima or have had one in the past, the services within this RFP are considered separate and CalOptima **will not** add them to an existing agreement.

Each deletion, addition, and modification, etc., to CalOptima's Sample Contract or BAA must be logged and submitted on the "Request to Negotiate Contract Terms" form. Failure to do so will result in your proposal being deemed non-responsive. Even if you currently have a contract or BAA with CalOptima or have had one in the past, a "Request to Negotiate Contract Terms" form

CalOptima may disqualify and terminate negotiations with any Offeror that did not take exception to a given Sample Contract or BAA provision in its proposal and subsequently attempts to do so during negotiations. As such, it is in Offeror's best interest to have the Sample Contract reviewed by counsel prior to submitting a proposal.

The successful Offeror will be required to comply with all applicable equal opportunity laws and regulations.

Sincerely,

Ryan Prest
Purchasing Manager

Table of Contents

List of RFP Attachments

SECTION I: CALOPTIMA BACKGROUND AND OVERVIEW

A. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

B. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

SECTION II: INSTRUCTIONS AND CONDITIONS

A. General Requirements

1.0 This RFP 19-021A contains a list of requirements for the successful Offeror. A qualified Offeror, for the purpose of this RFP 19-021A, is an Offeror that can reliably, competently and independently provide the required services to CalOptima for the entire term of the agreement. The contract term is One (1) year with Three (3), one year renewal options at CalOptima's discretion.

2.0 As required under Ordinance No. 3896 of the County of Orange, State of California, Offeror hereby acknowledges and agrees that the obligations of CalOptima under any resulting contract are solely the obligation of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

B. Instructions and Conditions

1.0 Examination of Proposal Documents

1.1 Before submitting a Proposal, each Offeror represents that it has thoroughly examined and become familiar with the work required under this RFP 19-021A and it is capable of performing quality work to achieve CalOptima's objectives.

1.2 Each Offeror must be satisfied by personal examination, and by such other means as it may prefer, as to the actual conditions and requirements under which the contract will be performed.

1.3 CalOptima reserves the right to remove from its list for future RFPs, for an undetermined period of time, the name of any Offeror for failure to accept a contract, failure to respond to two consecutive RFPs and/or unsatisfactory performance. Please note that a "No Bid" is considered a response.

2.0 Addenda

CalOptima may make changes to the requirements of this RFP 19-021A. Any CalOptima changes to the requirements will be made by written addendum to this RFP 19-021A. Any written addenda issued pertaining to this RFP 19-021A shall be incorporated into the terms and conditions of any resulting contract. CalOptima will not be bound to any modifications to, or deviations from, the requirements set forth in this RFP 19-021A as the result of oral instruction. All addenda will be submitted by CalOptima via BidSync.

3.0 Procurement Schedule

The following table presents the anticipated schedule for this procurement. All dates are subject to change at CalOptima's discretion. Changes to the schedule will be communicated via an addendum to this RFP through BidSync.

Event	Date
RFP 19-021A Issue Date	June 06, 2019
Written Questions due from Offerors via BidSync	June 24, 2019
Responses to Questions due from CalOptima via BidSync	June 27, 2019
Proposals due from Offerors via BidSync	July 11, 2019
Demonstrations/Interviews/Site Visits/Reference Checks	August 05 - 08, 2019
Vendor Selection	August 14, 2019

4.0 Procurement Point-of-Contact

4.1 All communications relating to this RFP 19-021A must be directed to CalOptima's designated contact below:

Ryan Prest
rprest@caloptima.org
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

4.2 Any and all communications relating to this RFP must be directed to the Vendor Management Point-of-Contact named above. Communications relating to this RFP between respondents and other CalOptima staff members concerning this RFP are strictly prohibited. Failure to comply with these requirements will result in Proposal disqualification.

5.0 Questions and Clarifications

5.1 If an Offeror desires an explanation or clarification of any kind regarding a provision of this RFP 19-021A, the Offeror must generate a written request for such explanation or clarification through BidSync by 2:00, PM Pacific Time, June 24, 2019. Inquiries received after 2:00 PM Pacific Time, June 24, 2019 will not be responded to.

5.2 CalOptima responses will be communicated via BidSync, and will be sent no later than 5:00 PM Pacific Time, June 27, 2019.

6.0 Proposal Preparation

6.1 Proposals shall be typed in 12 point font and submitted via BidSync in a Word, Excel or PDF format. Do not provide zip files. Offerors should not include any unnecessarily elaborate or promotional material.

6.2 Information shall be presented and submitted through BidSync and must be submitted in the order in which it is requested. Please limit your responses to no more than five (5) documents. Each file name must contain your company name and RFP number. The responses must directly address the items requested in each requirement. Complete, concise and specific responses are required. Lengthy narrative is discouraged.

6.3 Letter of Transmittal

A mandatory Letter of Transmittal shall be included with the Proposal and must, at a minimum, contain the following:

- Identification of Offeror, including name, address and telephone number.
- Name, title, e-mail address and telephone number of Offeror's representative during the period of proposal evaluation.
- Proposed working relationship between Offeror and subcontractors, and if not applicable, indicate so.
- A statement to the effect that the Proposal shall remain valid for a period of not less than 150 calendar days from the Proposal due date.
- Signature of a person authorized to bind Offeror to the terms of the Proposal.
- Either a statement indicating no contract changes or submit a Request to Negotiate Contract Terms as presented in this RFP as Attachment 5).
- A statement clarifying if you are bidding on one or both or the available select services.

7.0 Proposal Submittal

7.1 Date and Time

All Proposals must be submitted via BidSync and must be submitted no later than 2:00 PM Pacific Time, July 11, 2019. CalOptima recommends you begin the submission process well in advance of the proposal submission deadline to allow ample time for transmission.

7.2 Acceptance of Proposals

7.2.1 CalOptima reserves the right to accept or reject any and all proposals, or any item or part thereof, or to waive any informalities or irregularities in proposals.

7.2.2 CalOptima reserves the right to withdraw this RFP at any time without prior notice and CalOptima makes no representations that a contract will be awarded to any Offeror responding to this RFP.

7.2.3 CalOptima reserves the right to postpone proposal opening for its own convenience.

8.0 Pre-Contractual Expenses

8.1 Pre-contractual expenses are defined as expenses incurred by the Offeror in:

- preparing its proposal in response to this RFP;
- submitting its proposal to CalOptima;
- negotiating with CalOptima on any matter related to its proposal; or
- any other expenses incurred by the Offeror prior to date of award, if any, of the contract.

8.2 CalOptima shall not, in any event, be liable for any pre-contractual expenses incurred by Offeror in the preparation of its proposal. Offeror shall not include any such expenses as part of its proposal.

9.0 Joint Offers

Where two or more Offerors desire to submit a single proposal in response to this RFP 19-021A, they should do so on a prime-subcontractor basis rather than as a joint venture. CalOptima intends to contract with a single firm and not with multiple firms doing business as a joint venture.

10.0 Non-Collusion Affidavit

As part of its Proposal, Offerors are required to complete and sign the Non-Collusion Affidavit provided as RFP Attachment 2. Proposals submitted to CalOptima without a fully executed copy of the Non-Collusion Affidavit will be considered non-responsive.

11.0 Contract Type and Term

11.1 It is anticipated that the contract resulting from this solicitation, if awarded, will be a firm-fixed price contract unless otherwise specified.

11.2 The initial term of any resulting agreement shall be for a period of One (1) year, with an anticipated effective date of TBD, with Three (3) consecutive, one year renewal options at CalOptima's discretion.

12.0 Eligibility for Contract Award

CalOptima will not award this RFP or enter into a contract with any Offeror who is debarred, suspended or otherwise ineligible for the award of a contract or grant by any Federal agency or from participating in Federal Healthcare Programs. By submission of this proposal, Offeror

acknowledges and warrants that the Offeror and any of its officers, directors, owners, partners, or any person having primary management or supervisory responsibilities within the Offeror's business are not presently debarred, suspended, proposed for debarment or declared ineligible for the award of contracts by any Federal agency or from participating in any Federal healthcare programs. Offerors must complete RFP Attachment 3 entitled "Offeror Eligibility Certification" and submit as part of its proposal.

13.0 Withdrawal of Offers

Offers may be withdrawn only by signature of Offeror, provided the request is received by the person whose duty it is to open proposals prior to the time fixed for proposal opening. Each proposal opened will be considered to be a valid offer.

14.0 Use of Offeror Response and Accompanying Material

14.1 All materials submitted become the property of CalOptima and will not be returned. If the Offeror intends to submit confidential or proprietary information as part of the proposal, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

14.2 CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Offeror proposal. CalOptima reserves the unrestricted right to copy and disseminate the Offeror proposals for internal review and for review by external advisors, at CalOptima's sole discretion.

15.0 Evaluation and Award of Contract

15.1 Issuance of this RFP 19-021A or receipt of proposals does not commit CalOptima to award a contract. CalOptima reserves the right to withdraw this RFP 19-021A at any time without further notice and, furthermore, makes no representation that any contract will be awarded to any Offeror responding to this RFP 19-021A. CalOptima expressly reserves the right to postpone proposal opening for its own convenience; to accept or reject any or all proposals received in response to this RFP 19-021A; to waive informalities and minor irregularities in bids received; to reject any and all proposals responding to this RFP 19-021A without indicating any reasons for such rejection; to negotiate with other than the selected Offeror should negotiations with the selected Offeror be terminated; to negotiate with more than one Offeror simultaneously or to cancel all or part of this RFP 19-021A.

15.2 In no event will CalOptima be limited to selecting a successful Offeror based solely upon total cost submitted. Evaluation of the Proposals shall be generally based upon the reasonableness of price; experience in the market; capabilities of the Offeror to effectively complete the project requirements; financial stability and completeness of the Proposal response and the requested data. All proposals received as specified will be evaluated by CalOptima staff in accordance with the above criteria and additional sub-criteria that may be considered as relevant or pertinent by the evaluators.

15.3 In accordance with CalOptima's purchasing policy, CalOptima staff may select one or more responsive, responsible Offeror(s) whose Proposal(s) are most advantageous to CalOptima– price, quality and other factors considered.

15.4 False, incomplete, or unresponsive statements in connection with a Proposal may be cause for rejection. The evaluation and determination of fulfillment for the above requirements shall be in CalOptima's sole judgment and this judgment shall be final. Any Proposal not meeting terms and conditions may be rejected.

15.5 Offerors who submit a proposal in response to this RFP 19-021A shall be notified in writing regarding whether its firm was awarded the contract or not. Such notification shall be made within a reasonable time after the date the contract is executed.

16.0 Exceptions/Deviations

16.1 CalOptima requires each Offeror to state any exceptions to or deviations from the requirements of this RFP 19-021A, separating "technical" exceptions from "contractual" exceptions. Where Offeror wishes to propose alternative approaches to meeting CalOptima's technical requirements, these should be thoroughly explained.

16.2 Each deletion, addition, and modification, etc. to CalOptima's contract or BAA must be logged and submitted in the "Request to Negotiate Contract/BAA Terms" form (Attachment 5 of this RFP).

currently have a contract or BAA with CalOptima or have had one in the past, the services within this RFP are considered separate and CalOptima <u>will not</u> add them to an existing agreement.

17.0 Appendices

Information considered by Offeror to be pertinent to this project and which has not been specifically solicited in any of the aforementioned sections may be placed in a separate appendix section. Offerors are cautioned, however, that this does not constitute an invitation to submit large amounts of extraneous materials; appendices should be relevant and brief.

18.0 Non-Solicitation of Employees

Neither CalOptima nor CONTRACTOR shall solicit nor hire any personnel of the other during the Term of this Contract, or for a period of one year following the termination of this Contract, without the consent of the other party.

SECTION III: TECHNICAL AND PRICE PROPOSAL REQUIREMENTS

A. Technical Proposal Requirements

1.0 Corporate Capabilities

1.1 Qualifications and Experience

1.1.1 Provide a brief profile of the firm, including the types of services offered; the year founded; form of the organization (corporation, partnership, sole proprietorship); number, size and location of offices; number of employees.

1.1.2 Briefly describe the background of the company, including the formation, implementation of new business, sales, mergers, acquisitions, ownership, current lines of business and intended future lines of business. If applicable, indicate action to prevent disruption of current and/or new business.

1.1.3 Identify the senior management staff and their length of time with the company. Identify management staff that would be directly involved with the CalOptima contract and their length of time with the company.

1.1.4 Identify three (3) references of clients similar in scope and complexity to that of CalOptima. References shall include the name, title, email address, and telephone number of the person at the client organization who is most knowledgeable about the work.

1.1.5 Indicate any past or current material disputes including litigation with customers, provider groups, government entities, client groups and any other litigation with contingent liability of $500,000 or more. State the results or status of the dispute.

1.1.6 Is your company under investigation or being sued by any governmental agency? Has your company been barred from participation in a publicly-funded health program (such as Medicare or Medicaid)? If yes, provide a detailed explanation of the circumstances and status.

1.1.7 Provide details of any inquiry letters and/or negative audit results received from any state or federal agency or any outside business auditor.

1.1.8 Has your organization been audited in accordance with the Statements for Standards on Attestation Engagements (SSAE) 16 (formerly SAS 70 audit)? If yes, were any exceptions noted? If not audited, please explain.

1.1.9 If the respondent proposes to use subcontractor(s), it must describe any existing or ongoing relationships with the subcontractor(s); including project descriptions and the portions(s) of this RFP intended to be subcontracted

1.1.10 Identify subcontractors by company name, address, contact person, telephone number and project function and describe Offeror's experience working with each subcontractor.

2.0 Information Processing System (If you are proposing use of any systems, please complete)

2.1 Describe the current information processing system(s) used, highlighting features that ensure flexibility, timely updates of files, table-driven parameters, managed care orientation and timely, appropriate enhancements.

2.2 Describe the number, variety and location of processing platforms you use today. Are you planning a migration or consolidation of your system platforms? Describe the process, including testing and timeframes. Identify which platform(s) will be used to administer CalOptima's program.

2.3 Describe the security options related to user login and levels of security available by user profile.

2.4 Complete RFP Attachment 6: Security Questionnaire to describe your firm's standards for security, privacy, compliance and risk management and adherence to industry and government best practices.

2.5 Indicate the location and capacity of your data center(s). Describe your information systems disaster and recovery plans and identify applicable locations.

2.6 Quantify your application/system downtime monthly from January 1, 2015 to current. Identify scheduled and unscheduled downtime separately.

2.7 Do you operate your information processing system or do you have a subcontractor or vendor operate the system? If you are using a subcontractor(s), include the name(s).

2.8 Do you own the source code and manage all version upgrades, maintenance and application modifications internally? If not, use the table format below to identify entities and services performed.

System Subcontractors/Vendors					
Company Name	**Contact Name**	**Telephone**	**E Mail**	**System/ Application Supported**	**Service Provided**

2.9 Can the software be customized to meet CalOptima's specific needs, including Programming/development integration, APIs and interfaces?

2.10 Can 18 months of past utilization from other systems be loaded and maintained within your system? Please describe any limitations.

2.11 How does the software access within and across the public Internet? Does the software have web-browser access? Describe the features of your member web portal.

2.12 Describe in detail all available web functionality and tools that will be made available to CalOptima through any resulting agreement.

2.13 Itemize required software and hardware to be installed/operational by CalOptima to achieve on-line connectivity to your organization. Will you supply all or some required software and hardware for on-line connectivity? Identify these items specifically and in the Price Proposal.

2.14 What is the process and format used to transfer data to CalOptima?

2.15 Describe the design, development and implementation processes used to update and modify the current information processing system software to maintain client requirements and industry standards.

- Are system updates done on a client-specific basis or on a cyclical basis for all or multiple clients?
- Confirm your commitment to maintain the software and to provide "bug" fixes and work-around solutions.
- Provide a summary of updates in-progress or planned. What abilities and timeframes will CalOptima have to test the upgrade prior to implementation?
- CalOptima expects to receive updates and new versions at no additional fee during the contract period. Confirm that updates and new versions will be made available on this basis to CalOptima.
- Indicate if CalOptima has the option of declining or postponing implementation of system changes or enhancements.

3.0 Financial Management

3.1 Provide evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement:

3.1.1 If the respondent is a corporation that is required to report to the Securities and Exchange Commission, it must submit its two most recent SEC Forms 10K, Annual Reports.

3.1.2 If the respondent is *not* a corporation that is required to report to the Securities and Exchange Commission, it must submit its current financial statement plus previous two (2) years of audited financial reports including all supplements, management discussion and analysis, and actuarial options.

3.1.2.1 At a minimum, such financial statements and reports shall include: balance sheet; statement of income and expenses (also referred to as "statement of profit and loss"); statement of changes in financial position; cash flows; and capital expenditures.

3.1.3 If any change in ownership is anticipated during the twelve (12) months following the proposal due date, the respondent must describe the circumstances of such change and indicate when the change is likely to occur.

3.1.4 The respondent must identify any conditions (e.g., bankruptcy, pending litigation, planned office closures, impending merger) that may impede Offeror's ability to complete the project.

3.2 Include a copy of your billing invoice as part of your firms' proposal.

4.0 Proposed Staffing and Project Organization

4.1 Provide education, experience and applicable professional credentials of project staff.

4.2 Furnish brief resumes (not more than two [2] pages each) for the proposed Project Manager, Account Manager, and other key personnel.

4.3 Indicate adequacy of labor resources utilizing a table projecting the labor-hour allocation to the project by individual task.

4.4 Identify key personnel proposed to perform the work on the specified tasks and include major areas of subcontract work.

4.5 Include a project organization chart which clearly delineates communication/reporting relationships among the project staff.

4.6 Include a statement that key personnel will be available to the extent proposed for the duration of the project, acknowledging that no person designated as "key" to the project shall be removed or replaced without the prior written concurrence of CalOptima.

4.7 Identify the individuals who will be assisting with implementation, contract rollout, reporting and system questions. Include a list of qualifications and credentials for those individuals. Identify if any of these individuals continue in ongoing operation roles.

4.8 Describe the roles, responsibilities and deliverables of CalOptima and the Offeror during the implementation phase in a detailed work plan. The work plan must outline sequentially and describe the elements and activities that would be undertaken in completing the tasks; specify by name and job description, the person Offeror would assign to perform said task; the hourly rate of each person; rate for task identified; and include a schedule for completing the tasks in terms of elapsed weeks from the commencement date. Include details regarding the timeline needed before system is capable of being "live" for use after contract execution.

4.9 Describe in detail, the timeline dependencies for availability of required data feeds and interfaces to CalOptima systems in order to implement Offeror s system successfully based upon the timeline you propose.

4.10 What CalOptima resources are required by Offeror to meet the implementation timeframe?

B. Price Proposal Requirements

CalOptima is anticipating and hourly-rate bid for these types of services. If your firm would prefer to bill a different way, please submit that as a secondary offering to the RFP so we can review both options. If you are bidding for both services, please make sure your pricing is separate for each so we can evaluate all bidders for each specific service.

The successful Offeror shall not be allowed to invoice CalOptima throughout the duration of any resulting contract for any pricing not listed within the following pricing form. Pricing data contained in other areas of the Offeror's Proposal will not be considered.

C. Scope of Work

CalOptima is requesting proposals for two separate Health Homes Programs Select Services. They are:

- OBJECTIVE A - HHP Select Services - Housing Services
- OBJECTIVE B - HHP Select Services – Accompaniment Services

Interested bidders can bid on one of both of the select services below.

I. BACKGROUND

CalOptima contracts on a full or partial risk capitated basis with its delegated Health Maintenance Organizations and provider-sponsored organizations, known as Physician Hospital Consortia and Shared Risk Groups (jointly referred to as Health Networks), to provide care to approximately 75% of CalOptima members. Health Networks (HNs) are financially responsible according to their contract agreement to provide medically necessary services to their assigned members.

CalOptima serves the remaining members through a fee-for-service program known as "CalOptima Direct". CalOptima Direct network includes members who select to be in CalOptima Community Network (CCN) and members who are in specific categories (e.g., members with share of costs,

members with both Medicare and Medi-Cal) who are unable to select another network and would be served through the CalOptima Direct – Administrative program.

Health Homes Program (HHP)

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program (HHP). Statewide, HHP will be implemented in selected counties with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. CalOptima, along with other selected counties in California are implementing HHP on a phased basis:

- No sooner than January 1, 2020 for CalOptima members with eligible chronic physical conditions and substance use disorder (SUD); and,
- No sooner than July 1, 2020 for members with Serious Mental Illness (SMI) and/or Seriously Emotional Distress (SED).[1]

DHCS has developed the "Health Homes for Patients with Complex Needs Program", including person-centered coordination to improve member outcomes through two objectives:

- Coordination of physical health services, mental health services, substance use disorder services, community-based LTSS, palliative care, and social support needs; and,
- Reduction of avoidable health care costs, including hospital admission/readmissions, Emergency Department visits, and nursing facility stays

DHCS is targeting the top 3-5% highest risk/utilizing Medi-Cal members with specific multiple chronic physical conditions aligned with certain acuity criteria, or SMI whose outcomes may improve through HHP interventions. In summary, CalOptima Medi-Cal members must meet criteria established by DHCS including both of the 'chronic condition' and 'acuity' requirements. CalOptima's Medicare and members dually eligible for Medicare and Medi-Cal can participate through referrals only if eligibility criteria are met. Part of the HHP eligible members may meet HHP eligibility criteria of 'Chronic Homeless'. Details on these eligibility requirements and exclusion criteria can be found in the HHP Program Guide available at the following link: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx .

DHCS has identified the following six (6) HHP core services and expects these services to be available to all members enrolled in HHP:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and,
6. Referral to Community and Social Supports, including housing navigation and sustainability services.

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, Managed Care Plans (MCPs) will be responsible for overall administration, including development of the HHP network. HHP services will be coordinated through Community Based-Care Management Entities (CB-CMEs). HHP services will be provided primarily by a CB-CME under

[1] *Reference California SPA: 18-020 for SMI/SED definition at* https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-18-0020.pdf

a contract with CalOptima as the HHP Lead Entity. CB-CMEs will be responsible to coordinate with members, existing providers and other agencies.

CalOptima expects to be the CB-CME for members assigned to CalOptima Direct. Since HNs already provide most HHP services under their delegated contract, CalOptima has delegated CB-CME responsibilities to HNs for their assigned members. HNs may be permitted to subcontract for some select HHP services.

II. OBJECTIVE A – Housing Services

The purpose of this RFP is to solicit proposals from HHP select service providers, henceforth referred to as "OFFERORS", interested in contracting with CalOptima to provide Health Homes Program (HHP) ***housing navigation and sustainability services***. OFFEROR services shall be provided to CalOptima's Medi-Cal members enrolled in HHP program. For ease of administration, consistency and scale, CalOptima will require OFFEROR to make HHP services hereunder available to HNs, either through CalOptima's contract or a separate contract with individual HNs choosing to contract with OFFEROR for such services.

OFFEROR may also extend similar services, terms and conditions for other Medi-Cal programs supporting homeless population including, but not limited to, Whole Person Care (WPC). Such programs are administered either by CalOptima and/or other entities including the Orange County Health Care Agency (OCHCA).

CalOptima has the option to award contracts to a single or multiple OFFEROR(s), as needed in an effort to ensure the required coverage for its members. CalOptima has the option to retain any partial services in-house.

OFFEROR services shall be available to all CalOptima HHP enrolled members assigned to CalOptima Direct and any HHP enrolled member assigned to a CalOptima delegated HNs choosing to contract with OFFEROR for such services. OFFEROR will provide such services according to contract terms and expectations outlined by each contracted entity.

OFFEROR shall work with each contracted entity as applicable to ensure seamless access to the delivery of services and utilize processes and tools required by each individual entity.

Housing Navigation and Sustainability Services

The OFFEROR of Housing Services must have one or more HHP designated staff, referred to as a "Housing Navigator", who will assist members experiencing homelessness or at risk of homelessness, as directed by the contracted entity, as applicable. CalOptima will accept an application from the OFFEROR even if the OFFEROR can provide only one of the two services listed below.

The OFFEROR of Housing Services must provide one or both of the following:

- Individual Housing Transition Services and
- Individual Housing and Tenancy Sustaining Services

1. Individual Housing Transition Services to assist members with obtaining housing, such as individual outreach and assessments. These services include:

A. 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;

B. 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;

C. Assisting with the housing application process;

D. Assisting with the housing search process;

E. Identifying and securing resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

F. Ensuring that the living environment is safe and ready for move-in;

G. Assisting in arranging for and supporting the details of the move; and

H. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

I. Coordinating with the County for those HHP members that are also in the County's Coordinated Entry System as there may be housing vouchers or programs identified for the client through this system.

2. Individual 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:

A. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

a) Providing a plan for the client in recognition of these behaviors

b) Providing a plan for the landlord (who to call) if the behaviors are noted

B. Education and training on the roles, rights and responsibilities of the tenant and landlord;

C. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;

D. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;

E. Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;

F. Ensuring that the member is connected to social supports in the vicinity of their new community and that the other service providers connected with the member also know they are newly housed.

G. Assisting the client in accessing resources that may be necessary to obtain immediate need items including, but not limited to: toiletries, cleaning products, kitchen ware, bed, towels and linens, and refrigerator.

H. Assistance with the housing recertification process;

a) 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

b) Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

III. Performance Guarantee

OFFEROR commits to the performance as expected and comply with the Corrective Action Plan provided by CalOptima if failure to meet the requirements of the contract. CalOptima reserves the right to pursue compliance actions in accordance with CalOptima Policy HH.2002 and HH.2005.

IV. Claims Processing and Reporting

OFFEROR or its staff shall never charge a member directly for any service hereunder nor shall OFFEROR ever accept a gratuity from a member for such services.

DHCS has established a HIPAA compliant HHP specific HCPCS code 'G9008' which is defined as "Coordinated care fee, physician coordinated care oversight services". OFFEROR agrees to comply with all DHCS claims submission timeliness requirements. OFFEROR agrees to adhere to the Provider Dispute Resolution process according to DHCS requirements and CalOptima's expectations.

OFFEROR will use the following modifiers to identify non-clinical staff services, in-person and telephonic/telehealth 'visits', and other HHP services such as case notes documentation, case conferences, and tenant supportive services.

OFFEROR will use HCPCS code with corresponding modifier for billing and reporting as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
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, including case note documentation, case conferences and tenant supportive services	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed

V. Supplemental Information

CalOptima will evaluate OFFEROR based on all of the above requirements, service readiness as well as the responses to the "Supplemental Questionnaire" below. OFFEROR must respond as fully, accurately and completely as possible to each of the following questions as a part of its proposal response. OFFEROR shall respond with current state and how OFFEROR envisions meeting CalOptima's requirements.

All OFFERORs must provide information demonstrating:

A. Ability to capture, track and report the delivery of services described in Section II above.

B. Experience working with Medi-Cal members and/or similar racially, ethnically and culturally diverse populations.

C. Experience working with persons with multiple chronic conditions, SMI, and members experiencing homelessness.

D. Experience working with entities such as health networks, providers and county agencies and/or community-based organizations.

E. OFFEROR must submit their background check process for their staff for review by CalOptima.

F. Ability to hire, retain, manage and support paraprofessional or other staff with experience and knowledge of the population and processes specific to the designated service type as described below;

   a) If staff have insufficient required experience, please explain how OFFEROR would train staff to provide support services and participate in interdisciplinary care plans.

   b) Ability to provide services within two (2) business days of request.

   c) Ability to support members' need to speak in Orange County threshold languages.

G. Ability to receive, record and disseminate information about encounters with members , including services provided, findings, recommendations, referrals e.g., with member, health plan or other business partnerships involved in the care of members.

H. Confirm the ability to use tools created by CalOptima, to dedicate time for staff to train in use of these tools and to adopt internal processes (e.g., policies, desktops and reports) to track interventions, capture health outcomes, facilitate care planning and referral management.

I. Communication methods proposed to communicate with CalOptima and other contracted entities (such as health networks).

J. Current processes in place to handle urgent and emergent member grievances and coordinate resolution.

K. Experience working with Orange County Community Resources and target populations to ensure seamless access to the delivery of housing support services and to provide housing navigation services, not just referrals to housing, including:

   a) Working with individuals who are experiencing or may imminently be experiencing homelessness;
   b) Providing Individual Housing Transition Services, as described in Section II;
   c) Providing Tenancy Sustaining Services, as described in Section II;
   d) Working with Orange County housing agencies, permanent housing providers, including supportive housing providers, and other community-based organizations, Coordinated Entry process.
   e) Describe tools or standards that staff will follow to report or document the notes after services provided to each member.
   f) Describe OFFEROR's ability to be flexible with contracted entities to provide the same services with various expectations.

VI. OBJECTIVE B – Accompaniment Services

The purpose of this RFP is to solicit proposals from HHP select service providers, henceforth referred to as "OFFERORS", interested in contracting with CalOptima to provide Health Homes Program (HHP) ***accompaniment services.*** OFFEROR services shall be provided to CalOptima's Medi-Cal members enrolled in HHP program. For ease of administration, consistency and scale, CalOptima will require OFFEROR to make HHP services hereunder available to HNs, either through CalOptima's contract or a separate contract with individual HNs choosing to contract with OFFEROR for such services.

CalOptima has the option to award contracts to a single or multiple OFFEROR(s), as needed to ensure the required coverage for its members. CalOptima has the option to retain any partial services in-house.

OFFEROR services shall be available to all CalOptima HHP enrolled members assigned to CalOptima Direct and any HHP enrolled member assigned to a CalOptima delegated HNs choosing to contract with OFFEROR for such services. OFFEROR will provide such services according to contract terms and expectations outlined by each contracted entity.

OFFEROR shall work with each contracted entity as applicable to ensure seamless access to the delivery of services and utilize processes and tools required by each individual entity.

Accompaniment:

The OFFEROR of Accompaniment Service will be required to provide 'accompaniment' services to HHP members for medically necessary appointments in a timely manner (as described in the CalOptima Provider Manual, Section M6) as approved and requested by CalOptima and/or Health Networks according to the expectations outlined below:

A. Outreach to member in advance of scheduled appointment to coordinate, including to obtain appointment date and time, and to provide information on accompaniment process, what to expect at the appointment, identification of potential questions.
    a) On a case by case basis, as requested by CalOptima and/or Health Networks, discuss in advance of an appointment for special instructions.
    b) Contact member the business day prior to the appointment for reminder and confirmation of the appointment.
B. Provide same-day services to a member who needs accompaniment to an unplanned service such as urgent care or emergency department.
C. Traveling with member to an appointment or meeting member at provider office based upon member's need.
D. Attending appointment with member at clinical provider office as requested.
E. Members are expected to arrange their own transportation or request CalOptima to provide non-medical transportation to the appointment. OFFEROR is not permitted to drive member to the appointment or allow member to drive OFFEROR (staff) to the appointment.
F. CalOptima will identify HHP member for accompaniment services for specific appointment and notify OFFEROR.
G. CalOptima expects that most accompaniment will take place within Orange County.

a) CalOptima prefers OFFEROR to provide accompaniment throughout Orange County; CalOptima will accept proposals for services on a regional basis;

b) Out-of-county requests outside the ten (10) miles of Orange County may be required on a case-by-case basis.

H. OFFEROR must send to member and CalOptima, no later than 2 business days following the date of the appointment, a summary report of the discussion, questions raised, next appointment (if any) member next steps, and any referrals for follow-up by CalOptima. CalOptima and Health Network will provide standard form that OFFEROR will be required to complete.

I. OFFEROR must participate in care team meetings and implementing care plan, as requested. CalOptima and Health Network will notify OFFEROR and conduct Care team meetings outside of the member appointments.

VII. Performance Guarantee

OFFEROR commits to the performance as expected and comply with the Corrective Action Plan provided by CalOptima if failure to meet the requirements of the contract. CalOptima reserves the right to pursue compliance actions in accordance with CalOptima Policy HH.2002 and HH.2005.

VIII. Claims/Reimbursement Processing and Reporting

OFFEROR or its staff shall never charge a member directly for any service hereunder nor shall OFFEROR ever accept a gratuity from a member for such services.

DHCS has established a HIPAA compliant HHP specific HCPCS code 'G9008' which is defined as "Coordinated care fee, physician coordinated care oversight services". OFFEROR agrees to comply with all DHCS claims submission timeliness requirements. OFFEROR agrees to adhere to the Provider Dispute Resolution process according to DHCS requirements and CalOptima's expectations.

OFFEROR will use the following modifiers to identify non-clinical staff services, in-person and telephonic/telehealth 'visits', and other HHP services such as case notes documentation, case conferences, and driving to appointments.

OFFEROR will use HCPCS code with corresponding modifier for billing and reporting as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Non-Clinical Staff, including accompaniment	G9008	U4	15 Minutes equals 1 UOS; Multiple UO allowed
Phone/Telehealth: Provided by Non-Clini Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UO allowed
Other Health Home Services: Provided by Non-Clinical Staff, including participation in ICT, care planning and driving to appointments.	G9008	U6	15 Minutes equals 1 UOS; Multiple UO allowed

IX. Supplemental Information

CalOptima will evaluate OFFEROR based on all of the above requirements, service readiness, as well as the responses to the "Supplemental Questionnaire" below. OFFEROR must respond as fully, accurately

and completely as possible to each of the following questions as a part of its proposal response. OFFEROR shall respond with current state and how OFFEROR envisions meeting CalOptima's requirements.

All OFFERORs must provide information demonstrating:

A. Ability to capture, track and report the delivery of services described in Section II above.

B. Experience working with Medi-Cal members and/or similar population racially, ethnically and culturally diverse populations.

C. Experience working with persons with multiple chronic conditions, Substance Use Disorders and/or Serious Mental Illness.

D. Experience working with entities such as health networks, providers and county agencies and/or community-based organizations.

E. OFFEROR must submit their background check process for their staff for review by CalOptima.

F. Ability to hire, retain, manage and support paraprofessional or other staff with experience and knowledge of the population and processes specific to the designated service type as described below;

   a) If staff have insufficient required experience, please explain how OFFEROR would train staff to provide support services and participate in interdisciplinary care plans.

   b) Ability to provide services within two (2) business days of request.

   c) Ability to support members' need to speak in Orange County threshold languages.

G. Ability to receive, record and disseminate information about encounters with members, including services provided, findings, recommendations, referrals e.g., with member, health plan or other business partnerships involved in the care of members.

H. Confirm the ability to use tools created by CalOptima, to dedicate time for staff to train in use of these tools and to adopt internal processes (e.g., policies, desktops and reports) to track interventions, capture health outcomes, facilitate care planning and referral management.

I. Communication methods proposed to communicate with CalOptima and other contracted entities (such as health networks).

J. Current processes in place to handle urgent and emergent member grievances and coordinate resolutions.

K. Experience in providing accompaniment to appointments or direct face-to-face services to members related to physical health, mental health and/or social determinants of health services.

L. OFFEROR's process/ability to assign the designated staff to accompany the same member to future appointments.

M. How OFFEROR selects staff to accompany member (e.g., geographical, language/culture, type appointment) and, if applicable, how processes will be modified for HHP.

N. How staff currently prepares for an appointment/face-to-face session and what information may be needed from CalOptima.

O. Tools or standards staff will follow to report or document the notes after accompaniment event.

P. Describe OFFEROR's ability to be flexible with contracted entities to provide the same services with various expectations from contracted entities.

RFP Attachment 1: Mandatory Offeror Acknowledgement

ACKNOWLEDGEMENT

In signing this Proposal, Offeror acknowledges receipt of the RFP 19-021A and the following addenda, if any (expand list as necessary):

Addendum no. _____ , Received on: _____

Addendum no. _____ , Received on: _____

Addendum no. _____ , Received on: _____

I acknowledge receipt of RFP 19-021A and addenda cited.

I hereby certify on behalf of _____ that the contents of this Proposal are, to the best of my ability, completely in compliance with all requirements of the RFP 19-021A and the terms and conditions of the contract, without exceptions, other than those expressly listed and explained in this Proposal. This Proposal is an irrevocable offer, which shall remain in full force and effect for 150 calendar days after the Proposal due date.

Company Name: _____

Address: _____

Telephone Number: _____

Signature Of Person Authorized To Bind Offeror: _____

Signatory's Name And Title: _____

Date Signed: _____

RFP Attachment 2: Mandatory Non-Collusion Affidavit

NON-COLLUSION AFFIDAVIT

_____, being first duly sworn, deposes and says that he or she is_____ of _____ the party making the foregoing Proposal that the Proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the Proposal is genuine and not collusive or sham; that the Offeror has not directly or indirectly induced or solicited any other Offeror to put in a false or sham Proposal and has not directly or indirectly colluded, conspired, connived, or agreed with any Offeror or anyone else to put in a sham Proposal, or that anyone shall refrain from bidding; that the Offeror has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the Proposal price of the Offeror or any other Offeror or to fix any overhead, profit, or cost element of the Proposal price, or of that of any other Offeror, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the Proposal are true; and, further, that the Offeror has not, directly or indirectly, submitted his or her Proposal price or any breakdown thereof, or the contents thereof, or divulged information or date relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, bid depository, or to any member or agent thereof to effectuate a collusive or sham bid.

_____ _____

Signature Date

_____

Title

RFP Attachment 3: Offeror Eligibility Certification

OFFEROR ELIGIBILITY CERTIFICATION

Offeror certifies, to the best of its knowledge and belief, that that offeror and/or any of its Principals:

A. Are ☐, are not ☐ presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contract by any Federal agency or from participating in any Federal healthcare programs;

B. Have ☐, have not ☐, within a ten (10)-year period preceding this offer, been convicted of or had a civil judgement rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract or subcontract; violation of Federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violating Federal criminal tax laws, or receiving stolen property;

C. Are ☐, are not ☐ presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in Section (B); and

D. Have ☐, have not ☐, within a ten (10)-year period preceding this offer, been notified of any delinquent Federal taxes in an amount that exceeds $3,000 for which the liability remains unsatisfied.

For purposed of this certification, "Principal" means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g. general manager, plant manager, head of a division or business segment and similar positions).

By:
Name: _____
Title: _____
Company: _____
Date: _____

Revised February 2019

RFP Attachment 4: CalOptima Sample Contract and Sample BAA

Click on icon below for Attachment 4.

19-021A - Non-Medical Ancilla

19-021 - HHP Select Services - Sample BA

RFP Attachment 5: Request to Negotiate Contract/BAA Terms

Click on icon below for Attachment 5.

Request to
Negotiate Contract Te

RFP Attachment 6: Security Questionnaire

Offeror is required to certify that it (and any proposed subcontractors) comply with the following security provisions, as required in this RFP. Offeror must complete the following questionnaire and explain how you propose to meet any exceptions.

1. Information Security Program, Policy & Procedures

    a. Do you have documented information security policies and procedures? If so, list the titles of each policy.

    b. Does your security policy meet HIPAA requirements? Has it been audited by external auditor, and if so, when was it last audited?

    c. Do you have a formal information classification procedure? Describe in particular, how would patient data be categorized?

2. Personnel Security

    a. Has your organization formally appointed a central point of contact for security coordination, e.g. a designated information security officer and/or privacy officer? If so, whom, and what is their position within the organization?

    b. Does your organization perform background checks to examine and access an employees' or contractor's work and criminal history?

    c. Do you work with third parties, such as IT service providers that have access to or store your sensitive information?

    d. In the event of a security incident with one of your third-party vendors, what is the policy for alert notifications, timeline for resolution, etc? If such a process exists, provide the document as part of your response as Proposal Exhibit: Third-party Security Event Notices

3. Network Security

    a. Provide a diagram of your firms network configuration. Has your IT vendor provided information regarding how your sensitive information systems are protected?

    b. Are systems and networks that host, process and or transfer sensitive information "protected" (isolated or separated) from other systems and/or networks?

    c. Are internal and external networks separated by firewalls with access policies and rules?

    d. Is there a standard approach for protecting network devices to prevent unauthorized access/network related attacks and data-theft?

    e. Is sensitive information transferred to external recipients? If so, what controls are in place to protect sensitive information when transferred (e.g. with encryption?)

    f. How does your firm manage vulnerabilities and threats? How often are Vulnerability Assessments performed?

g. What is the remediation process for vulnerabilities that are discovered?

h. Are third party connections to your network monitored and reviewed to confirm authorized access and appropriate usage? How often does your firm attest third party network connectivity?

i. What network security tools do you have in place? (i.e., DLP, IPS/IDS, Advanced Malware Detection, Web Content Filtering, etc.).

j. Describe your methodology for tuning your security tools (i.e., DLP, IPS, Advanced Malware Detection, Web Content Filtering, etc.) How do you ensure your security tools are effective and up to date?

k. Does your firm conduct annual internal and external penetration tests by a 3rd party?

4. Logical Access

a. Do you have a formal access authorization process based on "least privilege" (employees are granted the least amount of access possible in order to perform their assigned duties) and need to know (access permissions are granted based upon the legitimate business need of the user to access the information)?

b. How are systems and applications configured to allow access only to authorized individuals?

c. Is there a list maintained of authorized users with access (administrative access) to operating systems?

d. Does your firms system support mobile devices? If so, describe in detail how your firm can control mobile device access.

e. Is sensitive information (e.g. social security numbers) masked or removed from, or encrypted within, documents and or websites before it is distributed?

f. Is software installation restricted for desktops, laptops and servers? What type of system hardening does your firm perform?

g. Is access to source application code restricted? If so, how? Is a list of authorized user maintained? How does your firm protect its source code?

h. Are user IDs for your system uniquely identifiable?

i. Do you have a process to review user accounts and related access? How does your firm do user attestation?

5. Operations Management

a. Has antivirus software been deployed and installed on your computers and supporting systems (e.g., desktops, servers and gateways?)

b. Are systems and networks monitored for security events? If so, describe monitoring in detail.

c. Do procedures exist to protect documents, computer media (e.g., tapes, disks, CD-ROMs, etc.) from unauthorized disclosure, modification, removal, and destruction? Is sensitive data encrypted when stored on laptop, desktop and server hard drives, flash drives, backup tapes, etc.?

d. Does your firm send backup tapes to an offsite vendor? If so, name the vendor.

e. Are there security procedures for the decommissioning (replacement) of IT equipment and IT storage devices which contain or process sensitive information? If so, please describe.

f. Are development, test and production environments separated from operational IT environments to protect production (actively used) applications from inadvertent changes or disruption?

g. Are duties separated, where appropriate, to reduce the opportunity for unauthorized modification, unintentional modification or misuse of the organization's IT assets?

h. Do formal change management procedures exist for networks, systems, desktops, software releases, deployments, and software vulnerability (e.g., Virus or Spyware) patching activities?

6. Incident Management and Investigations

a. Is a formalized and documented process in place for incidents and investigations?

b. How do you identify, respond to and mitigate suspected or known security incidents?

c. During the investigation of a security incident, is evidence properly collected and maintained?

d. Are incidents identified, investigated, and reported according to applicable legal requirements?

e. How are incidents escalated and communicated?

RFP Attachment 7: Campaign Contribution Disclosure

CALOPTIMA LEVINE ACT DISCLOSURE STATEMENT

California Government Code section 84308, commonly referred to as the "Levine Act," precludes an Officer of a local government agency from participating in the award of a contract if he or she receives any political contributions totaling more than $250 in the 12 months preceding the pendency of the contract award, and for three months following the final decision, from the person or company awarded the contract. This prohibition applies to contributions to the Officer, or received by the Officer on behalf of any other Officer, or on behalf of any candidate for office or on behalf of any committee. The Levine Act also requires disclosure of such contributions by a party to be awarded a specified contract. Please refer to Attachment A to this Statement for the complete statutory language.

Current members of the CalOptima Board of Directors are:

Ria Berger	Ron DiLuigi	Andrew Do	Dr. Nikan Khatibi
Alexander Nguyen, M.D.	Lee Penrose	Richard Sanchez	J. Scott Schoeffel
Michelle Steel	Paul Yost, M.D.	Doug Chaffee (Alternate)	

1. Have you or your company, or any agent on behalf of you or your company, made any political contributions of more than $250 to any CalOptima Director(s) in the 12 months preceding the date of the issuance of this request for proposal or request for qualifications?

___ YES ___ NO

If yes, please identify the Director(s):

2. Do you or your company, or any agency on behalf of you or your company, anticipate or plan to make any political contributions of more than $250 to any CalOptima Director(s) between the date of issuance of this request for proposals and the award of the contract, or in the three months following the award of the contract?

___ YES ___ NO

If yes, please identify the Director(s):

Answering yes to either of the two questions above does not preclude CalOptima from awarding a contract to your firm. It does, however, preclude the identified Director(s) from participating in the contract award process for this contract.

_____ _____

DATE (SIGNATURE OF AUTHORIZED OFFICIAL)

_____

(TYPE OR WRITE APPROPRIATE NAME, TITLE)

_____

(TYPE OR WRITE NAME OF COMPANY)

CALOPTIMA LEVINE ACT DISCLOSURE STATEMENT
Attachment A

California Government Code Section 84308

(a) The definitions set forth in this subdivision shall govern the interpretation of this section.

(1) "Party" means any person who files an application for, or is the subject of, a proceeding involving a license, permit, or other entitlement for use.

(2) "Participant" means any person who is not a party but who actively supports or opposes a particular decision in a proceeding involving a license, permit, or other entitlement for use and who has a financial interest in the decision, as described in Article 1 (commencing with Section 87100) of Chapter 7. A person actively supports or opposes a particular decision in a proceeding if he or she lobbies in person the officers or employees of the agency, testifies in person before the agency, or otherwise acts to influence officers of the agency.

(3) "Agency" means an agency as defined in Section 82003 except that it does not include the courts or any agency in the judicial branch of government, local governmental agencies whose members are directly elected by the voters, the Legislature, the Board of Equalization, or constitutional officers. However, this section applies to any person who is a member of an exempted agency but is acting as a voting member of another agency.

(4) "Officer" means any elected or appointed officer of an agency, any alternate to an elected or appointed officer of an agency, and any candidate for elective office in an agency.

(5) "License, permit, or other entitlement for use" means all business, professional, trade and land use licenses and permits and all other entitlements for use, including all entitlements for land use, all contracts (other than competitively bid, labor, or personal employment contracts), and all franchises.

(6) "Contribution" includes contributions to candidates and committees in federal, state, or local elections.

(b) No officer of an agency shall accept, solicit, or direct a contribution of more than two hundred fifty dollars ($250) from any party, or his or her agent, or from any participant, or his or her agent, while a proceeding involving a license, permit, or other entitlement for use is pending before the agency and for three months following the date a final decision is rendered in the proceeding if the officer knows or has reason to know that the participant has a financial interest, as that term is used in Article 1 (commencing with Section 87100) of Chapter 7. This prohibition shall apply regardless of whether the

officer accepts, solicits, or directs the contribution for himself or herself, or on behalf of any other officer, or on behalf of any candidate for office or on behalf of any committee.

(c) Prior to rendering any decision in a proceeding involving a license, permit or other entitlement for use pending before an agency, each officer of the agency who received a contribution within the preceding 12 months in an amount of more than two hundred fifty dollars ($250) from a party or from any participant shall disclose that fact on the record of the proceeding. No officer of an agency shall make, participate in making, or in any way attempt to use his or her official position to influence the decision in a proceeding involving a license, permit, or other entitlement for use pending before the agency if the officer has willfully or knowingly received a contribution in an amount of more than two hundred fifty dollars ($250) within the preceding 12 months from a party or his or her agent, or from any participant, or his or her agent if the officer knows or has reason to know that the participant has a financial interest in the decision, as that term is described with respect to public officials in Article 1 (commencing with Section 87100) of Chapter 7.

If an officer receives a contribution which would otherwise require disqualification under this section, returns the contribution within 30 days from the time he or she knows, or should have known, about the contribution and the proceeding involving a license, permit, or other entitlement for use, he or she shall be permitted to participate in the proceeding.

(d) A party to a proceeding before an agency involving a license, permit, or other entitlement for use shall disclose on the record of the proceeding any contribution in an amount of more than two hundred fifty dollars ($250) made within the preceding 12 months by the party, or his or her agent, to any officer of the agency. No party, or his or her agent, to a proceeding involving a license, permit, or other entitlement for use pending before any agency and no participant, or his or her agent, in the proceeding shall make a contribution of more than two hundred fifty dollars ($250) to any officer of that agency during the proceeding and for three months following the date a final decision is rendered by the agency in the proceeding. When a closed corporation is a party to, or a participant in, a proceeding involving a license, permit, or other entitlement for use pending before an agency, the majority shareholder is subject to the disclosure and prohibition requirements specified in subdivisions (b), (c), and this subdivision.

(e) Nothing in this section shall be construed to imply that any contribution subject to being reported under this title shall not be so reported.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Ladan Khamseh, Chief Operating Officer (714) 246-8400
Belinda Abeyta, Interim Executive Director, Operations, (714) 246-8400

Recommended Actions

The Whole-Child Model Family Advisory Committee Nominations Ad Hoc Committee recommends:

1) Reappoint the following individuals as Family Members on the Whole-Child Model Family Advisory Committee:
   a) Malissa Watson for a two-year term ending June 30, 2021;
   b) Pamela Patterson for a term ending November 30, 2019.

2) Reappoint the following individual as Community Representative:
   a) Sandra Cortez-Schultz for a term ending June 30, 2021.

3) New Appointment of the following individual as a Family Member:
   a) Brenda Deeley for a term ending June 30, 2021.

4) New Appointment of the following individual as a Consumer Advocate:
   a) Kathleen Lear for a term ending June 30, 2021

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016 and authorized the establishment of the Whole-Child Model incorporating California Children's Services (CCS) covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017 to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program.

The WCM FAC is comprised of eleven voting members, with seven to nine seats designated as family representatives and two to four designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's eleven seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional seats if there are not enough family representative candidates available to fill these seats.

For the current nomination process, the WCM FAC Ad Hoc committee members reviewed the applications from candidates on April 25, 2019 in preparation for the April 30, 2019 meeting. However, the WCM FAC did not have a quorum on April 30, 2019 to approve the Ad Hoc committee

Back to Agenda

recommendations. The WCM FAC scheduled one regular meeting and three special meetings between April 30, 2019 and August 30, 2019, but the WCM FAC was unable to meet minimum quorum requirements due to the resignation of an authorized family member representative and a community-based organization representative. Because of these circumstances, a quorum of the WCM FAC was not available to review and recommend the proposed slate of candidates.

Discussion

CalOptima staff conducted a recruitment process to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included various notification methods, such as sending informational flyers to Orange County agencies and community-based organizations (CBOs) representing California Children Services (CCS) children, posting recruitment announcements on the CalOptima website, as well as networking with the current WCM FAC committee members for qualified candidates. Upon receipt of applications from interested candidates, these applications were submitted to the WCM FAC Nominations Ad Hoc for review. Even assuming the Board appoints the recommended candidates, there will still be three vacancies on the committee. Recruitment efforts are ongoing to fill these vacancies.

Prior to the WCM FAC Nominations Ad Hoc committee meeting on April 25, 2019, Ad Hoc committee members received and evaluated the applications which had been received. The Ad Hoc, which included WCM FAC members Maura Byron, Grace Leroy-Loge and Kristin Rogers, recommended a candidate for each of the open seats and forwarded the proposed slate of candidates to the WCM FAC for consideration. However, as indicated, due to quorum issues, the WCM FAC has been unable to meet to make recommendations to the CalOptima Board of Directors.

Candidates for the open positions are as follows:

Authorized Family Member Representative

Brenda Deeley (New Appointment)*
Pamela Patterson (Reappointment through November 30, 2019, due to her daughter aging out of CCS)*
Malissa Watson (Reappointment)*

Brenda Deeley is the parent of a 17-year CalOptima member and CCS beneficiary who understands the public payer model. As a Public Relations/Public Affairs/Community Relations Strategist, Ms. Deeley has used her professional skills to work in advocacy for her daughter. She is currently the CEO of Brenda Deeley PR, LLC and has among her clients, Children's Hospital of Orange County (CHOC) and Pomona Valley Hospital Medical Center.

Pamela Patterson is the parent of a special needs adolescent receiving CCS services. Ms. Patterson is a special needs and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County.

Malissa Watson is the parent of a child who receives CCS services. Ms. Watson's desire is to assist families in navigating the CCS and CalOptima benefits. Ms. Watson is active in the community serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

*Indicates WCM FAC Ad Hoc recommendation

Back to Agenda

Community/Consumer Advocate's Representative
Kathleen Lear (New Appointment) *
Sandra Cortez-Schultz (Reappointment)*

Kathleen Lear is currently the chair of the Family Advisory Committee at CHOC. She is a substitute instructional assistant to special education children in the Los Alamitos Unified School District. Ms. Lear is also a parent champion for Creating Opportunities for Parent Empowerment (C.O.P.E.) where she provides support to families living with epilepsy. Ms. Lear has a child with special needs who is a CalOptima member.

Sandra Cortez-Schultz is the Customer Service Manager at CHOC. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working with the CCS program.

Fiscal Impact
Each family representative appointed to the WCM FAC is authorized to receive a stipend of up to $50 per committee meeting attended. Funding for stipends provided to WCM-FAC family representatives is a budgeted item under the CalOptima Fiscal Year 2019-20 Operating Budget. There is no additional fiscal impact related to the recommended action.

Rationale for Recommendation
As stated in CalOptima Policy AA.1217 – Whole Child Model Family Advisory Committee, the WCM FAC established a Nominations Ad Hoc committee to review the potential candidates for vacancies on the Committee. Four WCM FAC meetings were scheduled between April 30, 2019 and August 30, 2019, but the WCM FAC was unable to achieve a quorum at these meetings due to committee vacancies. Therefore, there is no longer the possibility of achieving quorum without the appointment of additional committee members. Recruitment is an on-going initiative for this committee. To ensure a working quorum going forward, the WCM FAC Nominations Ad Hoc committee recommends Board of Directors approval of the recommended slate of candidates.

Concurrence
Whole-Child Model Family Advisory Ad Hoc Nominations Committee
Gary Crockett, Chief Counsel

Attachment
AA.1217 – Whole Child Model Family Advisory Committee

/s/ Michael Schrader — *9/25/2019*
Authorized Signature — **Date**

*Indicates WCM FAC Ad Hoc recommendation

Back to Agenda

Policy #:	AA.1271
Title:	**Whole Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Schrader 07/25/2019*
Effective Date:	06/07/2018
Revised Date:	05/02/2019

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (**WCM**) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the **Whole-Child Model** Family Advisory Committee (**WCM** FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the **WCM** FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regard to **California Children's Services (CCS)** provided by CalOptima Medi-Cal's implementation of the **WCM**.

B. CalOptima's Board encourages **Member** and community involvement in CalOptima programs.

C. **WCM** FAC **Members** shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the **WCM** FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the **WCM** FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. **WCM** FAC members shall have direct or indirect contact with CalOptima **Members**.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the **WCM** FAC shall be comprised of eleven (11) voting members representing **CCS** family members, as well as consumer advocates representing **CCS** families. Except as noted below, each voting member shall serve a two (2)-year term with no limits on the number of terms a representative may serve. The initial appointments of **WCM** FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The **WCM** FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

   1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

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

a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima **Member** who is a current recipient of ***CCS*** services;

b. CalOptima **Members** eighteen (18)-twenty-one (21) years of age who are current recipients of ***CCS*** services; or

c. Current CalOptima **Members** over the age of twenty-one (21) who transitioned from **CCS** services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving **CCS** services, including:

a. Community-based organizations; or

b. Consumer advocates.

3. While two (2) of the **WCM** FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) **WCM** FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a **WCM** FAC member or family member representative.

5. A family representative, in accordance with Section II.F.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Policy GA.5004: Travel Policy.

G. Stipends

1. CalOptima may provide a reasonable per diem payment of up to $50 per meeting to a **Member** or family representative serving on the **WCM** FAC. CalOptima shall maintain a log of each payment provided to the **Member** or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The **WCM** FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

I. **WCM** FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the **WCM** FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new **WCM** FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, **WCM** FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this policy.

1. The **WCM** FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The **WCM** FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The **WCM** FAC chair or vice chair shall ask for three (3) to four (4) members from the **WCM** FAC to serve on a nomination ad hoc subcommittee. **WCM** FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The **WCM** FAC nomination ad hoc subcommittee shall:

a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

b. Forward the prospective chair, vice chair, and slate of candidate(s) to the **WCM** FAC for review and approval.

2. Following approval from the **WCM** FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the **WCM** FAC.

M. Upon appointment to **WCM** FAC and annually thereafter, **WCM** FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the **WCM** FAC.

N. **WCM** FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a **WCM** FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the **WCM** FAC members' attendance at **WCM** FAC meetings. As the attendance log is a public record, for any request from a member of the public, the **WCM** FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the **WCM** FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. **WCM** FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. **WCM** FAC meeting frequency

1. **WCM** FAC shall meet at least quarterly.

2. **WCM** FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. **WCM** FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in **CCS** which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving **CCS**;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in **Threshold Languages**.

3. Prospective candidates must submit a **WCM** Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the **WCM** FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first **WCM** FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. **WCM** FAC nomination evaluation process

1. The **WCM** FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee. For the first nomination process, **Member Advisory Committee (MAC)** members shall serve on the nominations ad hoc subcommittee to review candidates for **WCM** FAC.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to **WCM** FAC nomination ad hoc subcommittee meeting (including the initial **WCM** FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. **WCM** FAC selection and approval process for prospective chair, vice chair, and **WCM** FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to **WCM** FAC (or in the first year, the **MAC**) for review and approval. Following **WCM** FAC's approval (or in the first year, the **MAC**), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The **WCM** FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following **WCM** FAC meeting.

3. **WCM** FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee Application
B. Whole Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee Application
D. Whole Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Policy GA.5004: Travel Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

A. 07/19/19: Department of Health Care Services
B. 09/07/18: Department of Health Care Services

VII. BOARD ACTION(S)

A. 05/02/19: Regular Meeting of the CalOptima Board of Directors
B. 06/07/18: Regular Meeting of the CalOptima Board of Directors
C. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute a new three-way agreement (Agreement) between CalOptima, the California Department of Health Care Services and the Centers for Medicare & Medicaid Services for the Cal MediConnect Program that incorporates an extension of the program for additional Demonstration Years (DY) 6 through 8, new provisions and other regulatory updates.

Background

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

On March 13, 2019, the CMS Medicare-Medicaid Coordination Office (MMCO) provided MMPs with initial *draft* contract language, for review and comments on a subset of 2 new and 2 modified provisions that would be incorporated into the CMC Three-way agreement. At that time, MMCO noted that CMS and DHCS were continuing to work to update the Agreement, and this language was still subject to change based on CMS and DHCS clearance processes. The *draft* Agreement language included:

- A new section on limited One-Sided Risk Corridors that will be established for DY 6-8.
- A new section for the Disenrollment Penalty criteria, effective with 2019 MMP disenrollment rates.
- Modified provision on Quality Withhold percentages to increase from 3% in DY 3-5 (2017 - 2018 - 2019) to **4%** in DY 6-8 (2020 - 2021 - 2022).

Back to Agenda

- Extending the Contract Term to be renewed in one-year terms through 12/31/2022.

On May 31, 2019, CMS MMCO shared the full redlined version of the Agreement for a 2-week MMP comment period. The vast majority of edits to the Agreement reflect current regulatory provisions that are already in effect and not anticipated to impact MMPs in a negative way. There are a handful of provisions that take effect in 2020, and those provisions are noted with dates in the Agreement.

The overall Agreement updates are related to:

1. Medicare regulations that went into effect in 2018;
2. Medicaid regulations that went into effect with the 2018 rating cycle;
3. Demonstrations timeframe extension, including financial provisions previously shared with the MMPs during the 3/14/19 *draft* version; and
4. Incorporating language from Dual Plan Letter (DPL) 15-001: *Interdisciplinary Care Team and Individual Care Plan Requirements for MMPs* into the Three-way agreement.

Based on the contract changes, CalOptima has begun implementation of certain requirements such as DRA False Claims Act education policy, preclusion review and overpayment notification requirements. On June 24, 2019 and July 17, 2019, CMS and DHCS held conference calls with all the MMPs in California to discuss significant questions or comments MMP plans may have had on the redlined changes to the Agreement. CMS messaged verbally that they were working to effectuate this new Three-way agreement update as soon as possible, as some of the Demonstration provisions were effective for 2019 (e.g., the Disenrollment Penalty), while they did not indicate a specific effective date.

Upon receipt of the redline version of the new Three-way Agreement on May 31, 2019, CalOptima staff reviewed changes in the requirements and submitted clarifying comments and feedback to CMS/DHCS.

Discussion

The final version of the new Three-way Agreement for signatures was received by CalOptima on September 9, 2019, with an effective date for September 1, 2019. CMS requested signatures by September 18, 2019. CalOptima staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, until such time there was an opportunity for the CalOptima Board to review the new Agreement during the October 3, 2019 meeting, and execute shortly thereafter. Given the timing of the receipt of the Three-way agreement, CalOptima staff was not able to present the new Agreement to the Board at an earlier Board meeting. The issuance of the Agreement with a retroactive effective date is similar to the Three-way Agreement the Board executed on September 7, 2017, with an effective date of August 22, 2017.

CalOptima staff will evaluate the document to determine whether any subsequent policy and procedure (P&P) changes are needed to align with requirements in the new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action on these P&Ps.

The following is a summary of key changes contained in the new Three-way Agreement:

Back to Agenda

<table>
<tr><th>Section</th><th>Summary of change in Requirement</th></tr>
<tr><td>General updates</td><td>Throughout the Agreement, section reference corrections, general formatting and grammatical updates were made.</td></tr>
<tr><td>Definitions</td><td>A couple of existing definitions were revised for clarity.</td></tr>
<tr><td>Continuity of Care</td><td>2.8.4 Update to standardize language with existing DPL 16-002: Continuity of Care, to only require verification that an enrollee has an existing relationship with an out-of-network provider once within the previous 12-months from the date of enrollment in order to be eligible for continuity of care with that provider.</td></tr>
<tr><td>Compliance</td><td>2.1.4.1 New provision to reiterate existing requirement to report all employees, providers, and Enrollees suspected of Fraud, waste, and/or Abuse that warrant investigation to DHCS – Office of Inspector General, the Medicaid Fraud Control Unit and CMS.
2.1.8 New provision for MMPs that make or receive payments under the contract of at least $5,000,000, to adopt and implement written policies for all employees that provide detailed information about the False Claims Act and other Federal and State laws, including information about rights of employees to be protected as whistleblowers.</td></tr>
<tr><td>Enrollee Grievances

Enrollee Appeals</td><td>Updates to both grievance and appeals provisions to standardize language with Medicaid regulations that went into effect in 2018.

2.15.1.3 and 2.15.3.5.5 Effective January 1, 2020, Contractors <u>with</u> a Knox-Keene license may <u>not allow</u> extensions to resolve Appeals. This is not applicable to CalOptima since it does not have a Knox-Keene license.</td></tr>
<tr><td>Continuation of Benefits Pending an Appeal</td><td>2.15.16 New provision to require the MMP to act in accordance with the decision favorable to the Enrollee in the event Enrollee pursues an Appeal under multiple external forums and the external decisions conflict.</td></tr>
<tr><td>Interdisciplinary Care Team (ICT) and Individual Care Plan (ICP)</td><td>2.5.2.8 and 2.5.2.9 Update to standardize language with existing DPL 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for MMPs.</td></tr>
<tr><td>Provider Network</td><td>2.9.5 New provision to assure that all network providers that provide Medicare Covered Services do not appear on the CMS preclusion list in order to submit claims for reimbursement or otherwise participate in the Medicare program. Similarly, MMP to ensure that all such providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements.</td></tr>
<tr><td>Demonstration Year Dates</td><td>4.1.2.1 Revised provision to add DY 6-8:
<table>
<tr><th>Demonstration Year</th><th>Calendar Dates</th></tr>
<tr><td>6</td><td>January 1, 2020 – December 31, 2020</td></tr>
<tr><td>7</td><td>January 1, 2021 – December 31, 2021</td></tr>
<tr><td>8</td><td>January 1, 2022 – December 31, 2022</td></tr>
</table></td></tr>
<tr><td>Underlying Rate Structure for the <u>Medi-Cal</u> Component</td><td>4.2.1.1 Revised the provision to define the existing four risk adjustment population categories for DY 1-3 only.
4.2.1.1.2 New provision to define the four risk adjustment population categories that will apply for DY 4-8.</td></tr>
<tr><td>Aggregate Savings Percentages</td><td>4.2.3.2 New provision to specify savings percentages will not be applied to the Part D component of the rate.</td></tr>
</table>

Back to Agenda

Section	Summary of change in Requirement
One-Sided Risk Corridor Parameters	4.4 New provisions on One-Sided Risk Corridors that will be established for DY 6-8, with definitions of gains/losses and five (5) bands with specified percentage payments to DHCS & CMS for payment/recoupment of Up-side risk corridors.
Allowable Expenditures	4.4.1.3 Updated language in provision regarding CMS and DHCS reserving the right to adjust expenditures for services that are significantly above the median reimbursement rate of other comparable plans. The State and CMS will provide additional detail regarding the methodology for considering adjustments to expenditures in separate technical guidance.
Risk Sharing Settlement	4.4.3 New provision on the risk corridor calculation being net of an MLR remittance, in the event the MMP qualifies to make both risk corridor payment as well as an MLR remittance to CMS & DHCS. CMS and the State shall determine final settlement of payments made by the MMP to CMS and the State, and data submission shall be in the form and manner prescribed by DHCS and CMS, necessary to calculate and verify the final settlement after the end of each applicable Demonstration Year.
Quality Withholds	4.8.1.3 Revised provision to incorporate DY 6-8 and define that the quality withhold will increase from 3% in DY 3-5 to **4%** in DY 6-8.
Disenrollment Penalty	4.10 New provision to impose a retrospective financial penalty in the Medicare A/B component of the Capitation Rate for MMPs with high disenrollment rates, effective with 2019 MMP disenrollment rates, for MMPs that do not meet the benchmark to maintain the median MMPs performance from measurement year 2017/DY 3. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect Demonstration and to align incentives for MMPs to improve quality for all Enrollees.
Identified Overpayments	4.14.2 New provision to reiterate requirements to promptly report to DHCS and CMS any identified overpayments due to Fraud, within sixty (60) calendar days when it has identified overpayments. The MMP must adopt and implement P&Ps for recoveries of overpayments from Network Providers.
Contract Term	5.8 Extending the Contract Term to be renewed in one-year terms through 12/31/2022.

Based on review by CalOptima's departments primarily impacted by these provisions, staff does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

The recommended action to execute the new Three-way Agreement, inclusive of amendments to the Medi-Cal component rate structure, aggregate savings percentages, one-sided risk corridor parameters, allowable expenditures, risk sharing settlement, quality withholds, and disenrollment penalty noted in

Back to Agenda

the discussion above, were anticipated and accounted for in the CalOptima Consolidated Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019.

Under the FY 2019-20 OneCare Connect Operating Budget the amount for the 4% quality withhold is estimated at $9.5 million. This is an increase of approximately 33% from the prior fiscal year. Staff assumed that 75% of the withheld amount is receivable for FY 2019-20.

Specific to the one-sided risk corridor, a payment back to the state is required for plans that achieve a net surplus greater than 5%. Based on CalOptima's Cal MediConnect Program performance, staff does not anticipate a payment back to the state in the immediate future.

Management also plans to account for the provisions under the new three-way agreement in future operating budgets. The recommended action to incorporate other regulatory updates is expected to be budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new Three-Way Agreement with DHCS and CMS is necessary to ensure compliance with the requirements and for the continued operation of CalOptima's Cal MediConnect (OneCare Connect) program through December 31, 2022. Additionally, the CalOptima FY 2019-20 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment are consistent with the approved budget.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to the Agreement with DHCS and CMS for Cal MediConnect.

/s/ Michael Schrader — *9/25/2019*

Authorized Signature — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM ~~12~~ 18 | *Rev. 10/3/19*

The following is a summary of amendments to the three-way agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015
New three-way agreement (Agreement), to replace prior agreement in its entirety Extends the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).	September 7, 2017
New three-way agreement (Agreement), to replace prior agreement in its entirety Removal of language pertaining to In-Home Supportive Services (IHSS) and incorporates other regulatory updates.	December 7, 2017
New three-way agreement (Agreement), to replace prior agreement in its entirety Extends the Agreement for an additional three (3) years to December 31, 2022, additional Demonstration Years (DY) 6 through 8, and incorporates new provisions and other regulatory updates.	Pending

/

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

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, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion

CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

Back to Agenda

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect 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
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
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
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

Back to Agenda

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

Back to Agenda

- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

Back to Agenda

- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Consider Modifications to CalOptima Quality Improvement Policies and Procedures Related to Annual Policy Review

Contact
David Ramirez, M.D., Chief Medical Officer, 714-246-8400

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) to modify existing Policies and Procedures, as follows:
1. GG.1607: Monitoring Adverse Actions
2. GG.1608: Full Scope Site Reviews
3. GG.1620: Quality Improvement Committee
4. GG.1639: Post-Hospital Discharge Medication Supply

Background/Discussion
As a County Organized Health System (COHS), CalOptima contracts with state and federal agencies to provide health care services to beneficiaries in Orange County.

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified laws, regulatory guidance, contracts and business practices as part of its annual policy review process and on an ad hoc basis.

CalOptima regularly reviews its Policies and Procedures to ensure they are up to date and aligned with federal and state health care program requirements and laws as well as CalOptima operations. CalOptima staff have reviewed the Policies and Procedures to ensure consistency with applicable federal and state health care program laws, regulations and/or guidance.

Summary of Changes
CalOptima Policy and Procedure updates include the following, but are not limited to:
- Recent regulatory updates
- Annual review revisions
- Updates to business operations
- National Committee for Quality Assurance (NCQA) standards

The following table lists new and/or modified policies that are presented for approval:

Back to Agenda

	Policy	Summary of Change(s)	Reason for Change
1.	GG.1607: Monitoring Adverse Actions	Policy GG.1607 establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and Organizations Providers (OPs). The main change to the policy was including language regarding Center for Medicare & Medicaid Services (CMS) requirement to check the Preclusion List as part of monitoring adverse actions.	• Annual Review; CMS Regulatory requirement
2.	GG.1608: Full Scope Site Reviews	This policy outlines CalOptima's site review requirements, per Department of Health Care Services (DHCS) Policy Letter (PL) 14-004, including the Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review Survey (PARS), and the process by which CalOptima conducts, scores, tracks and reports site reviews in accordance with applicable state and federal guidelines. Changes include: • Addition to the policy that CalOptima may collect additional information at primary care provider (PCP) sites during the FSR process including, but 45 not limited to, information on member experience and timely access to Covered Services. • Updated statement that CalOptima must resurvey the PCP, and the PCP must pass with at least a score of eighty percent (80%) to be considered a CalOptima network provider. Any Corrective Action Plan (CAP) issued must be completed per CAP timeline requirements. • Updated process related to CalOptima unannounced site visit when one (1) or more member complaints related to physical accessibility or member safety is identified. If any issue related to physical accessibility or member safety, then CalOptima shall conduct an unannounced site visit no later than seven (7) calendar	•Annual Review, Updated business operations, and added more specificity language

	Policy	Summary of Change(s)	Reason for Change
		days after identification, depending on the severity of the identified patient safety or physical accessibility issue. However, for complaints of appearance or cleanliness, will be tracked and trended; if there are more than three (3) in a 12-month period an unannounced site visit will be conducted. • Updated statement that Credentialing and Peer Review Committee (CPRC) will provide updates related to FSR/MRR/PARS to the CalOptima Quality Improvement Committee quarterly.	
3.	GG.1620: Quality Improvement Committee	The policy describes CalOptima's Quality Improvement Committee (QIC) and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for members and providers; satisfaction for members and other customers; maintenance of quality standards, licensing, contract and regulatory compliance; and continued accreditation by the National Committee for Quality Assurance (NCQA). The policy reflects the QIC Charter but had no major changes in 2019.	•Annual Review
4.	GG.1639: Post-Hospital Discharge Medication Supply	Purpose of this policy is to ensure that contracted hospitals provide for members at least a seventy-two (72) hour supply of medication upon discharge when the medication is needed to prevent the member's condition from worsening. The requirement can be met either by providing the seventy-two (72)-hour supply or providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply. Medications normally requiring prior authorization are exempted when needed after hours (nights, weekends and holidays).	•Annual Review

Back to Agenda

Fiscal Impact
The recommended action to adopt modifications to CalOptima's Quality Improvement policies and procedures based on the annual policy review has no additional fiscal impact on the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation
To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations and rules, CalOptima staff recommends that the Board approve and adopt the presented CalOptima Policies and Procedures. The updated Policies and Procedures will supersede the prior versions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. GG.1607: Monitoring Adverse Actions (redlined and clean versions)
2. GG.1608: Full Scope Site Reviews (redlined and clean versions)
3. GG.1620: Quality Improvement Committee (redlined and clean versions)
4. GG.1639: Post-Hospital Discharge Medication Supply (redlined and clean versions)

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

Policy #:	GG.1607Δ
Title:	**Monitoring Adverse ~~Activities~~Actions**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	12/95
Last Review Date:	TBD~~06/01/17~~
Last Revised Date:	TBD~~06/01/17~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process for ongoing monitoring of ~~contracted~~the actions taken by external entities including, without limitation, licensing boards or ~~non-contracted~~agencies, regulatory agencies and/or other entities against CalOptima practitioners ~~and~~or Healthcare Delivery ~~Organization's~~Organizations (HDOs~~) Adverse Activity.~~).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles.

~~B. A Health Network shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles that at a minimum, is in accordance with this Policy.~~

~~C. CalOptima shall take appropriate action against practitioners or HDOs when the CalOptima Quality Improvement (QI) Department identifies adverse activity.~~

~~D. CalOptima shall notify practitioners and HDOs if limiting practice, in writing, within thirty (30) calendar days.~~

~~E.~~B. Adverse ~~Activities~~actions include~~-~~, but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 ~~report~~ with the Medical Board of California and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

DRAFT 20190918_QAC

Back to Agenda

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG); ~~or~~

9. Any action taken by System for Award Management (SAM~~); or~~); or~~.~~

~~9.~~10. Any provider listed on the CMS Preclusion List.

~~10. A pattern or trend concerning quality of care issues and complaints that have been identified through the CalOptima Quality Improvement Department.~~

C. CalOptima shall refer information of adverse actions taken against CalOptima practitioners or HDOs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing and Peer Review Committee for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in Federal or State health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors practitioners and HDOs on an ongoing basis to identify ~~Adverse Activities~~adverse actions that may affect participation in CalOptima program.

B. CalOptima monitors various State and Federal boards, agencies, and databanks for ~~Adverse Activity(ies)~~adverse actions including:

1. OIG exclusion list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports, and continuous monitoring NPDB reports;

4. Medicare Opt-Out Physicians: upon Credentialing and Recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon Credentialing and Recredentialing and ongoing on a monthly basis; ~~and~~

DRAFT_20190918_QAC

Back to Agenda

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions~~.; and~~

7. California State Licensing Boards for all practitioners within FACETS; checked monthly and quarterly as reports are published;~~.~~

8. CMS Preclusion List as published by CMS, upon Credentialing and Recredentialing, and ongoing on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse ~~activity that limits or removes a practitioner's right to practice will be reported~~actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the ~~Quality~~CalOptima Medical Director ~~for approval. Once approved, the~~, Provider Relations ~~or~~, Health Network Relations ~~Departments will be notified. In addition,~~ , and Provider Data Management ~~Services~~Systems (PDMS~~) will be notified and will enter an alert in Facets™ which will also be captured in Guiding Care for the UM staff's notification.~~).

~~E. Any adverse activities identified shall be tracked in the adverse activity database.~~

~~F.~~E. Upon credentialing and recredentialing, adverse ~~activities~~actions identified in the tracking database will be summarized and added to the practitioner and HDO file ~~in Credentialing database~~.

~~G.~~F. ~~On a bi-monthly basis or earlier, depending on the nature of the adverse activity and CalOptima requirements, the~~ QI Department shall report, in a confidential manner, all adverse action findings to the Credentialing Peer Review Committee (CPRC).

~~H.~~G. ~~On a quarterly basis, CalOptima's Grievance & Appeals Resolution Services (GARS) Department~~ CalOptima shall ~~report to the Quality Improvement Committee (QIC) all complaints, including a summary of~~also monitor and consider internal quality data ~~analysis, regarding service, attitude, and access,~~(e.g. potential quality issues (PQIs), and Member grievances between re-credentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

~~I.~~H. The QI Department shall forward all Practitioner and HDO potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

~~J.~~I. CalOptima shall inform affected practitioners or HDOs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

~~K.~~J. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files~~,~~ and shall ensure that all Credentialing files are up-to-date.

~~L.~~K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

DRAFT 20190918 Q&C

~~a.~~1. The report to DHCS shall include the following:

~~i.~~a. Contract status (by delegated entity, if applicable) with the named provider.

~~ii.~~b. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

~~M. Any alert affecting Health Networks will be communicated through the Health Network Relations Department, as applicable.~~

~~N.~~L. ~~Any alert~~Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
~~B. California Business and Professions Code, §4022~~
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~A. ~~CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage~~
~~E.~~D. CalOptima PACE Program Agreement
~~F.~~E. CalOptima Policy CMC.9001: Member Complaint Process
~~G.~~F. CalOptima Policy CMC.9002: Member Grievance Process
~~H.~~G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
~~I.~~H. CalOptima Policy GG.1611: Potential Quality Issue Review Process
~~J.~~I. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
~~K.~~J. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
~~L.~~K. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~M.~~L. CalOptima Policy HH.1102: CalOptima Member Complaint
~~N.~~M. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Providers Information, CalOptima Providers Directory, and Web-based Directory.
~~O.~~N. CalOptima Policy MA.9002: Member Grievance Process
~~P.~~O. CalOptima Policy MA.9006: Provider Complaint Process
~~Q.~~P. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~R.~~Q. Department of Health Care Services All Plan Letter 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
~~S.~~R. Title 42 United States Code §11101 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 08/04/17: Department of Health Care Services

VII. BOARD ACTIONS

DRAFT 20190918_QAC

A.~~—~~ ~~06/01/17:~~ Regular Meeting of the CalOptima Board of Directors
B. 11/29/18: Regular Meeting of the Credentialing Peer Review Committee
C. 02/12/19: Regular Meeting of the Quality Improvement Committee
D. 09/18/19: Regular Meeting of the Quality Assurance Committee

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Retired	02/01/2013	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE

DRAFT_20190918_QAC

1
2

DRAFT_20190918_QAC

IX. GLOSSARY

Term	Definition
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Support Services (LTSS) Providers	A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), radiology centers, clinical laboratories, rehabilitation facilities.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner who practices independently under state law, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Audiologist furnishing covered services.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

DRAFT 06/09/17 QAC

Policy #:	GG.1607Δ
Title:	**Monitoring Adverse Actions**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	12/95
Last Review Date:	TBD
Last Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

DRAFT_20190918_QAC

I. PURPOSE

This policy establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima practitioners or Healthcare Delivery Organizations (HDOs).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles.

B. Adverse actions include, but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 with the Medical Board of California and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG);

Back to Agenda

9. Any action taken by System for Award Management (SAM); or

10. Any provider listed on the CMS Preclusion List.

C. CalOptima shall refer information of adverse actions taken against CalOptima practitioners or HDOs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing and Peer Review Committee for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in Federal or State health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors practitioners and HDOs on an ongoing basis to identify adverse actions that may affect participation in CalOptima program.

B. CalOptima monitors various State and Federal boards, agencies, and databanks for adverse actions including:

1. OIG exclusion list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports, and continuous monitoring NPDB reports;

4. Medicare Opt-Out Physicians: upon Credentialing and Recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions;

7. California State Licensing Boards for all practitioners within FACETS; checked monthly and quarterly as reports are published;

8. CMS Preclusion List as published by CMS, upon Credentialing and Recredentialing, and ongoing on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the CalOptima Medical Director, Provider Relations, Health Network Relations, and Provider Data Management Systems (PDMS).

DRAFT_20190918_QAC

Back to Agenda

E. Upon credentialing and recredentialing, adverse actions identified in the tracking database will be summarized and added to the practitioner and HDO file.

F. QI Department shall report, in a confidential manner, all adverse action findings to the Credentialing Peer Review Committee (CPRC).

G. CalOptima shall also monitor and consider internal quality data (e.g. potential quality issues (PQIs), and Member grievances between re-credentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

H. The QI Department shall forward all Practitioner and HDO potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

I. CalOptima shall inform affected practitioners or HDOs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

J. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files and shall ensure that all Credentialing files are up-to-date.

K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

1. The report to DHCS shall include the following:

a. Contract status (by delegated entity, if applicable) with the named provider.

b. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

L. Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy CMC.9001: Member Complaint Process

DRAFT_20190918_QAC

Back to Agenda

F. CalOptima Policy CMC.9002: Member Grievance Process
G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
H. CalOptima Policy GG.1611: Potential Quality Issue Review Process
I. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
J. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.1102: CalOptima Member Complaint
M. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Providers Information, CalOptima Providers Directory, and Web-based Directory.
N. CalOptima Policy MA.9002: Member Grievance Process
O. CalOptima Policy MA.9006: Provider Complaint Process
P. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
Q. Department of Health Care Services All Plan Letter 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
R. Title 42 United States Code §11101 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 08/04/17: Department of Health Care Services

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 11/29/18: Regular Meeting of the Credentialing Peer Review Committee
C. 02/12/19: Regular Meeting of the Quality Improvement Committee
D. 09/18/19: Regular Meeting of the Quality Assurance Committee

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Retired	02/01/2013	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare

DRAFT_20190918_QAC

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE

1

DRAFT_20190918_QRC

IX. GLOSSARY

Term	Definition
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Support Services (LTSS) Providers	A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), radiology centers, clinical laboratories, rehabilitation facilities.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner who practices independently under state law, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Audiologist furnishing covered services.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

DRAFT 20190918 QAC

Ongoing Monitoring Website Information ~~01-25-2017~~

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 6332322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions: http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed: http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **~~Enforcement Public Document Search (Search by Name or Lic: http://www2.mbc.ca.gov/PDL/Search.aspx~~**	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final

Ongoing Monitoring Website Information ~~01-25-2017~~

Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov ~~Enforcement/Disciplines(916) 9288390 Ext. 6~~	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** ~~**Subscribe to e-mail Alerts**~~ ~~**http://www.ombc.ca.gov/consumers/enforce_action.shtml**~~	Quarterly via the Website E-Mail Distribution list:
~~**Licensing Board, Address and Phone Numbers**~~	~~**Practitioner Types**~~	~~**Website/links**~~	~~**Report Frequency**~~

Ongoing Monitoring Website Information ~~01-25-2017~~

Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 ~~Email: BPM@dca.ca.gov~~ ~~Enforcement Program~~ ~~Central File Room~~ ~~Medical Board of California~~ ~~2005 Evergreen Street, Suite 1200~~ ~~Sacramento, CA 95815~~ ~~FAX: (916) 263-2420~~	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. ~~History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses~~ varies/ check monthly
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 ~~Email: acupuncture@dca.ca.gov~~ ~~To order copies of actions send to Attn of Consumer Protection Program~~	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** ~~**Sign up for subscribers list for disciplinary actions:**~~ ~~**https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**~~	Monthly running report listed Alpha Newer actions highlighted with date in blue. ~~Note: Board meetings are held quarterly.~~

Revised 05-01-18~~1 25 2017~~, Revised 12/21/18-, Revised 1/11/2019
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

Back to Agenda

Ongoing Monitoring Website Information ~~01-25-2017~~

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 ~~E-Mail:~~ ~~BBSWebmaster@bbs.ca.gov~~	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **~~Sign up for subscribers list for disciplinary actions.~~** **~~https://www.dca.ca.gov/webapps/bbs/subscribe.php~~**	**Via Subscriptions Only** Information must be obtained via subscription. Monthly ~~For Subscribers:~~ ~~E-mail reports were sent:~~
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Monthly

Ongoing Monitoring Website Information ~~01-25-2017~~

Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov ~~Enforcement Unit PH: 916-274-6326~~	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	Monthly ~~Note: At the end of the list it provides a date posted.~~ ~~As of 12/31/2016~~

~~Licensing Board, Address and Phone Numbers~~	~~Practitioner Types~~	~~Website~~	~~Report Frequency~~

Ongoing Monitoring Website Information ~~01-25-2017~~

California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 ~~Email: cbot@dca.ca.gov~~ ~~Email: EnfPrg@dca.ca.gov~~	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** ~~**Sign up for subscribers list for disciplinary actions: https://www.dca.ca.gov/webapps/bot/subscribe.php**~~	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. M~~Recommend m~~onthly review. ~~The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.~~

Ongoing Monitoring Website Information ~~01-25-2017~~

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** ~~**Sign up for subscribers list for disciplinary actions:**~~ ~~**https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**~~	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	Monthly ~~Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.~~

Ongoing Monitoring Website Information ~~01-25-2017~~

Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-5033221.**	PhD, PsyD	**www.psychboard.ca.gov** ~~**Sign up for subscribers list for disciplinary actions:**~~ ~~**https://www.dca.ca.gov/webapps/psychboard/subscribe.php**~~	**Via Subscriptions Only** Information must be obtained via subscription~~.~~ . Varies Monthly ~~For Subscribers:~~ ~~E-mail~~

~~**Licensing Board, Address and Phone Numbers**~~	~~**Practitioner Types**~~	~~**Website**~~	~~**Report Frequency**~~
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www rn.ca.gov/enforcement/unlicprac.shtml**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Ongoing Monitoring Website Information ~~01-25-2017~~

~~**National Council of State Board of Nursing (BCSBN)**~~ ~~111 East Wacker Drive, Suite 2900~~ ~~Chicago, IL 60601-4277~~ ~~Phone:(312) 525-3600~~ ~~Fax: (312) 279-1032~~ ~~Email: info@ncsbn.org~~ ~~.~~	~~Additional information for RN/LVN/NP/CNM~~	~~**www.nursys.com**~~ ~~To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions.~~ ~~**https://www.nursys.com/EN/ENDefault.aspx**~~	~~.~~
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** ~~As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.~~	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

~~**Site Name, Address and Phone Numbers**~~	~~**Service**~~	~~**Website**~~	~~**Report Frequency**~~
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction &exclusions	**www.oig hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** ~~**Direct Link to exclusion database**~~ ~~**http://oig.hhs.gov/exclusions/exclusions_list.asp**~~	**Monthly** ~~(see note under instructions regarding subscribing notifications)~~

Ongoing Monitoring Website Information ~~01-25-2017~~

~~**Noridian Healthcare Solutions Medicare Opt-Out Physicians JE MAC**~~ ~~**1855-609-9960 Select Provider Enrollment**~~ ~~**https://med.noridianmedicare.com/web/jeb**~~	~~Medicare Opt-Out~~	~~**https://www.noridianmedicare.com**~~ ~~Link to JE Part B~~ ~~**https://med.noridianmedicare.com/web/jeb**~~ ~~**Direct Link to Opt-Out Reports: https://med.noridianmedicare.com/web/jeb/enrollment/optout/opt-out-listing**~~	~~**Quarterly**~~ ~~Last update:~~ ~~01/19/17(updated 1/20/17)~~ ~~08/15/16~~ ~~06/13/16 (6/10/16)~~ ~~12/23/15~~ ~~10/30/15 Northern~~ ~~10/08/15 Southern~~ ~~08/14/15~~ ~~07/07/15~~ ~~04/13/15~~ ~~03/11/15~~ ~~01/28/15~~
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	**Quarterly**

Ongoing Monitoring Website Information ~~01-25-2017~~

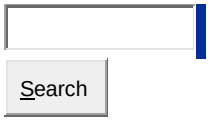
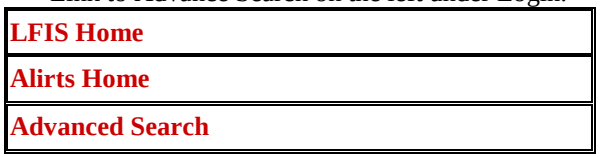
CMS.gov **Centers for Medicare & Medicaid Services**	**The Preclusion List**	CMS will make the initial Preclusion List available to Plans beginning **January 1, 2019** on a secure website and updates will be made available approximately every 30 days, around the first business day of each month. Details on how it will be distributed to Quality Improvement is TBD.	**Monthly and Upon Initial and Recredentialing Cycle.**

~~Site Name, Address and Phone Numbers~~	~~Service~~	~~Website~~	~~Report Frequency~~
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**: **http://files medi-cal.ca.gov/pubsdoco/SandILanding.asp**	**Monthly**

Ongoing Monitoring Website Information ~~01-25-2017~~

SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** ~~Note: The SAM website has a user guide:~~ ~~Link to SAM User Guide v1.8.3 of 350:~~	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	**Monthly via Lexis Nexist Monitoring ~~NA~~**

Additional Websites for Initial and Recredentialing Verifications

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default htm **To search for a facility** • Enter name in box that is found in top right corner  or • Link to Advance Search on the left under Login.  **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.

Additional Websites for Initial and Recredentialing Verifications

The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

~~Site Name, Address and Phone Numbers~~	~~Service~~	~~Website~~	~~Instructions and Comments~~

Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Additional Websites for Initial and Recredentialing Verifications

Back to Agenda

Additional Websites for Initial and Recredentialing Verifications

~~Site Name, Address and Phone Numbers~~	~~Service~~	~~Website~~	~~Instructions and Comments~~

Additional Websites for Initial and Recredentialing Verifications

Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR2016-06-01/html/2016-12479 htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses - **American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** - **American Nurses Credentialing Center** (ANCC) - **National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) - **Pediatric Nursing Certification Board** (PNCB) - **American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa net/**	Informational only to verify board certification	**Board Certification**

Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Board Certification, Address and Phone Numbers	**Practitioner Types**	**Website**	**Instructions and Comments**	**Verification Type**
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

Additional Websites for Initial and Recredentialing Verifications

e specialty certifying boards are ently approved under California law for : DPMs – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	**Practitioner Types**	**Website/links**	**Report Frequency**
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 6332322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions: http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed: http://www.mbc.ca.gov/Publications/Disciplinary_Actions/**	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final

Ongoing Monitoring Website Information

Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	Quarterly via the Website E-Mail Distribution list:

Ongoing Monitoring Website Information

Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. varies/ check monthly
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml**	Monthly running report listed Alpha Newer actions highlighted with date in blue.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov**	**Via Subscriptions Only** Information must be obtained via subscription. Monthly
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Monthly

Ongoing Monitoring Website Information

Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	Monthly

Ongoing Monitoring Website Information

California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml**	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Monthly review.

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

Back to Agenda

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov**	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	Monthly

Ongoing Monitoring Website Information

Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-5033221.**	PhD, PsyD	**www.psychboard.ca.gov**	**Via Subscriptions Only** Information must be obtained via subscription. Varies Monthly
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www rn.ca.gov/enforcement/unlicprac.shtml**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Ongoing Monitoring Website Information

Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml**	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction &exclusions	**www.oig hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/**	**Monthly**
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProvider SupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	**Quarterly**

Ongoing Monitoring Website Information

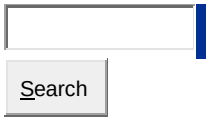
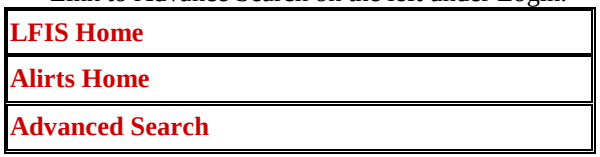
CMS.gov **Centers for Medicare & Medicaid Services**	**The Preclusion List**	CMS will make the initial Preclusion List available to Plans beginning **January 1, 2019** on a secure website and updates will be made available approximately every 30 days, around the first business day of each month. Details on how it will be distributed to Quality Improvement is TBD.	**Monthly and Upon Initial and Recredentialing Cycle.**

Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**: **http://files medi-cal.ca.gov/pubsdoco/SandILanding.asp**	**Monthly**

Ongoing Monitoring Website Information

SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/**	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	**Monthly via Lexis Nexist Monitoring**

Additional Websites for Initial and Recredentialing Verifications

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default htm **To search for a facility** • Enter name in box that is found in top right corner  or • Link to Advance Search on the left under Login.  **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.

Additional Websites for Initial and Recredentialing Verifications

The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Additional Websites for Initial and Recredentialing Verifications

Additional Websites for Initial and Recredentialing Verifications

Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR2016-06-01/html/2016-12479 htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses - **American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** - **American Nurses Credentialing Center** (ANCC) - **National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) - **Pediatric Nursing Certification Board** (PNCB) - **American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa net/**	Informational only to verify board certification	**Board Certification**

Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Board Certification, Address and Phone Numbers	**Practitioner Types**	**Website**	**Instructions and Comments**	**Verification Type**
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

Additional Websites for Initial and Recredentialing Verifications

e specialty certifying boards are ently approved under California law for : DPMs – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Policy #:	GG.1608Δ
Title:	**Full Scope Site Reviews**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/96
~~Last Review Date:~~	~~02/01/18~~
~~Last~~ Revised Date:	~~02/01/18~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

DRAFT 20190918QAC

I. PURPOSE

This policy outlines CalOptima's site review process, including the **Facility Site Review (FSR)**, **Medical Record Review (MRR)**, and **Physical Accessibility Review Survey (PARS)**, and the process by which CalOptima conducts, scores, tracks, and reports site reviews in accordance with applicable state and federal guidelines.

II. POLICY

A. CalOptima shall assess the quality, safety, and accessibility of sites where care is delivered in accordance with Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid (CMS) guidelines and regulations.

B. CalOptima may delegate **FSR**, **MRR**, and **PARS** to a Knox-Keene licensed full service health care service plan that is contracted with CalOptima as a **Health Network**. Such delegated health plan shall conduct **FSR**, **MRR**, and **PARS** in accordance with the provisions of this Policy and in compliance with applicable DHCS and CMS guidelines and regulations.

C. CalOptima shall retain responsibility and accountability for the coordination and consolidation of **FSR**, **MRR**, or **PARS** and shall not delegate such reviews to a **Health Network**, except where CalOptima approves a delegation to a full service Knox-Keene licensed **Health Maintenance Organization (HMO)** in accordance with Section II.B of this Policy.

D. CalOptima's Quality Improvement (QI) Department shall conduct **FSR**, **MRR**, and **PARS**, as well as subsequent periodic site reviews, as part of the initial **credentialing** and recredentialing process, regardless of the status of other certification or accreditation, if:

1. There is no documented evidence that the **Primary Care Provider (PCP)** site has a current passing score on a survey conducted by another Medi-Cal Managed Care health plan; or

2. A **PCP** from a certified **PCP** site moves to a new site that has not been previously reviewed.

E. A Full Scope/Periodic Site Review consists of the **FSR** and **MRR**.

1. CalOptima is not required to conduct a **Full Scope Site Review** for a **PCP** site if a new **PCP** is added to a **PCP** site that has a current passing **Full Scope Site Review** score.

Back to Agenda

F. **Full** Scope Site Reviews shall be conducted by specified CalOptima staff as outlined in Section III.~~H~~ A of this Policy.

G. CalOptima's QI Department shall conduct a **FSR** for new **PCP** sites that have never received a **FSR** or have not had a passing review in the past three (3) years.

H. CalOptima's QI Department shall conduct a **MRR survey** for new **PCP** sites within ninety (90) calendar days of the date CalOptima first assigns **Members** to the **PCP**~~, except~~. CalOptima may defer the review an additional ninety (90) calendar days only if the new **PCP** ~~has a "shared" medical records system or the site does~~does not have a sufficient number of **Members assigned** to complete a review of ten (10) ~~medical~~**Medical Records.** At the end of six (6) months, if the **PCP** still has fewer than ten (10) assigned **Member Medical Records,** CalOptima must complete an MRR on the total number of records available, and adjust the scoring according to the number of records~~.~~ reviewed.

I. CalOptima's QI Department shall conduct a **PARS** at the time of initial **credentialing** for the following:

1. All **PCP** offices;

2. **Specialty Care Provider** offices, **Community Based Adult Services (CBAS) Provider Sites**, and **Ancillary Service Provider Sites** serving a high volume of **Seniors and Persons with Disabilities (SPD)**; and

3. **Specialty Care Provider** offices and **Ancillary Service Provider Sites** included in the provider directory who are serving a high volume of OneCare Connect **Members**.

J. CalOptima shall conduct a subsequent **FSR**, **MRR**, and **PARS** of a **PCP** site at least every three (3) years.

1. CalOptima may waive ~~a~~an **FSR**, **MRR**, and/or **PARS** for a pre-contracted **PCP** site if the **PCP** site has documented proof that ~~a~~an **FSR**, **MRR**, and/or **PARS** with a passing score was completed by a Medi-Cal Managed Care health plan within the past three (3) years.

2. CalOptima may conduct ~~a~~an **FSR**, **MRR**, and/or **PARS** more frequently if required by local collaborative decision, or if CalOptima determines that it is necessary based on monitoring, evaluation, or **Corrective Action Plan (CAP)** follow-up issues.

K. CalOptima shall monitor a **PCP** site between each regularly scheduled **FSR**.

1. CalOptima shall conduct an ~~Interim Audit~~ interim audit midcycle (approximately eighteen (18) months) after the previous audit date to evaluate the nine (9) Critical Elements from the **FSR**.

a. If there was no **Critical Element CAP** received during the previous audit, the office will receive an attestation to sign and return to CalOptima attesting all Critical Elements are in effect.

b. If the **Critical Elements CAP** was received during the previous audit, an on-site audit will be conducted on the **Critical Elements** only.

DRAFT 20190918QAC

Back to Agenda

L. CalOptima's QI Department shall score the **FSR**, **MRR**, and **PARS** in accordance with Section III.D of this Policy.

M. CalOptima's QI Department shall identify deficiencies and request **Corrective Action Plans (CAP)** for **FSR** and **MRR** deficiencies, in accordance with Section III.E of this Policy.

1. ~~CAPS~~**CAPs** will not be issued for **PARS** results, as these results are informational.

2. CalOptima shall document **PARS** results and make survey records available to DHCS for review upon request.

N. **Members** shall not receive **Covered Services** at a new **PCP** site until the site receives a passing **FSR** score, as outlined in Section III.D.1 of this Policy, and/or completes required **CAPs** issued by CalOptima's QI Department.

O. Notwithstanding the corrective action time requirements set forth in this Policy, CalOptima shall not allow an existing **PCP** site with major or serious uncorrected deficiencies to continue providing care to **Members** until the site corrects all such deficiencies.

P. All **Health Networks** shall accept CalOptima site review surveys status or results to coordinate and consolidate site audits for shared **PCPs**.

Q. A **PCP** shall notify CalOptima when the **PCP** intends to relocate its practice at least thirty (30) calendar days prior to the relocation. Upon notification of the relocation, CalOptima shall conduct an **FSR**, **MRR**, and **PARS** on the new location, except as described in Section II.E.1 of this Policy.

1. If a PCP notifies CalOptima after the move:

a. CalOptima will permit assigned **Members** to continue to see the PCP;

b. CalOptima will not assign new **Members** to the PCP until CalOptima conducts an **FSR** on the new location; and

c. CalOptima will complete an **FSR** on the new location within thirty (30) calendar days of the notification of the move.

R. The site review process described in this policy shall remain confidential and protected from disclosure in accordance with applicable law.

S. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** Complaints related to physical accessibility or **Member** safety, pursuant to Section III.F of this Policy, are filed with CalOptima's QI Department.

T. CalOptima may collect additional information at **PCP** sites during the **FSR** process, including but not limited to, information on member experience, and timely access to **Covered Services**.

III. PROCEDURE

DRAFT 20190918QAC

A. **Facility Site Review:**

1. The **FSR** includes on-site inspection and interviews with site personnel to review criteria outlined by DHCS including, but not limited to, the following nine (9) ~~critical elements~~**Critical Elements** that may adversely affect a **Member's** health or safety:

   a. Exit doors and aisles are unobstructed and escape accessible;

   b. Airway management equipment is appropriate to the practice and populations served (e.g., oxygen delivery systems, oral airways, nasal canula or mask, Ambu bag) and are present on site;

   c. Only qualified and trained personnel retrieve, prepare, or administer medications;

   d. The Physician must review and follow-up with referrals, consultation reports and diagnostic test results;

   e. Only lawfully authorized persons dispense drugs to patients;

   f. Personal Protective Equipment (PPE) is readily available for staff use;

   g. Needlestick safety precautions are practiced on site;

   h. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport, and shipping; and

   i. Spore testing of autoclave or steam sterilizer is completed at least monthly with documented results.

B. **Medical Record Review:**

1. CalOptima may conduct the **MRR** at the same time as the **FSR**, or at another mutually agreed-upon time.

   a. CalOptima shall conduct an initial **MRR** within ninety (90) calendar days after the first (1st) day **Members** are assigned to the **PCP**, except if the **PCP** has a "shared" **Medical Records** system, as described in Section III.B.2.b of this Policy.

   b. CalOptima may grant an extension of ninety (90) calendar days if the new **PCP** does not have a sufficient number of **Members** assigned to complete a review of ten (10) **Medical Records**.

   c. If, at six (6) months after the first (1st) day **Members** are assigned to the **PCP**, the **PCP** still has fewer than ten (10) assigned **Member Medical Records**, CalOptima shall conduct a **MRR** of all available **Member Medical Records**.

   d. CalOptima shall adjust the scoring of the **MRR** according to the number of records reviewed.

DRAFT_20190918OAC

Back to Agenda

2.~~-~~ **Medical Record** selection

a. Individual PCP Medical Record system

~~i.~~ The **MRR** is based on a survey standard of ten (10) randomly selected **Medical Records** per **PCP**, consisting of five (5) pediatric and five (5) adult and/adults or obstetric (OB) records.

~~ii.~~i. ~~Prior to initiating the MRR, a Certified Reviewer shall determine the Member populations (adult, pediatric, OB/Comprehensive Perinatal Services Program (CPSP)) served by the PCP site, and shall determine the medical records and audit tools appropriate for the PCP site.~~

~~iii.~~ii. If a **PCP** site has only pediatric, only adult, or only obstetric patients, CalOptima shall conduct the **MRR** on ten (10) records in the preventive care area relevant to the **Member** population served at the **PCP** site.

iii. Prior to initiating the **MRR**, a **Certified Site Reviewer** shall determine the **Member** populations (adult, pediatric, OB/Comprehensive Perinatal Services Program (CPSP)) served by the **PCP** site, and shall determine the **Medical Records** and audit tools appropriate for the **PCP** site.

b. Shared PCP Medical Record system

i. CalOptima shall consider a **PCP** site where documentation of patient care by multiple **PCPs** occurs in the same medical record as a "shared" **Medical Records** system. Shared **Medical Records** shall be considered those that are not identifiable as separate records belonging to any specific **PCP**.

ii. If a new **PCP** joins a **PCP** site that uses a shared **Medical Records** system that has a current passing **MRR** Survey score, CalOptima shall review the new **PCP** according to the periodic review cycle of the **PCP** site.

iii. CalOptima shall select **Medical Records** by random selection, using every other **Medical Record**, as follows:

Number of PCPs at the site	Number of Medical Records to be pulled by the staff	Number of Medical Records to be randomly selected and reviewed
1-3	10-20	10
4-6	20-40	20
7 or greater	30-60	30

a) CalOptima shall select **Medical Records** randomly from all **PCPs** at the site.

b) CalOptima shall select **Medical Records** for CalOptima **Members** only.

DRAFT 20190918QAC

c) CalOptima prefers that each **Medical Record** include at least three (3) visits within the twelve (12) months preceding the date of review.

C. **Physical Accessibility Review Survey:**

1. The **PARS** for **PCP** and Specialist sites shall evaluate access for **Members** with disabilities to parking, building, elevator, and restroom facilities. It includes twenty-nine (29) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

2. The **PARS** for ~~Ancillary Provider Sites~~**ancillary provider sites** shall evaluate ancillary facility site access for **Members** with disabilities to parking, building, elevator, restrooms, diagnostic and treatment room/equipment use. It includes thirty-four (34) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

3. The **PARS** for **CBAS** ~~Provider Sites evaluates~~**provider sites** evaluate facility site access for **Members** with disabilities to parking, building, elevator, participant areas, and restrooms. It includes twenty-four (24) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

4. Scoring of the **PARS**:

   a. Physical accessibility shall be determined as Basic or Limited based on the type of site assessment.

   b. To meet Basic Access requirements, all critical elements found in the **PARS** specific to the provider site must be met.

   c. **PCPs**, as well as **Specialty Care Providers**, **Ancillary Service**, and **CBAS** Provider **sites** serving a high volume of **SPD** and OneCare Connect **Members** will receive a deficiency and be classified as Limited Access if one (1) or more of the critical elements of the **PAR Survey** are not met.

5. **PARS** Deficiencies Process:

   a. If deficiencies in one (1) or more of the critical elements are identified, the facility site shall be deemed Limited Access, in accordance with the **PARS**.

      i. CalOptima shall provide a record of deficiencies to the office receiving the **PARS** to maintain compliance with the Americans with Disabilities Act (ADA).

         a) The reviewer will summarize the list of deficiencies and discuss all deficiencies at the exit interview with the **PCP** and will send a summary of deficiencies to the facility manager within forty-five (45) calendar days of the review.

      ii. The office must address all deficiencies and provide reasons why deficiencies will not be corrected to meet ADA requirements.

DRAFT_20190918QAC

a) The **PCP** or facility manager shall respond to CalOptima within thirty (30) calendar days of the **PARS** review for how deficiencies will be addressed, including the timeframe and activities for correcting identified deficiencies.

iii. If major construction deficiencies are identified, the office must have the property management company provide a written statement, on their business letterhead, as to why the deficiency cannot be corrected.

iv. Upon receipt of the letter, it will be filed with the **FSR** folder and reported to DHCS upon request.

v. If the deficiencies are minor and within reason to correct and the provider refuses to make the corrections the issue will be taken to **Credentialing and Peer Review Committee (CPRC)** for discussion and a decision.

6. CalOptima shall publish physical accessibility indicators including, but not limited to, level of access results met per provider site as either Basic Access or Limited Access, in the Provider Directory and Web-based Directory.

D. **Facility Site Review** and **Medical Record Review** Survey Scoring

1. Scoring of the **FSR** and **MRR**:

a. **FSR** and **MRR** shall only be completed and scored by designated personnel, in accordance with Section III.~~H~~ I of this Policy.

b. To pass a **Full Scope Site Review**, a **PCP** site shall achieve a minimum score of eighty percent (80%) on both the **FSR** and the **MRR**.

i. CalOptima shall not average the **FSR** and the **MRR** scores.

ii. A score below eighty percent (80%) on either the **FSR** or **MRR** shall be considered a non-passing **Full Scope Site Review** score.

c. CalOptima shall award only full point value for any scored element on the **FSR** or **MRR**. CalOptima shall not award any partial points.

i. If an element does not fully meet criteria, the **Certified Site Reviewer** shall give a score of zero (0) for that element.

ii. The **Certified Site Reviewer** shall determine the "not applicable" status of a criterion based on the relevance to the **Member** population served at the **PCP** site, and the site-specific assessment.

iii. The **Certified Site Reviewer** shall document a written explanation for every score of zero (0) points, and every criterion determined as "not applicable".

d. After completing the **FSR** and **MRR**, the **Certified Site Reviewer** shall calculate the **PCP** site score in each survey to determine the compliance rate and the need for follow-up.

DRAFT 20190918QAC

e. The minimum passing score for the **FSR** ~~and MRR~~ is eighty percent (80%) of the total points available. A **PCP** site may earn up to one hundred fifty (150) points for a site review with the following compliance level categories:

Compliance Categories	**Compliance Rate**
Exempted Pass	Ninety percent (90%) or above without deficiencies in critical elements, pharmaceutical services, or infection control
Conditional Pass	Eighty to eighty-nine percent (80-89%); or Ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control
Not Pass	Below eighty percent (80%)

f. N/A applies to any scored item that does not apply to a specific site, as determined by the Certified Site Reviewer.

g. The **MRR** contains three (3) general categories of Format, Documentation, and Coordination/Continuity of Care, and three (3) specific preventive categories of Pediatric Preventive, Adult Preventive, and OB/CPSP. **PCP** sites may earn up to twenty-three (23) points for the three (3) general categories multiplied by the number of ~~medical records~~**Medical Records** reviewed, plus the points given for the preventive services categories, as follows:

i. Pediatric Preventive: Nineteen (19) points multiplied by the number of pediatric ~~medical records~~**Medical Records** reviewed;

ii. Adult Preventive: Fifteen (15) points multiplied by the number of adult ~~medical records~~**Medical Records** reviewed; and

iii. OB/CPSP: Twenty (20) points multiplied by the number of OB/CPSP ~~medical records~~**Medical Records** reviewed.

~~h. PCP sites may earn a full point if the scored element meets the applicable criteria. CalOptima must not award partial points for any scored element that the reviewer considers only "partially" met. PCP sites must earn zero points if an element does not meet the applicable criteria. The reviewer must determine the "not applicable" (N/A) status of each criterion based on a site-specific assessment. The Certified Site Reviewer must explain all criteria scored as zero points or assessed as N/A. The MRR compliance levels are as follows:~~

h. The **MRR** compliance levels are as follows:

Compliance Categories	**Compliance Rate**
Exempted Pass	Ninety percent (90%) or above: Total score is >90% and all section scores are eighty percent (80~~%~~%) or above
Conditional Pass	Eighty to eighty-nine percent (80-89%): Total **MRR** is eighty to eighty-nine percent (80-89~~%~~%) or any section (s) is <80%
Not Pass	Below eighty percent (80%)

DRAFT_20190180AC

Back to Agenda

i. Any section score of <80% requires a **CAP** for the entire **MRR**, regardless of the total **MRR** score.

j. A non-passing score for a **PCP** site by one health plan shall be considered a non-passing score for all other health plans.

E. Identified Deficiencies and **CAPs**

1. The **CAP** is a standardized, pre-formatted document developed to assist a **PCP** in meeting DHCS requirements. The **CAP** includes the following:

   a. Deficiencies identified through the **FSR** and **MRR** processes;

   b. Corrective action required in order to comply with DHCS standards;

   c. Evidence of correction;

   d. Projected and actual dates of the deficiency correction;

   e. Date correction is implemented;

   f. **PCP** or **Designee** responsible for corrective actions;

   g. Name and title of the Certified Site Reviewer; and

   h. A section for verification of corrections.

2. The **CAP** contains three (3) separate sections:

   a. **FSR**;

   b. Critical elements; and

   c. **MRR**.

3. The **CAP** includes Disclosure and Release statements regarding **CAP** submission timelines and authorization to furnish results of the reviews and corrective actions to other health plans and **Health Networks**.

4. Government agencies that have authority over health plans and authorized county entities in California shall have access to this data.

5. The **CAP** informs the **PCP** that participating health plans collaborated for the **FSR** and **MRR** and agreed to accept the review findings and to furnish to each other the reviews and **CAPs**.

6. CalOptima shall furnish the results of reviews and **CAPs** to the **Health Network** with which the **PCP** site is affiliated.

DRAFT_20190918QAC

7. CalOptima shall maintain the signed **FSR CAP** and/or **MRR CAP** in the **PCP** site file. The **CAPs** shall include, at a minimum, the following:

    a. All pages of the **CAP**, with documented deficiencies;

    b. Signed **CAP** face sheet;

    c. Signed attestation; and

    d. Evidence of corrections.

8. CalOptima shall require a **CAP** for a score of less that eighty percent (80%) or for a score of ninety percent (90%) or greater with deficiencies in the areas of critical elements, Pharmaceuticals, or infection control.

9. **CAP** Process

    a. The **Certified Site Reviewer** shall complete the **FSR** and the **MRR**, and shall document the deficiencies on the surveys and the **CAP**.

    b. Upon completion of the review process, the Certified Site Reviewer shall conduct an exit interview with the **PCP** or the **PCP** site contact to discuss the findings and required corrective actions.

    c. The **Certified Site Reviewer** shall instruct the **PCP** or **PCP** site contact that the signature of the **PCP** or **PCP** site contact acknowledges the receipt of the **CAP** and agreement to comply with the designated timeframes for corrective actions as outlined in Section III.E.~~17~~ 16 of this Policy.

10. **PCP** Process for Noting Corrections on the **CAP** Document

    a. The **PCP** or **Designee** shall document the corrective actions taken in the "Corrective Action" required column. The **PCP** or **Designee** shall document the date of implementation of the required corrective actions. Additional steps taken to implement the corrective actions may be documented in this column.

    b. The **PCP** or **Designee** shall initial the appropriate column of the **CAP** to indicate the person responsible for the corrective actions.

    c. The **PCP** or **Designee** shall attach evidence of corrections, such as, but not limited to, applicable policies and procedures, sample forms, invoices for purchased items and services, training in-service agendas, and sign-in sheets.

11. **FSR CAP** Follow-up Process

    a. Verification of correction of identified deficiencies may be accomplished by **PCP** submission of the appropriate evidence of correction.

DRAFT 20190918QAC

b. **CAP** verification may require an on-site visit forty-five (45) calendar days after the date of the review if there is insufficient evidence to determine compliance, or if the deficiency cannot be verified in writing. The **Certified Site Reviewer** shall determine the need for the on-site visit.

12. **MRR CAP** Follow-up Process

    a. The **Certified Site Reviewer** shall determine the process for **CAP** follow-up.

    b. The process may include the following activities:

        i. Score less than eighty percent (80%): On-site visit to verify processes implemented.

        ii. Score between eighty and eight-nine percent (80 – 89%): Documented **CAP** or a **CAP** verification visit and focused record review may be requested at the discretion of the **Certified Site Reviewer**.

        iii. Score ninety to one hundred percent (90 – 100%): Exempted Pass without **CAP**.

13. CalOptima shall monitor the **CAP** until completion. CalOptima shall communicate information regarding a **PCP** Site that shows no improvement, or non-compliance with the required **CAP** activities within the DHCS designated timeframes, to all affiliated **Health Networks**.

14. Review and Acceptance of **CAP**

    a. Following receipt of the completed **CAP**, CalOptima shall evaluate or verify corrections to approve the **CAP**.

    b. CalOptima shall communicate **CAP** approval, in writing, to the **PCP** and his or her assigned CalOptima contracted **Health Network(s)**. CalOptima shall issue a quality Provider Site Certificate to the **PCP** site.

    c. If CalOptima does not accept a **PCP** site's **CAP**, a **Certified Site Reviewer** shall follow-up with the **PCP** for technical assistance, and to ensure compliance with completion of required activities.

15. ~~Pre~~CalOptima shall conduct pre-contractual **PCP** site reviews, and will accept sites with a passing score of eighty percent (80%) or above.

    a. A new **PCP** site that receives a score between eighty and eighty-nine percent (80-89%) (Conditional pass) shall not be considered a **Health Network PCP** until the **PCP** site submits a **CAP** and CalOptima accepts the **CAP**.

    b. A new **PCP** site that receives a score below eighty percent (80%) (Not Pass) shall not be accepted into a **Health Network** ~~until the PCP site submits a CAP and CalOptima verifies and accepts the CAP~~. CalOptima must resurvey the **PCP**, and the **PCP** must pass with at least a score of eighty percent (80%) to be considered a CalOptima network provider. Any **CAPs** issued must be completed per **CAP** timeline requirements.

DRAFT_20190918QAC

16. CalOptima shall not assign new Members to a PCP with a score below eighty percent (80%) in the FSR or MRR. CalOptima shall resume Member assignment after the PCP completes corrections within the designated time frames and CalOptima closes the CAP.

17. Time Fframes for **CAP** Activities

    a. At the time of the **FSR** or **MRR**, a Certified Site Reviewer shall notify the **PCP** or **Designee** of the following:

        i. All survey scores, including the non-passing survey scores;

        ii. Deficiencies in the areas of critical elements, Pharmaceuticals Services, or infection control;

        iii. Other deficiencies determined by the Certified Site Reviewer to require immediate corrective action; and

        iv. **CAP** requirements to correct deficiencies.

    b. Within three (3) business days after the survey date, CalOptima shall notify **Health Network** of a **PCP** site that does not meet the passing score of eighty percent (80%) for the **FSR** or the **MRR**.

    c. Within ten (10) business days after the survey date:

        i. The **PCP** or **Designee** shall submit to CalOptima a completed **CAP**, with verification for all critical elements and other deficiencies determined by the reviewer to require immediate corrective action.

        ii. CalOptima shall provide a survey findings report and a formal written request for corrections of all other non-critical element deficiencies to the **PCP**.

        iii. CalOptima shall ensure that sites found deficient in any critical element during a site review shall correct 100% of the deficiencies regardless of the sites' overall survey score.

    d. Within forty-five (45) calendar days after the survey date, CalOptima shall evaluate and verify corrections of all critical elements and other deficiencies, including deficiencies in infection control and pharmaceutical services, determined by the **Certified Site Reviewer** to require immediate corrective action.

    e. Within forty-five (45) calendar days after the date of the written **CAP** request, the **PCP** shall submit to CalOptima a **CAP** for all identified deficiencies, other than critical elements,

        i. If CalOptima does not receive the **CAP** within thirty (30) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** with a reminder that the **CAP** is due in fifteen (15) calendar days.

DRAFT 20190918QAC

ii. CalOptima shall document all contacts with the **PCP** or **Designee** in the **PCP** site file.

f. Within ninety (90) calendar days after the date of the written **CAP** request, CalOptima shall review the submitted **CAP**, and revise and approve the **CAP** and timelines. If additional corrective action is required to complete the **CAP**, the **PCP** shall complete all corrective actions within thirty (30) calendar days.

g. If a **PCP** fails to complete corrections within one-hundred-twenty (120) calendar days after the date of the written **CAP** request:

i. CalOptima shall re-survey the **PCP** site twelve (12) months after the date of the site survey.

ii. CalOptima may impose disciplinary action up to and including administrative termination from CalOptima.

h. CalOptima shall provide the **PCP** with written notification of **Member** reassignment at least ninety (90) calendar days prior to such reassignment.

18. **PCP** Non-Compliance with **CAP** Completion Requirements

a. If a **PCP** submits a **CAP**, but continues to be non-compliant with the **CAP** request, the Certified Site Reviewer shall follow up to provide technical support, in order assist the **PCP** in **CAP** completion.

b. Delayed **CAP** Submission Process:

i. If the **PCP** fails to complete and submit a **CAP** for critical elements, within ten (10) business days after the date of the review, the Certified Site Reviewer shall communicate by telephone with the **PCP** or **Designee**, or send a second and final critical element **CAP** request letter to the **PCP**. If the **PCP** fails to submit required documentation within seventy-two (72) hours after the second (2nd) notice, CalOptima may impose disciplinary action up to and including reassignment of **Members**.

ii. If CalOptima does not receive the **CAP** for non-critical element deficiencies within forty-five (45) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** or **Designee** and request the **CAP** completion within seventy-two (72) hours. If CalOptima does not receive the **CAP** within seventy-two (72) hours, CalOptima shall notify all **Health Networks** and may impose disciplinary action up to and including termination from CalOptima.

iii. CalOptima shall report a **PCP** who fails to submit a **CAP** within the established timelines to the appropriate committee for review and action.

c. CalOptima shall not assign new **Members** to a **PCP** who fails to correct deficiencies within established timelines. If a **PCP** fails to comply with survey criteria within established timelines, CalOptima shall remove the **PCP** from the CalOptima networks and shall appropriately reassign **Members** to other **PCPs**.

DRAFT 20190918QAC

d. **PCPs** removed from a contracted **Health Network** may appeal CalOptima's decision in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

F. CalOptima shall review other performance indicators such as **Member** complaints, grievances, and Potential Quality Issues. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** complaints related to physical accessibility or **Member** safety is identified. If any issue related to physical accessibility or **Member** safety then CalOptima shall conduct an unannounced site visit no later than seven (7) calendar days of identification, depending on the severity of the identified patient safety or physical accessibility issue.

~~F.~~G. If the QI Department identifies issues ~~related to the provider site, including~~such as, but not limited to ~~physical accessibility,~~ physical appearance, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping, then CalOptima shall ~~conduct~~monitor sites and determine when an unannounced ~~site~~ visit~~.~~ is required.

~~1.~~ To identify the need for an unannounced site visit, the QI Department ~~shall review~~monitors Grievance and Appeals Resolution Services (GARS) ~~quarterly activity of~~related to complaints~~.~~

~~2.~~1. ~~CalOptima's QI Department~~ with provider sites. If a provider site receives three (3) or more separate complaints within twelve (12) months, CalOptima shall conduct an unannounced ~~facility site~~ visit ~~within sixty (60) calendar days of the identified Complaint(s).~~.

~~3.~~2. If the standard threshold of eighty percent (80%) is not met upon review, the site will receive a **CAP**.

a. The **CAP** must include how the Provider will address and correct deficiencies.

~~4.~~3. CalOptima's Provider and Health Network Relations Departments, in conjunction with the **FSR** Nurse Auditor, shall collaborate with the Provider site to ensure that the site meets the required threshold of eighty percent (80%).

~~5.~~4. CalOptima shall evaluate deficient sites within forty-five (45) calendar days of the **CAP** issuance until the site meets the threshold score of eighty percent (80%).

~~6.~~5. CalOptima shall conduct a follow-up site visit to evaluate correction of deficiencies, utilizing the Industry Collaborative Effort (ICE) Provider Office Site Quality Site Visit Tool & **CAP**.

a. If deficiencies have not been addressed within sixty (60) calendar days of the unannounced visit or sooner, a physician panel shall be put on hold until deficiencies are resolved.

b. CalOptima shall monitor the facility site every six (6) months following the **CAP** resolution to evaluate the effectiveness of the corrections.

~~G.~~H. Tracking, Reporting, and Trending

1. On a quarterly basis, CalOptima's QI Department shall report a summary of **FSR**, **MRR** and **PARS** activity and action plans to the **CPRC** for monitoring. Reports include assessments, findings, monitoring of previous issues and next steps. **CPRC** will provide quarterly updates to the **CalOptima Quality Improvement Committee (QIC~~.~~)**.

DRAFT 20190918QAC

Back to Agenda

~~2. CalOptima's QI Department shall conduct a satisfaction survey after on-site reviews and address any issues identified by survey after aggregate analysis and consultation with appropriate committees, such CPRC and QIC.~~

~~3.~~ CalOptima's QI Department shall conduct an annual assessment of the **PARS** process and report findings to the **Credentialing Peer Review Committee (CPRC)** and **CalOptima Quality Improvement Committee (QIC)**.

~~4. On a quarterly basis, CalOptima's QI Department shall report to the QIC the PARS QI Work Plan which will address the following:~~

~~a. Assessments, findings, monitoring of previous issues and next steps; and~~

~~b. Results in the form of metrics along with the next steps.~~

~~5.~~2. Annually the **PARS** process and findings will be reported to the **QIC** as follows:

a. Assessment of completion of planned activities and the objectives of the plan were met;

b. Identification of issues or barriers that impacted meeting the objectives;

c. Recommended interventions to overcome barriers and issues identified;

d. Overall effectiveness of the **PARS** compliance; and

e. Annual assessment of **PARS** process and findings shall be included in CalOptima's annual evaluation.

~~6.~~3. On a monthly basis CalOptima shall notify **Health Networks** of all **FSR**, **MRR**, **PARS** conducted and the scores from the prior month.

~~H.~~I. Review Personnel, Training and Certification

1. **FSR** and **MRR** shall be completed by appropriately trained staff, as outlined in this section.

   a. In accordance with DHCS guidance, **PARS** need not be completed by a Registered Nurse (RN) or physician.

   b. **PARS** shall be completed by appropriately trained CalOptima QI staff.

2. Initial certification: A candidate for certification as a Master Trainer, Trainer, or **Certified Site Reviewer** shall meet the following criteria ~~defined~~ as defined by DHCS.

3. Certification of Managed Care Plan Site Reviewers and Trainers

DRAFT 20190918QAC

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Possess current and valid California RN, MD or DO license. Possess current California RN or MD license.	**X**	**X**	**X**
Have experience in training (small groups or individuals) or conducting groups in a health-related field within the past five (5) years; or experience conducting Quality Improvement activities such as medical audits, site reviews, or utilization management activities	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.		**X**	**X**
Completion of a minimum of ten tandem site reviews to include Attachment A and Attachment B criteria and guidelines according to APL 14-004. Knowledge of Facility Site Review Frequently Asked Questions (FAQs). Completion of a minimum of three (3) site reviews according to the 02-002 Site Review Policy and Tools.			**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer.		**X**	
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL 14-004 include Attachment A and Attachment B criteria and guidelines; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of one (1) year as a Trainer/Certified Site Reviewer.	**X**		
Completion of the inter-rater site review process which involves an onsite review with:			
-DHCS MCQMD Nurse Evaluator	**X**		
-Certified Master Trainer		**X**	
-Certified Trainer or Certified Master Trainer			**X**
Achieving an inter-rater score within 10% of **FSR** and 10% of **MRR** ~~Designated Plan~~ Trainer or Master Trainer scores			**X**
Achieving an inter-rater score within 5% of **FSR** and 5% **MRR** of the Master Trainer's scores		**X**	

DRAFT 20190918QAC

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Achieving an inter-rater score within 5% of **FSR** and 5% of **MRR** of the DHCS MCQMD Nurse Evaluator	**X**		
Completion and submission of the "Application Request for Certification" to MCQMD (Enclosure A) (Plans have the option to use the application or develop other forms for trainers and reviewers).	**X**		

4. Physicians and RNs designated as Master Trainer, ~~Designated Plan~~ Trainers and **Certified Site Reviewers** will be required to meet the following criteria to maintain their certification.

Re-Certification Criteria	Master Trainer	Trainer	Site Reviewer
Verification of current and valid California RN, MD or DO license	**X**	**X**	**X**
Must be employed or affiliated with a DHCS Managed Care Plan	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Participate in DHCS MCQMD sponsored site review teleconferences or meetings as defined by the MCQMD Site Review Workgroup	**X**		
Participate in MCQMD sponsored site review training as defined by DHCS	**X**	**X**	**X**
Maintain DHCS certificate number regardless of Health Plan affiliation	**X**		
A new certificate is issued by the primary Managed Care Plan if there is a change in employment		**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

5. A new employee who was previously certified as a Master Trainer, Trainer or **Certified Site Reviewer** by another Medi-Cal Managed Care health plan, but who was not subsequently re-certified, shall meet the following criteria for re-certification by CalOptima:

DRAFT 20190918QAC

Re-Certification Criteria for new employees with lapsed certification	Master Trainer	Trainer	Site Reviewer
Verification of current California RN or MD license	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of certification. Verification of trainers' continued responsibility for training on the MMCD Site Review Policy and Tools and completion of a minimum of five site reviews since initial certification or re-certification	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.	**N/A**	**X**	**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

6. As part of the certification/re-certification process, Master Trainers, ~~Designated Plan~~ Trainers and potential or **Certified Site Reviewers** must complete the inter-rater review (IRR) process. This process requires the Master Trainers, ~~Designated Plan~~ Trainers or **Certified Site Reviewers** to participate in a site review with a designated rater such as the plan Master Trainer or ~~Designated Plan~~ Trainer. Both individuals will concurrently complete and score all elements of the **Facility Site Review** Survey and **Medical Record Review** Survey tools. The Master Trainer, ~~Designated Plan~~ Trainer or **Certified Site Reviewer** must achieve an inter-rater score as defined by DHCS and/or the Site Review Workgroup.

7. Physicians and RNs meeting all ~~of~~ the certification criteria, ~~including~~and achieving an adequate inter-rater score as defined by DHCS, will be certified. All individuals who are certified will receive a certificate issued by DHCS MCQMD or the ~~MCP.~~Medi-Cal Managed Care health Plan. Plans shall follow the instructions for certificate completion. Physicians and RNs who are certified will be authorized to sign site review surveys with the designation of Department of Health Care Services Master Trainer (DHCS-MT), Department of Health Care Services ~~Designated Plan~~ Trainer (DHCS-DPT), or a Department of Health Care Services **Certified Site Reviewer** (DHCS-**CSR**).

DRAFT_20190918QAC

Back to Agenda

8. If the Master Trainer, ~~Designated Plan~~ Trainer, or **Certified Site Reviewer** ~~does~~has not ~~achieve the~~achieved an adequate inter-rater score defined by DHCS, they may repeat the inter-rater review process. The designated rater and the individual with a non-passing inter-rater score will jointly assess training needs, and develop and implement a training plan prior to conducting a second inter-rater review. Trainers and site reviewers are allowed two (2) opportunities to become certified.

9. One or more of the following may lead to the revocation of certification for the DPT and **CSR** conducting DHCS-approved ~~facility site review and medical record review~~**Facility Site Review** and **Medical Record Review** surveys by CalOptima:

   a. Did not maintain current and valid California RN, MD or DO license;

   b. Resignation, termination, or lack of affiliation from CalOptima;

   c. No participation in the DHCS sponsored inter-rater reliability unless pre-approved by the CalOptima MT or QI Director;

   d. More than two (2) failed ~~facility site review~~**Facility Site Review** survey and/or ~~medical record review~~**Medical Record Review** survey inter-rater reliability scores; and/or

   e. Noncompliance with maintenance of certification criteria.

   f. The above applies to the revocation of MT Certification as determined by DHCS.

10. Assigning Certificate Numbers

    a. A Trainer or **Certified Site Reviewer** shall receive a certificate upon successfully completing the initial and subsequent certification.

    b. CalOptima shall issue certificates to a Trainer or **Certified Site Reviewer**. DHCS shall issue certificates to a Master Trainer.

    c. The certificates shall contain a series of numeric and alpha values to identify the health plan, county, month, and year the certification was granted, and identification code and level of designation for Master Trainer, Trainer, or **Certified Site Reviewer**.

    d. A certificate may be issued in the following format: 000-04-0702-01-A

000	Plan identification Code (CalOptima)
04	Plan Code
0702	Month and Year Certification Granted
01	Plan Trainer or Site Reviewer
A	Master Trainer or Other Trainer
B	Site Reviewer

DRAFT 20190918QAC

11. CalOptima shall maintain certification records including, but not limited to, site review training activities and documentation to support the issuance of certificates.

IV. ATTACHMENTS

Not Applicable

DRAFT_20190918QAC

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B.A. CalOptima Health Network Service Agreement~~
~~C.A. CalOptima Policy HH.1101: CalOptima Provider Complaint~~
~~D.~~B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health Network Service Agreement
D. CalOptima Policy HH.1101: CalOptima Provider Complaint
E. Department of Health Care Services (DHCS) Policy Letter (PL) 12-006: Revised Facility Site Review Tool
F. Department of Health Care Services (DHCS) Policy Letter (PL) ~~13~~03-002: Certification of Managed Care Plan Staff Responsible for the Conduct of Primary Care Provider Site Reviews
G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004: Site Reviews: Facility Site Review and Medical Record Review
H. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 14-005: Facility Site Review / Physical-Accessibility Reviews
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-023: Facility Site Review Tools for Ancillary Service and Community-Based Adult Services Providers
J. National Committee for Quality Assurance (NCQA) ~~2017~~2019 Standards: MED ~~4~~3-Practitioner Office Site Quality

VI. REGULATORY AGENCY APPROVALS

A. 04/30/15: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	01/01/1996	GG.1608	PCP Site Reviews	Medi-Cal
Revised	01/01/1998	GG.1608	PCP Site Reviews	Medi-Cal
Revised	04/01/1999	GG.1608	PCP Site Reviews	Medi-Cal
Revised	08/01/2000	GG.1608	PCP Site Reviews	Medi-Cal
Revised	10/01/2002	GG.1608	Facility Site Reviews	Medi-Cal
Revised	10/01/2003	GG.1608	Facility Site Reviews	Medi-Cal
Effective	10/01/2005	MA.7011	Practitioner Office Site Reviews	OneCare
Revised	03/01/2007	MA.7011	Full Scope Practitioner Office Site Reviews	OneCare
Revised	04/01/2007	GG.1608	Facility Site Review	Medi-Cal
Revised	09/01/2011	MA.7011	Full Scope Site Reviews	OneCare
Revised	09/01/2011	GG.1608	Full Scope Site Reviews	Medi-Cal

DRAFT_20190918QAC

Revised	02/01/2013	GG.1608	Full Scope Site Reviews	Medi-Cal 1 OneCare 2
Revised	12/01/2014	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2015	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2016	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	10/10/2017	GG.1608a	Facility Site Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608b	Medical Record Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608c	Facility Site Review and Medical Record Review Collaboration Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608d	Scoring Process for Facility Site Review and Medical Record Review	Medi-Cal OneCare
Retired	10/10/2017	GG.1608e	Facility Site Review and Medical Record Review Corrective Action Plan	Medi-Cal OneCare
Retired	10/10/2017	GG.1608f	Review Personnel, Training and Certification	Medi-Cal OneCare
Revised	10/01/2017	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2018	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	02/13/2018	MA.7011	Full Scope Site Reviews	OneCare
Revised		GG.1608Δ	Full Scope Site Reviews	OneCare

DRAFT 2019 QAC

IX. GLOSSARY

Term	Definition
Ancillary Service Provider Sites	Ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services such as radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations
Ancillary Services	For the purposes of this policy, ancillary services refers to diagnostic and therapeutic services such as, but not limited to: radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.
CBAS Providers Sites	CBAS provider sites include all facilities that provide bundled CBAS services, and do not include Licensed Only Adult Day Health Care centers and Programs of All-Inclusive Care for the Elderly (PACE). CBAS services (defined in W&I Code section 14550.5 and provided each day of attendance) include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on the participant's Individual Care Plan.
CBAS Services	For purposes of this policy, CBAS services include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on a Member's Individual Care Plan.
Certified Site Reviewer (CSR)	An appropriately qualified and trained physician or registered nurse (RN) who is responsible for conducting provider site reviews, in accordance with DHCS Policy Letter 14-004 and subsequent updates.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

DRAFT 06/06/18 POAC

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Critical Elements (CE)	Nine critical elements of the site review that defines the potential for adverse effects on patient health and safety, and has a scored weight of two points on the FSR tool.
Designee	For the purposes of this policy, a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role, as determined by CalOptima QI staff.
Facility Site Review (FSR) Survey	A DHCS tool utilized to assess the quality, safety, and accessibility of PCPs and high-volume specialists physician offices.
Full Scope Site Review	For the purposes of this policy, means a comprehensive site review as required by DHCS guidelines which encompass a Facility Site Review (FSR) and Medical Record Review (MRR) of a Primary Care Provider (PCP) site.
Health Network	A Physician Hospital Consortium (PHC~~), Physician Medical Group (PMG~~), a physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide ~~Covered Services~~covered services to Members assigned to that Health Network.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Medical Record	For the purposes of this policy, a medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including high volume specialists, CBAS and ancillary service providers.
Potential Quality Issues (PQIs)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised.

DRAFT – NOT APPROVED BY BOARD

Term	Definition
Primary Care Provider (PCP)	For the purposes of this policy, a primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

1

DRAFT_20190918QAC

Policy #:	GG.1608Δ
Title:	**Full Scope Site Reviews**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/96
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

DRAFT 20190918QAC

I. PURPOSE

This policy outlines CalOptima's site review process, including the **Facility Site Review (FSR)**, **Medical Record Review (MRR)**, and **Physical Accessibility Review Survey (PARS)**, and the process by which CalOptima conducts, scores, tracks, and reports site reviews in accordance with applicable state and federal guidelines.

II. POLICY

A. CalOptima shall assess the quality, safety, and accessibility of sites where care is delivered in accordance with Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid (CMS) guidelines and regulations.

B. CalOptima may delegate **FSR**, **MRR**, and **PARS** to a Knox-Keene licensed full service health care service plan that is contracted with CalOptima as a **Health Network**. Such delegated health plan shall conduct **FSR**, **MRR**, and **PARS** in accordance with the provisions of this Policy and in compliance with applicable DHCS and CMS guidelines and regulations.

C. CalOptima shall retain responsibility and accountability for the coordination and consolidation of **FSR**, **MRR**, or **PARS** and shall not delegate such reviews to a **Health Network**, except where CalOptima approves a delegation to a full service Knox-Keene licensed **Health Maintenance Organization (HMO)** in accordance with Section II.B of this Policy.

D. CalOptima's Quality Improvement (QI) Department shall conduct **FSR**, **MRR**, and **PARS**, as well as subsequent periodic site reviews, as part of the initial **credentialing** and recredentialing process, regardless of the status of other certification or accreditation, if:

1. There is no documented evidence that the **Primary Care Provider (PCP)** site has a current passing score on a survey conducted by another Medi-Cal Managed Care health plan; or

2. A **PCP** from a certified **PCP** site moves to a new site that has not been previously reviewed.

E. A Full Scope/Periodic Site Review consists of the **FSR** and **MRR**.

1. CalOptima is not required to conduct a **Full Scope Site Review** for a **PCP** site if a new **PCP** is added to a **PCP** site that has a current passing **Full Scope Site Review** score.

Back to Agenda

F. **Full** Scope Site Reviews shall be conducted by specified CalOptima staff as outlined in Section III.A of this Policy.

G. CalOptima's QI Department shall conduct a **FSR** for new **PCP** sites that have never received a **FSR** or have not had a passing review in the past three (3) years.

H. CalOptima's QI Department shall conduct a **MRR survey** for new **PCP** sites within ninety (90) calendar days of the date CalOptima first assigns **Members** to the **PCP.** CalOptima may defer the review an additional ninety (90) calendar days only if the new **PCP** does not have a sufficient number of **Members assigned** to complete a review of ten (10) **Medical Records.** At the end of six (6) months, if the **PCP** still has fewer than ten (10) assigned **Member Medical Records,** CalOptima must complete an MRR on the total number of records available, and adjust the scoring according to the number of records reviewed.

I. CalOptima's QI Department shall conduct a **PARS** at the time of initial **credentialing** for the following:

1. All **PCP** offices;

2. **Specialty Care Provider** offices, **Community Based Adult Services (CBAS) Provider Sites**, and **Ancillary Service Provider Sites** serving a high volume of **Seniors and Persons with Disabilities (SPD)**; and

3. **Specialty Care Provider** offices and **Ancillary Service Provider Sites** included in the provider directory who are serving a high volume of OneCare Connect **Members**.

J. CalOptima shall conduct a subsequent **FSR**, **MRR**, and **PARS** of a **PCP** site at least every three (3) years.

1. CalOptima may waive an **FSR**, **MRR**, and/or **PARS** for a pre-contracted **PCP** site if the **PCP** site has documented proof that an **FSR**, **MRR**, and/or **PARS** with a passing score was completed by a Medi-Cal Managed Care health plan within the past three (3) years.

2. CalOptima may conduct an **FSR**, **MRR**, and/or **PARS** more frequently if required by local collaborative decision, or if CalOptima determines that it is necessary based on monitoring, evaluation, or **Corrective Action Plan (CAP)** follow-up issues.

K. CalOptima shall monitor a **PCP** site between each regularly scheduled **FSR**.

1. CalOptima shall conduct an interim audit midcycle (approximately eighteen (18) months) after the previous audit date to evaluate the nine (9) Critical Elements from the **FSR**.

a. If there was no **Critical Element CAP** received during the previous audit, the office will receive an attestation to sign and return to CalOptima attesting all Critical Elements are in effect.

b. If the **Critical Elements CAP** was received during the previous audit, an on-site audit will be conducted on the **Critical Elements** only.

L. CalOptima's QI Department shall score the **FSR**, **MRR**, and **PARS** in accordance with Section III.D of this Policy.

DRAFT 20190918QAC

Back to Agenda

M. CalOptima's QI Department shall identify deficiencies and request **Corrective Action Plans (CAP)** for **FSR** and **MRR** deficiencies, in accordance with Section III.E of this Policy.

1. **CAPs** will not be issued for **PARS** results, as these results are informational.

2. CalOptima shall document **PARS** results and make survey records available to DHCS for review upon request.

N. **Members** shall not receive **Covered Services** at a new **PCP** site until the site receives a passing **FSR** score, as outlined in Section III.D.1 of this Policy, and/or completes required **CAPs** issued by CalOptima's QI Department.

O. Notwithstanding the corrective action time requirements set forth in this Policy, CalOptima shall not allow an existing **PCP** site with major or serious uncorrected deficiencies to continue providing care to **Members** until the site corrects all such deficiencies.

P. All **Health Networks** shall accept CalOptima site review surveys status or results to coordinate and consolidate site audits for shared **PCPs**.

Q. A **PCP** shall notify CalOptima when the **PCP** intends to relocate its practice at least thirty (30) calendar days prior to the relocation. Upon notification of the relocation, CalOptima shall conduct an **FSR**, **MRR**, and **PARS** on the new location, except as described in Section II.E.1 of this Policy.

1. If a PCP notifies CalOptima after the move:

   a. CalOptima will permit assigned **Members** to continue to see the PCP;

   b. CalOptima will not assign new **Members** to the PCP until CalOptima conducts an **FSR** on the new location; and

   c. CalOptima will complete an **FSR** on the new location within thirty (30) calendar days of the notification of the move.

R. The site review process described in this policy shall remain confidential and protected from disclosure in accordance with applicable law.

S. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** Complaints related to physical accessibility or **Member** safety, pursuant to Section III.F of this Policy, are filed with CalOptima's QI Department.

T. CalOptima may collect additional information at **PCP** sites during the **FSR** process, including but not limited to, information on member experience, and timely access to **Covered Services**.

III. PROCEDURE

A. **Facility Site Review:**

1. The **FSR** includes on-site inspection and interviews with site personnel to review criteria outlined by DHCS including, but not limited to, the following nine (9) **Critical Elements** that may adversely affect a **Member's** health or safety:

   a. Exit doors and aisles are unobstructed and escape accessible;

DRAFT 20190918OAC

Back to Agenda

b. Airway management equipment is appropriate to the practice and populations served (e.g., oxygen delivery systems, oral airways, nasal canula or mask, Ambu bag) and are present on site;

c. Only qualified and trained personnel retrieve, prepare, or administer medications;

d. The Physician must review and follow-up with referrals, consultation reports and diagnostic test results;

e. Only lawfully authorized persons dispense drugs to patients;

f. Personal Protective Equipment (PPE) is readily available for staff use;

g. Needlestick safety precautions are practiced on site;

h. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport, and shipping; and

i. Spore testing of autoclave or steam sterilizer is completed at least monthly with documented results.

B. **Medical Record Review:**

1. CalOptima may conduct the **MRR** at the same time as the **FSR**, or at another mutually agreed-upon time.

a. CalOptima shall conduct an initial **MRR** within ninety (90) calendar days after the first (1st) day **Members** are assigned to the **PCP**, except if the **PCP** has a "shared" **Medical Records** system, as described in Section III.B.2.b of this Policy.

b. CalOptima may grant an extension of ninety (90) calendar days if the new **PCP** does not have a sufficient number of **Members** assigned to complete a review of ten (10) **Medical Records**.

c. If, at six (6) months after the first (1st) day **Members** are assigned to the **PCP**, the **PCP** still has fewer than ten (10) assigned **Member Medical Records**, CalOptima shall conduct a **MRR** of all available **Member Medical Records**.

d. CalOptima shall adjust the scoring of the **MRR** according to the number of records reviewed.

2. **Medical Record** selection

a. Individual PCP Medical Record system

i. The **MRR** is based on a survey standard of ten (10) randomly selected **Medical Records** per **PCP**, consisting of five (5) pediatric and five (5) adult and/adults or obstetric (OB) records.

ii. If a **PCP** site has only pediatric, only adult, or only obstetric patients, CalOptima shall conduct the **MRR** on ten (10) records in the preventive care area relevant to the **Member** population served at the **PCP** site.

DRAFT_20190918QAC

Back to Agenda

iii. Prior to initiating the **MRR**, a **Certified Site Reviewer** shall determine the **Member** populations (adult, pediatric, OB/Comprehensive Perinatal Services Program (CPSP)) served by the **PCP** site, and shall determine the **Medical Records** and audit tools appropriate for the **PCP** site.

b. Shared PCP Medical Record system

i. CalOptima shall consider a **PCP** site where documentation of patient care by multiple **PCPs** occurs in the same medical record as a "shared" **Medical Records** system. Shared **Medical Records** shall be considered those that are not identifiable as separate records belonging to any specific **PCP**.

ii. If a new **PCP** joins a **PCP** site that uses a shared **Medical Records** system that has a current passing **MRR** Survey score, CalOptima shall review the new **PCP** according to the periodic review cycle of the **PCP** site.

iii. CalOptima shall select **Medical Records** by random selection, using every other **Medical Record**, as follows:

Number of PCPs at the site	Number of Medical Records to be pulled by the staff	Number of Medical Records to be randomly selected and reviewed
1-3	10-20	10
4-6	20-40	20
7 or greater	30-60	30

a) CalOptima shall select **Medical Records** randomly from all **PCPs** at the site.

b) CalOptima shall select **Medical Records** for CalOptima **Members** only.

c) CalOptima prefers that each **Medical Record** include at least three (3) visits within the twelve (12) months preceding the date of review.

C. **Physical Accessibility Review Survey:**

1. The **PARS** for **PCP** and Specialist sites shall evaluate access for **Members** with disabilities to parking, building, elevator, and restroom facilities. It includes twenty-nine (29) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

2. The **PARS** for **ancillary provider sites** shall evaluate ancillary facility site access for **Members** with disabilities to parking, building, elevator, restrooms, diagnostic and treatment room/equipment use. It includes thirty-four (34) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

3. The **PARS** for **CBAS provider sites** evaluate facility site access for **Members** with disabilities to parking, building, elevator, participant areas, and restrooms. It includes twenty-four (24) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

4. Scoring of the **PARS**:

DRAFT_20190918QAC

a. Physical accessibility shall be determined as Basic or Limited based on the type of site assessment.

b. To meet Basic Access requirements, all critical elements found in the **PARS** specific to the provider site must be met.

c. **PCPs**, as well as **Specialty Care Providers**, **Ancillary Service**, and **CBAS** Provider **sites** serving a high volume of **SPD** and OneCare Connect **Members** will receive a deficiency and be classified as Limited Access if one (1) or more of the critical elements of the **PAR Survey** are not met.

5. **PARS** Deficiencies Process:

a. If deficiencies in one (1) or more of the critical elements are identified, the facility site shall be deemed Limited Access, in accordance with the **PARS**.

i. CalOptima shall provide a record of deficiencies to the office receiving the **PARS** to maintain compliance with the Americans with Disabilities Act (ADA).

a) The reviewer will summarize the list of deficiencies and discuss all deficiencies at the exit interview with the **PCP** and will send a summary of deficiencies to the facility manager within forty-five (45) calendar days of the review.

ii. The office must address all deficiencies and provide reasons why deficiencies will not be corrected to meet ADA requirements.

a) The **PCP** or facility manager shall respond to CalOptima within thirty (30) calendar days of the **PARS** review for how deficiencies will be addressed, including the timeframe and activities for correcting identified deficiencies.

iii. If major construction deficiencies are identified, the office must have the property management company provide a written statement, on their business letterhead, as to why the deficiency cannot be corrected.

iv. Upon receipt of the letter, it will be filed with the **FSR** folder and reported to DHCS upon request.

v. If the deficiencies are minor and within reason to correct and the provider refuses to make the corrections the issue will be taken to **Credentialing and Peer Review Committee (CPRC)** for discussion and a decision.

6. CalOptima shall publish physical accessibility indicators including, but not limited to, level of access results met per provider site as either Basic Access or Limited Access, in the Provider Directory and Web-based Directory.

D. **Facility Site Review** and **Medical Record Review** Survey Scoring

1. Scoring of the **FSR** and **MRR**:

a. **FSR** and **MRR** shall only be completed and scored by designated personnel, in accordance with Section III.I of this Policy.

DRAFT 20190180AC

Back to Agenda

b. To pass a **Full Scope Site Review**, a **PCP** site shall achieve a minimum score of eighty percent (80%) on both the **FSR** and the **MRR**.

i. CalOptima shall not average the **FSR** and the **MRR** scores.

ii. A score below eighty percent (80%) on either the **FSR** or **MRR** shall be considered a non-passing **Full Scope Site Review** score.

c. CalOptima shall award only full point value for any scored element on the **FSR** or **MRR**. CalOptima shall not award any partial points.

i. If an element does not fully meet criteria, the **Certified Site Reviewer** shall give a score of zero (0) for that element.

ii. The **Certified Site Reviewer** shall determine the "not applicable" status of a criterion based on the relevance to the **Member** population served at the **PCP** site, and the site-specific assessment.

iii. The **Certified Site Reviewer** shall document a written explanation for every score of zero (0) points, and every criterion determined as "not applicable".

d. After completing the **FSR** and **MRR**, the **Certified Site Reviewer** shall calculate the **PCP** site score in each survey to determine the compliance rate and the need for follow-up.

e. The minimum passing score for the **FSR** is eighty percent (80%) of the total points available. A **PCP** site may earn up to one hundred fifty (150) points for a site review with the following compliance level categories:

Compliance Categories	**Compliance Rate**
Exempted Pass	Ninety percent (90%) or above without deficiencies in critical elements, pharmaceutical services, or infection control
Conditional Pass	Eighty to eighty-nine percent (80-89%); or Ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control
Not Pass	Below eighty percent (80%)

f. N/A applies to any scored item that does not apply to a specific site, as determined by the Certified Site Reviewer.

g. The **MRR** contains three (3) general categories of Format, Documentation, and Coordination/Continuity of Care, and three (3) specific preventive categories of Pediatric Preventive, Adult Preventive, and OB/CPSP. **PCP** sites may earn up to twenty-three (23) points for the three (3) general categories multiplied by the number of **Medical Records** reviewed, plus the points given for the preventive services categories, as follows:

i. Pediatric Preventive: Nineteen (19) points multiplied by the number of pediatric **Medical Records** reviewed;

ii. Adult Preventive: Fifteen (15) points multiplied by the number of adult **Medical Records** reviewed; and

DRAFT 20190918QAC

iii. OB/CPSP: Twenty (20) points multiplied by the number of OB/CPSP **Medical Records** reviewed.

h. The **MRR** compliance levels are as follows:

Compliance Categories	Compliance Rate
Exempted Pass	Ninety percent (90%) or above: Total score is >90% and all section scores are eighty percent (80%) or above
Conditional Pass	Eighty to eighty-nine percent (80-89%): Total **MRR** is eighty to eighty-nine percent (80-89%) or any section (s) is <80%
Not Pass	Below eighty percent (80%)

i. Any section score of <80% requires a **CAP** for the entire **MRR**, regardless of the total **MRR** score.

j. A non-passing score for a **PCP** site by one health plan shall be considered a non-passing score for all other health plans.

E. Identified Deficiencies and **CAPs**

1. The **CAP** is a standardized, pre-formatted document developed to assist a **PCP** in meeting DHCS requirements. The **CAP** includes the following:

a. Deficiencies identified through the **FSR** and **MRR** processes;

b. Corrective action required in order to comply with DHCS standards;

c. Evidence of correction;

d. Projected and actual dates of the deficiency correction;

e. Date correction is implemented;

f. **PCP** or **Designee** responsible for corrective actions;

g. Name and title of the Certified Site Reviewer; and

h. A section for verification of corrections.

2. The **CAP** contains three (3) separate sections:

a. **FSR**;

b. Critical elements; and

c. **MRR**.

3. The **CAP** includes Disclosure and Release statements regarding **CAP** submission timelines and authorization to furnish results of the reviews and corrective actions to other health plans and **Health Networks**.

DRAFT 20190918 QAC

4. Government agencies that have authority over health plans and authorized county entities in California shall have access to this data.

5. The **CAP** informs the **PCP** that participating health plans collaborated for the **FSR** and **MRR** and agreed to accept the review findings and to furnish to each other the reviews and **CAPs**.

6. CalOptima shall furnish the results of reviews and **CAPs** to the **Health Network** with which the **PCP** site is affiliated.

7. CalOptima shall maintain the signed **FSR CAP** and/or **MRR CAP** in the **PCP** site file. The **CAPs** shall include, at a minimum, the following:

    a. All pages of the **CAP**, with documented deficiencies;

    b. Signed **CAP** face sheet;

    c. Signed attestation; and

    d. Evidence of corrections.

8. CalOptima shall require a **CAP** for a score of less that eighty percent (80%) or for a score of ninety percent (90%) or greater with deficiencies in the areas of critical elements, Pharmaceuticals, or infection control.

9. **CAP** Process

    a. The **Certified Site Reviewer** shall complete the **FSR** and the **MRR**, and shall document the deficiencies on the surveys and the **CAP**.

    b. Upon completion of the review process, the Certified Site Reviewer shall conduct an exit interview with the **PCP** or the **PCP** site contact to discuss the findings and required corrective actions.

    c. The **Certified Site Reviewer** shall instruct the **PCP** or **PCP** site contact that the signature of the **PCP** or **PCP** site contact acknowledges the receipt of the **CAP** and agreement to comply with the designated timeframes for corrective actions as outlined in Section III.E.16 of this Policy.

10. **PCP** Process for Noting Corrections on the **CAP** Document

    a. The **PCP** or **Designee** shall document the corrective actions taken in the "Corrective Action" required column. The **PCP** or **Designee** shall document the date of implementation of the required corrective actions. Additional steps taken to implement the corrective actions may be documented in this column.

    b. The **PCP** or **Designee** shall initial the appropriate column of the **CAP** to indicate the person responsible for the corrective actions.

    c. The **PCP** or **Designee** shall attach evidence of corrections, such as, but not limited to, applicable policies and procedures, sample forms, invoices for purchased items and services, training in-service agendas, and sign-in sheets.

11. **FSR CAP** Follow-up Process

DRAFT 20190918QAC

a. Verification of correction of identified deficiencies may be accomplished by **PCP** submission of the appropriate evidence of correction.

b. **CAP** verification may require an on-site visit forty-five (45) calendar days after the date of the review if there is insufficient evidence to determine compliance, or if the deficiency cannot be verified in writing. The **Certified Site Reviewer** shall determine the need for the on-site visit.

12. **MRR CAP** Follow-up Process

    a. The **Certified Site Reviewer** shall determine the process for **CAP** follow-up.

    b. The process may include the following activities:

        i. Score less than eighty percent (80%): On-site visit to verify processes implemented.

        ii. Score between eighty and eight-nine percent (80 – 89%): Documented **CAP** or a **CAP** verification visit and focused record review may be requested at the discretion of the **Certified Site Reviewer**.

        iii. Score ninety to one hundred percent (90 – 100%): Exempted Pass without **CAP**.

13. CalOptima shall monitor the **CAP** until completion. CalOptima shall communicate information regarding a **PCP** Site that shows no improvement, or non-compliance with the required **CAP** activities within the DHCS designated timeframes, to all affiliated **Health Networks**.

14. Review and Acceptance of **CAP**

    a. Following receipt of the completed **CAP**, CalOptima shall evaluate or verify corrections to approve the **CAP**.

    b. CalOptima shall communicate **CAP** approval, in writing, to the **PCP** and his or her assigned CalOptima contracted **Health Network(s)**. CalOptima shall issue a quality Provider Site Certificate to the **PCP** site.

    c. If CalOptima does not accept a **PCP** site's **CAP**, a **Certified Site Reviewer** shall follow-up with the **PCP** for technical assistance, and to ensure compliance with completion of required activities.

15. CalOptima shall conduct pre-contractual **PCP** site reviews, and will accept sites with a passing score of eighty percent (80%) or above.

    a. A new **PCP** site that receives a score between eighty and eighty-nine percent (80-89%) (Conditional pass) shall not be considered a **Health Network PCP** until the **PCP** site submits a **CAP** and CalOptima accepts the **CAP**.

    b. A new **PCP** site that receives a score below eighty percent (80%) (Not Pass) shall not be accepted into a **Health Network**. CalOptima must resurvey the **PCP**, and the **PCP** must pass with at least a score of eighty percent (80%) to be considered a CalOptima network provider. Any **CAPs** issued must be completed per **CAP** timeline requirements.

DRAFT – 20190918QAC

16. CalOptima shall not assign new Members to a PCP with a score below eighty percent (80%) in the FSR or MRR. CalOptima shall resume Member assignment after the PCP completes corrections within the designated time frames and CalOptima closes the CAP.

17. Time Frames for **CAP** Activities

    a. At the time of the **FSR** or **MRR**, a Certified Site Reviewer shall notify the **PCP** or **Designee** of the following:

        i. All survey scores, including the non-passing survey scores;

        ii. Deficiencies in the areas of critical elements, Pharmaceuticals Services, or infection control;

        iii. Other deficiencies determined by the Certified Site Reviewer to require immediate corrective action; and

        iv. **CAP** requirements to correct deficiencies.

    b. Within three (3) business days after the survey date, CalOptima shall notify **Health Network** of a **PCP** site that does not meet the passing score of eighty percent (80%) for the **FSR** or the **MRR**.

    c. Within ten (10) business days after the survey date:

        i. The **PCP** or **Designee** shall submit to CalOptima a completed **CAP**, with verification for all critical elements and other deficiencies determined by the reviewer to require immediate corrective action.

        ii. CalOptima shall provide a survey findings report and a formal written request for corrections of all other non-critical element deficiencies to the **PCP**.

        iii. CalOptima shall ensure that sites found deficient in any critical element during a site review shall correct 100% of the deficiencies regardless of the sites' overall survey score.

    d. Within forty-five (45) calendar days after the survey date, CalOptima shall evaluate and verify corrections of all critical elements and other deficiencies, including deficiencies in infection control and pharmaceutical services, determined by the **Certified Site Reviewer** to require immediate corrective action.

    e. Within forty-five (45) calendar days after the date of the written **CAP** request, the **PCP** shall submit to CalOptima a **CAP** for all identified deficiencies, other than critical elements,

        i. If CalOptima does not receive the **CAP** within thirty (30) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** with a reminder that the **CAP** is due in fifteen (15) calendar days.

        ii. CalOptima shall document all contacts with the **PCP** or **Designee** in the **PCP** site file.

    f. Within ninety (90) calendar days after the date of the written **CAP** request, CalOptima shall review the submitted **CAP**, and revise and approve the **CAP** and timelines. If additional

DRAFT 20190918QAC

corrective action is required to complete the **CAP**, the **PCP** shall complete all corrective actions within thirty (30) calendar days.

g. If a **PCP** fails to complete corrections within one-hundred-twenty (120) calendar days after the date of the written **CAP** request:

i. CalOptima shall re-survey the **PCP** site twelve (12) months after the date of the site survey.

ii. CalOptima may impose disciplinary action up to and including administrative termination from CalOptima.

h. CalOptima shall provide the **PCP** with written notification of **Member** reassignment at least ninety (90) calendar days prior to such reassignment.

18. **PCP** Non-Compliance with **CAP** Completion Requirements

a. If a **PCP** submits a **CAP**, but continues to be non-compliant with the **CAP** request, the Certified Site Reviewer shall follow up to provide technical support, in order assist the **PCP** in **CAP** completion.

b. Delayed **CAP** Submission Process:

i. If the **PCP** fails to complete and submit a **CAP** for critical elements, within ten (10) business days after the date of the review, the Certified Site Reviewer shall communicate by telephone with the **PCP** or **Designee**, or send a second and final critical element **CAP** request letter to the **PCP**. If the **PCP** fails to submit required documentation within seventy-two (72) hours after the second (2nd) notice, CalOptima may impose disciplinary action up to and including reassignment of **Members**.

ii. If CalOptima does not receive the **CAP** for non-critical element deficiencies within forty-five (45) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** or **Designee** and request the **CAP** completion within seventy-two (72) hours. If CalOptima does not receive the **CAP** within seventy-two (72) hours, CalOptima shall notify all **Health Networks** and may impose disciplinary action up to and including termination from CalOptima.

iii. CalOptima shall report a **PCP** who fails to submit a **CAP** within the established timelines to the appropriate committee for review and action.

c. CalOptima shall not assign new **Members** to a **PCP** who fails to correct deficiencies within established timelines. If a **PCP** fails to comply with survey criteria within established timelines, CalOptima shall remove the **PCP** from the CalOptima networks and shall appropriately reassign **Members** to other **PCPs**.

d. **PCPs** removed from a contracted **Health Network** may appeal CalOptima's decision in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

F. CalOptima shall review other performance indicators such as **Member** complaints, grievances, and Potential Quality Issues. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** complaints related to physical accessibility or **Member** safety is identified. If any issue related to physical accessibility or **Member** safety then CalOptima shall conduct an

DRAFT 20190918QAC

Back to Agenda

unannounced site visit no later than seven (7) calendar days of identification, depending on the severity of the identified patient safety or physical accessibility issue.

G. If the QI Department identifies issues such as, but not limited to physical appearance, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping, then CalOptima shall monitor sites and determine when an unannounced visit is required.

1. To identify the need for an unannounced site visit, the QI Department monitors Grievance and Appeals Resolution Services (GARS) related to complaints with provider sites. If a provider site receives three (3) or more separate complaints within twelve (12) months, CalOptima shall conduct an unannounced visit.

2. If the standard threshold of eighty percent (80%) is not met upon review, the site will receive a **CAP**.

   a. The **CAP** must include how the Provider will address and correct deficiencies.

3. CalOptima's Provider and Health Network Relations Departments, in conjunction with the **FSR** Nurse Auditor, shall collaborate with the Provider site to ensure that the site meets the required threshold of eighty percent (80%).

4. CalOptima shall evaluate deficient sites within forty-five (45) calendar days of the **CAP** issuance until the site meets the threshold score of eighty percent (80%).

5. CalOptima shall conduct a follow-up site visit to evaluate correction of deficiencies, utilizing the Industry Collaborative Effort (ICE) Provider Office Site Quality Site Visit Tool & **CAP**.

   a. If deficiencies have not been addressed within sixty (60) calendar days of the unannounced visit or sooner, a physician panel shall be put on hold until deficiencies are resolved.

   b. CalOptima shall monitor the facility site every six (6) months following the **CAP** resolution to evaluate the effectiveness of the corrections.

H. Tracking, Reporting, and Trending

1. On a quarterly basis, CalOptima's QI Department shall report a summary of **FSR**, **MRR** and **PARS** activity and action plans to the **CPRC** for monitoring. Reports include assessments, findings, monitoring of previous issues and next steps. **CPRC** will provide quarterly updates to the **CalOptima Quality Improvement Committee (QIC)**.

2. CalOptima's QI Department shall conduct an annual assessment of the **PARS** process and report findings to the **Credentialing Peer Review Committee (CPRC)** and **CalOptima Quality Improvement Committee (QIC)**. Annually the **PARS** process and findings will be reported to the **QIC** as follows:

   a. Assessment of completion of planned activities and the objectives of the plan were met;

   b. Identification of issues or barriers that impacted meeting the objectives;

   c. Recommended interventions to overcome barriers and issues identified;

DRAFT_20190918QAC

d. Overall effectiveness of the **PARS** compliance; and

e. Annual assessment of **PARS** process and findings shall be included in CalOptima's annual evaluation.

3. On a monthly basis CalOptima shall notify **Health Networks** of all **FSR**, **MRR**, **PARS** conducted and the scores from the prior month.

I. Review Personnel, Training and Certification

1. **FSR** and **MRR** shall be completed by appropriately trained staff, as outlined in this section.

a. In accordance with DHCS guidance, **PARS** need not be completed by a Registered Nurse (RN) or physician.

b. **PARS** shall be completed by appropriately trained CalOptima QI staff.

2. Initial certification: A candidate for certification as a Master Trainer, Trainer, or **Certified Site Reviewer** shall meet the following criteria as defined by DHCS.

3. Certification of Managed Care Plan Site Reviewers and Trainers

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Possess current and valid California RN, MD or DO license. Possess current California RN or MD license.	**X**	**X**	**X**
Have experience in training (small groups or individuals) or conducting groups in a health-related field within the past five (5) years; or experience conducting Quality Improvement activities such as medical audits, site reviews, or utilization management activities	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.		**X**	**X**
Completion of a minimum of ten tandem site reviews to include Attachment A and Attachment B criteria and guidelines according to APL 14-004. Knowledge of Facility Site Review Frequently Asked Questions (FAQs). Completion of a minimum of three (3) site reviews according to the 02-002 Site Review Policy and Tools.			**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer.		**X**	

DRAFT 20190918QAC

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL 14-004 include Attachment A and Attachment B criteria and guidelines; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of one (1) year as a Trainer/Certified Site Reviewer.	**X**		
Completion of the inter-rater site review process which involves an onsite review with:			
-DHCS MCQMD Nurse Evaluator	**X**		
-Certified Master Trainer		**X**	
-Certified Trainer or Certified Master Trainer			**X**
Achieving an inter-rater score within 10% of **FSR** and 10% of **MRR** Trainer or Master Trainer scores			**X**
Achieving an inter-rater score within 5% of **FSR** and 5% **MRR** of the Master Trainer's scores		**X**	
Achieving an inter-rater score within 5% of **FSR** and 5% of **MRR** of the DHCS MCQMD Nurse Evaluator	**X**		
Completion and submission of the "Application Request for Certification" to MCQMD (Enclosure A) (Plans have the option to use the application or develop other forms for trainers and reviewers).	**X**		

4. Physicians and RNs designated as Master Trainer, Trainers and **Certified Site Reviewers** will be required to meet the following criteria to maintain their certification.

Re-Certification Criteria	Master Trainer	Trainer	Site Reviewer
Verification of current and valid California RN, MD or DO license	**X**	**X**	**X**
Must be employed or affiliated with a DHCS Managed Care Plan	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Participate in DHCS MCQMD sponsored site review teleconferences or meetings as defined by the MCQMD Site Review Workgroup	**X**		
Participate in MCQMD sponsored site review training as defined by DHCS	**X**	**X**	**X**

DRAFT 20190918QA

Back to Agenda

Re-Certification Criteria	Master Trainer	Trainer	Site Reviewer
Maintain DHCS certificate number regardless of Health Plan affiliation	**X**		
A new certificate is issued by the primary Managed Care Plan if there is a change in employment		**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

5. A new employee who was previously certified as a Master Trainer, Trainer or **Certified Site Reviewer** by another Medi-Cal Managed Care health plan, but who was not subsequently re-certified, shall meet the following criteria for re-certification by CalOptima:

Re-Certification Criteria for new employees with lapsed certification	Master Trainer	Trainer	Site Reviewer
Verification of current California RN or MD license	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of certification. Verification of trainers' continued responsibility for training on the MMCD Site Review Policy and Tools and completion of a minimum of five site reviews since initial certification or re-certification	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.	**N/A**	**X**	**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

6. As part of the certification/re-certification process, Master Trainers, Trainers and potential or **Certified Site Reviewers** must complete the inter-rater review (IRR) process. This process requires the Master Trainers, Trainers or **Certified Site Reviewers** to participate in a site

DRAFT 2019 QAC

review with a designated rater such as the plan Master Trainer or Trainer. Both individuals will concurrently complete and score all elements of the **Facility Site Review** Survey and **Medical Record Review** Survey tools. The Master Trainer, Trainer or **Certified Site Reviewer** must achieve an inter-rater score as defined by DHCS and/or the Site Review Workgroup.

7. Physicians and RNs meeting all the certification criteria, and achieving an adequate inter-rater score as defined by DHCS, will be certified. All individuals who are certified will receive a certificate issued by DHCS MCQMD or the Medi-Cal Managed Care health Plan. Plans shall follow the instructions for certificate completion. Physicians and RNs who are certified will be authorized to sign site review surveys with the designation of Department of Health Care Services Master Trainer (DHCS-MT), Department of Health Care Services Trainer (DHCS-DPT), or a Department of Health Care Services **Certified Site Reviewer** (DHCS-**CSR**).

8. If the Master Trainer, Trainer, or **Certified Site Reviewer** has not achieved an adequate inter-rater score defined by DHCS, they may repeat the inter-rater review process. The designated rater and the individual with a non-passing inter-rater score will jointly assess training needs, and develop and implement a training plan prior to conducting a second inter-rater review. Trainers and site reviewers are allowed two (2) opportunities to become certified.

9. One or more of the following may lead to the revocation of certification for the DPT and **CSR** conducting DHCS-approved **Facility Site Review** and **Medical Record Review** surveys by CalOptima:

    a. Did not maintain current and valid California RN, MD or DO license;

    b. Resignation, termination, or lack of affiliation from CalOptima;

    c. No participation in the DHCS sponsored inter-rater reliability unless pre-approved by the CalOptima MT or QI Director;

    d. More than two (2) failed **Facility Site Review** survey and/or **Medical Record Review** survey inter-rater reliability scores; and/or

    e. Noncompliance with maintenance of certification criteria.

    f. The above applies to the revocation of MT Certification as determined by DHCS.

10. Assigning Certificate Numbers

    a. A Trainer or **Certified Site Reviewer** shall receive a certificate upon successfully completing the initial and subsequent certification.

    b. CalOptima shall issue certificates to a Trainer or **Certified Site Reviewer**. DHCS shall issue certificates to a Master Trainer.

    c. The certificates shall contain a series of numeric and alpha values to identify the health plan, county, month, and year the certification was granted, and identification code and level of designation for Master Trainer, Trainer, or **Certified Site Reviewer**.

    d. A certificate may be issued in the following format: 000-04-0702-01-A

000	Plan identification Code (CalOptima)

DRAFT 20190918 PAC

Back to Agenda

04	Plan Code
0702	Month and Year Certification Granted
01	Plan Trainer or Site Reviewer
A	Master Trainer or Other Trainer
B	Site Reviewer

11. CalOptima shall maintain certification records including, but not limited to, site review training activities and documentation to support the issuance of certificates.

IV. ATTACHMENTS

Not Applicable

DRAFT_20190918QAC

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health Network Service Agreement
D. CalOptima Policy HH.1101: CalOptima Provider Complaint
E. Department of Health Care Services (DHCS) Policy Letter (PL) 12-006: Revised Facility Site Review Tool
F. Department of Health Care Services (DHCS) Policy Letter (PL) 03-002: Certification of Managed Care Plan Staff Responsible for the Conduct of Primary Care Provider Site Reviews
G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004: Site Reviews: Facility Site Review and Medical Record Review
H. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 14-005: Facility Site Review / Physical-Accessibility Reviews
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-023: Facility Site Review Tools for Ancillary Service and Community-Based Adult Services Providers
J. National Committee for Quality Assurance (NCQA) 2019 Standards: MED 3-Practitioner Office Site Quality

VI. REGULATORY AGENCY APPROVALS

A. 04/30/15: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1608	PCP Site Reviews	Medi-Cal
Revised	01/01/1998	GG.1608	PCP Site Reviews	Medi-Cal
Revised	04/01/1999	GG.1608	PCP Site Reviews	Medi-Cal
Revised	08/01/2000	GG.1608	PCP Site Reviews	Medi-Cal
Revised	10/01/2002	GG.1608	Facility Site Reviews	Medi-Cal
Revised	10/01/2003	GG.1608	Facility Site Reviews	Medi-Cal
Effective	10/01/2005	MA.7011	Practitioner Office Site Reviews	OneCare
Revised	03/01/2007	MA.7011	Full Scope Practitioner Office Site Reviews	OneCare
Revised	04/01/2007	GG.1608	Facility Site Review	Medi-Cal
Revised	09/01/2011	MA.7011	Full Scope Site Reviews	OneCare
Revised	09/01/2011	GG.1608	Full Scope Site Reviews	Medi-Cal
Revised	02/01/2013	GG.1608	Full Scope Site Reviews	Medi-Cal OneCare
Revised	12/01/2014	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE

DRAFT 20190918OAC

Back to Agenda

Revised	12/01/2015	GG.1608Δ	Full Scope Site Reviews	Medi-Cal 1 OneCare 2 OneCare Connect PACE
Revised	05/01/2016	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	10/10/2017	GG.1608a	Facility Site Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608b	Medical Record Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608c	Facility Site Review and Medical Record Review Collaboration Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608d	Scoring Process for Facility Site Review and Medical Record Review	Medi-Cal OneCare
Retired	10/10/2017	GG.1608e	Facility Site Review and Medical Record Review Corrective Action Plan	Medi-Cal OneCare
Retired	10/10/2017	GG.1608f	Review Personnel, Training and Certification	Medi-Cal OneCare
Revised	10/01/2017	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2018	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	02/13/2018	MA.7011	Full Scope Site Reviews	OneCare
Revised		GG.1608Δ	Full Scope Site Reviews	OneCare

DRAFT 20190918QAC

IX. GLOSSARY

Term	Definition
Ancillary Service Provider Sites	Ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services such as radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations
Ancillary Services	For the purposes of this policy, ancillary services refers to diagnostic and therapeutic services such as, but not limited to: radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.
CBAS Providers Sites	CBAS provider sites include all facilities that provide bundled CBAS services, and do not include Licensed Only Adult Day Health Care centers and Programs of All-Inclusive Care for the Elderly (PACE). CBAS services (defined in W&I Code section 14550.5 and provided each day of attendance) include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on the participant's Individual Care Plan.
CBAS Services	For purposes of this policy, CBAS services include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on a Member's Individual Care Plan.
Certified Site Reviewer (CSR)	An appropriately qualified and trained physician or registered nurse (RN) who is responsible for conducting provider site reviews, in accordance with DHCS Policy Letter 14-004 and subsequent updates.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	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.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.

Back to Agenda

Term	Definition
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Critical Elements (CE)	Nine critical elements of the site review that defines the potential for adverse effects on patient health and safety, and has a scored weight of two points on the FSR tool.
Designee	For the purposes of this policy, a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role, as determined by CalOptima QI staff.
Facility Site Review (FSR) Survey	A DHCS tool utilized to assess the quality, safety, and accessibility of PCPs and high-volume specialists physician offices.
Full Scope Site Review	For the purposes of this policy, means a comprehensive site review as required by DHCS guidelines which encompass a Facility Site Review (FSR) and Medical Record Review (MRR) of a Primary Care Provider (PCP) site.
Health Network	A Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that Health Network.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Medical Record	For the purposes of this policy, a medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including high volume specialists, CBAS and ancillary service providers.
Potential Quality Issues (PQIs)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised.
Primary Care Provider (PCP)	For the purposes of this policy, a primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

DRAFT 2019 QIQAC

Term	Definition
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

1

DRAFT_20190918QAC

Policy #:	GG.1620
Title:	**Quality Improvement Committee**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/05
~~Last Review Date:~~	~~03/01/18~~
~~Last~~ Revised Date:	~~03/01/18~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes CalOptima's **Quality Improvement Committee (QIC)** and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for ~~Members~~**members** and ~~Providers~~**providers**; satisfaction for ~~Members~~**members** and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the **National Committee for Quality Assurance (NCQA)**.

II. POLICY

A. The **Quality Improvement Committee (QIC)** shall provide overall direction for the quality management and improvement process and ensure that activities are consistent with CalOptima's strategic goals and priorities. The **QIC** shall:

1. Ensure and improve the quality of ~~Member~~**member** care by objectively and systematically monitoring and evaluating the quality, timeliness, and appropriateness of clinical care and services provided to ~~Members~~**members**, and pursue opportunities for improvement;

2. Design, manage, and improve all work processes that are related to clinical care, service, access, and quality ~~including, but not limited~~in order to:

   a. Improve quality of care received by ~~Members~~**members**;

   b. Increase ~~Member~~**member** satisfaction;

   c. Minimize rework and costs;

   d. Minimize the time involved in delivery of ~~Member~~**member** care and service;

   e. Improve organizational quality improvement functions and processes to both internal and external customers;

   f. Collect clear, accurate, and appropriate date to analyze problems and measure improvement; and

DRAFT 20190918QAC

Back to Agenda

g. Coordinate and communicate department-specific and system-wide organizational information.

B. The ***QIC*** shall use a variety of ~~quality improvement~~Quality Improvement (QI) methodologies dependent on the type of opportunity for improvement identified (i.e., Plan/Do/Study/Act model).

III. PROCEDURE

A. Membership

1. The ***QIC*** Chairperson shall be the CalOptima Chief Medical Officer, ~~Deputy Chief Medical Officer~~ or ~~Designee~~**designee**, CalOptima.

2. The ~~Voting Members~~voting **members** shall consist of:

a. Four (4) ~~participating~~ physicians or practitioners, with at least two (2) practicing physicians or practitioners;

b. CalOptima Chief Medical Officer (CMO~~)/Deputy Chief Medical Officer (DCMO~~);

~~a.~~ CalOptima Medical ~~Director, Utilization Management (UM), also representing the UM Committee;~~

c. ~~CalOptima Medical Director, Behavioral Health (BH), also representing the BH QI Committee~~Directors;

d. Executive Director of Clinical Operations;

e. Executive Director of Network Management; and

f. Executive Director of Operations.

3. The ***QIC*** shall be supported by:

a. Executive Director of Quality and ~~Analytics~~Population Health Management;

b. Director of Quality Improvement;

c. Director of Quality Analytics;

d. Director, Population Health ~~Education & Disease~~ Management~~; and~~

e. Committee recorder as assigned.

B. Quorum

1. A quorum consists of a ~~majority~~minimum of ~~the~~six (6) voting ***members*** ~~at least six (6)~~ of which at least four (4) are physicians or practitioners. Once a quorum is attained, the meeting may

DRAFT 20190918QAC

Back to Agenda

proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as the attendance in person or participation by telephone.

C. The ***QIC*** shall meet at least eight (8) times per calendar year, and report to the Board Quality Assurance Committee (QAC) quarterly.

D. Participating ***members*** of the ***QIC*** shall complete the confidentiality statement in accordance with GG.1628: Confidentiality of Quality Improvement Activities. Participating ***members*** shall sign a Conflict of Interest Attestation and Conflict of Interest Disclosure form in accordance with CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest.

E. The Chief Medical Officer and/or his or her ~~Designee~~***designee*** shall report ***QIC*** activities to the ~~Quality Assurance Committee~~QAC and Board of Directors.

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Policy GG.1628: Confidentiality of Quality Improvement Activities
B. CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest
C. Quality Improvement Program
D. Quality Improvement Committee Flow Chart
E. Quality Improvement Committee (QIC) Charter

VI. REGULATORY AGENCY ~~APPROVALS~~APPROVAL(S)

A. 11/23/15: Department of Health Care Services

VII. BOARD ~~ACTIONS~~ACTION(S)

~~Not Applicable~~

~~REVIEW/~~None to Date

VIII. REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/2005	MA.7002	Quality Improvement Committee	Medi-Cal
Revised	04/01/2013	GG.1620	Quality Improvement Committee	Medi-Cal OneCare

DRAFT 20190918QAC

Back to Agenda

~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Revised	08/01/2015	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	04/01/2017	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	03/01/2018	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

DRAFT_20190918OAC

Back to Agenda

IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Member	An enrollee-beneficiary of a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

DRAFT_20190918QIC

Back to Agenda

Policy #:	GG.1620
Title:	**Quality Improvement Committee**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/05
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

DRAFT 20190918QAC

I. PURPOSE

This policy describes CalOptima's **Quality Improvement Committee (QIC)** and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for **members** and **providers**; satisfaction for **members** and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the **National Committee for Quality Assurance (NCQA)**.

II. POLICY

A. The **Quality Improvement Committee (QIC)** shall provide overall direction for the quality management and improvement process and ensure that activities are consistent with CalOptima's strategic goals and priorities. The **QIC** shall:

1. Ensure and improve the quality of **member** care by objectively and systematically monitoring and evaluating the quality, timeliness, and appropriateness of clinical care and services provided to **members**, and pursue opportunities for improvement;

2. Design, manage, and improve all work processes that are related to clinical care, service, access, and quality in order to:

   a. Improve quality of care received by **members**;

   b. Increase **member** satisfaction;

   c. Minimize rework and costs;

   d. Minimize the time involved in delivery of **member** care and service;

   e. Improve organizational quality improvement functions and processes to both internal and external customers;

   f. Collect clear, accurate, and appropriate date to analyze problems and measure improvement; and

Back to Agenda

g. Coordinate and communicate department-specific and system-wide organizational information.

B. The ***QIC*** shall use a variety of Quality Improvement (QI) methodologies dependent on the type of opportunity for improvement identified (i.e., Plan/Do/Study/Act model).

III. PROCEDURE

A. Membership

1. The ***QIC*** Chairperson shall be the CalOptima Chief Medical Officer, or **designee**, CalOptima.

2. The voting **members** shall consist of:

   a. Four (4) physicians or practitioners, with at least two (2) practicing physicians or practitioners;

   b. CalOptima Chief Medical Officer (CMO);

   c. CalOptima Medical Directors;

   d. Executive Director of Clinical Operations;

   e. Executive Director of Network Management; and

   f. Executive Director of Operations.

3. The ***QIC*** shall be supported by:

   a. Executive Director of Quality and Population Health Management;

   b. Director of Quality Improvement;

   c. Director of Quality Analytics;

   d. Director, Population Health Management

   e. Committee recorder as assigned.

B. Quorum

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

C. The ***QIC*** shall meet at least eight (8) times per calendar year, and report to the Board Quality Assurance Committee (QAC) quarterly.

D. Participating ***members*** of the ***QIC*** shall complete the confidentiality statement in accordance with GG.1628: Confidentiality of Quality Improvement Activities. Participating ***members*** shall sign a

DRAFT_20190918QAC

Back to Agenda

Conflict of Interest Attestation and Conflict of Interest Disclosure form in accordance with CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest.

E. The Chief Medical Officer and/or his or her ***designee*** shall report ***QIC*** activities to the QAC and Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Policy GG.1628: Confidentiality of Quality Improvement Activities
B. CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest
C. Quality Improvement Program
D. Quality Improvement Committee Flow Chart
E. Quality Improvement Committee (QIC) Charter

VI. REGULATORY AGENCY APPROVAL(S)

A. 11/23/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	10/01/2005	MA.7002	Quality Improvement Committee	Medi-Cal
Revised	04/01/2013	GG.1620	Quality Improvement Committee	Medi-Cal OneCare
Revised	08/01/2015	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	04/01/2017	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	03/01/2018	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

DRAFT 20190918QAC

Back to Agenda

IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Member	An enrollee-beneficiary of a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

DRAFT_20190918QAC

~~Policy #:~~ ~~GG.1639A~~

~~Title:~~ ~~**Post-Hospital Discharge Medication Supply**~~

~~Department:~~ ~~Medical Affairs~~

~~Section:~~ ~~Quality Improvement~~

~~CEO Approval:~~ ~~Michael Schrader~~

~~Effective Date:~~ ~~11/1/14~~

~~Last Review Date:~~ ~~11/1/15~~

~~Last Revision Date:~~ ~~11/1/15~~

~~This policy shall apply to the following CalOptima line of business (LOB):~~

- ~~Medi-Cal~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

Policy #: GG.1639A

Title: **Post-Hospital Discharge Medication Supply**

Department: Medical Affairs

Section: Quality Improvement

CEO Approval: Michael Schrader

Effective Date: 11/01/2014

Revised Date: TBD

Applicable to:

☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

To describe the process by which CalOptima shall provide oversight of contracted hospitals to ensure that **Members** have access to seventy-two (72)-hour supply of covered outpatient drugs in an **emergency situation**.

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. Hospitals shall ensure that discharged **Members** have access to at least a seventy-two (72) hour supply of any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

~~A.~~ For ~~The CalOptima Director of Provider Network Management or designee shall manage the hospital contracting process.~~

~~B. CalOptima shall require credentialing of all contracted hospitals.~~

B. ~~CalOptima shall oversee only contracts with hospitals that are licensed for participation in the~~ the purpose of this policy, an emergency situation would include any covered outpatient drug needed for continuity of care that routinely require prior authorization, which would be delayed due to after-hours (nights, weekends and holidays), the 72-hour supply is an exception to the prior authorization processes.

~~C.~~ The Quality Improvement Department~~Medi-Cal program.~~

~~D.~~C. ~~CalOptima~~ shall monitor hospitals to ensure that a **Member** has access to at least a seventy-two (72-)-hour emergency supply of a covered outpatient or **Medically Necessary** medications when prior authorization is not available, and when the medication is needed without delay to prevent the **Member's** condition from worsening~~.~~.

DRAFT_20190918QAC

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

~~E.~~D. Routine discharge prescriptions and prescriptions for an emergency supply of medication shall be filled at the **Member's** ~~Pharmacy~~pharmacy, in accordance with CalOptima ~~policy~~Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies.

~~CalOptima~~

E. CalOptima's Pharmacy Department shall monitor **Members** recently discharged from the hospital and assist the **Member** or the **Member's** pharmacy with access to at least a seventy-two (72-)-hour supply of **Medically Necessary** medications.

F. CalOptima's Customer Service Department shall inform **Members** of their right to receive the seventy-two (72)-hour covered outpatient drug supply through the ~~medication reconciliation program and Transition of Care program~~**Member** Handbook and at least annually through the **Member** newsletter.

~~G.~~ CalOptima's Provider Relations Department shall ~~ensure that the 72-hour emergency supply of the covered prescription drug is prepared and administered in accordance with the orders of a licensed independent practitioner responsible for the Member's care, and in accordance with all applicable laws and regulations.~~

~~4.~~ ~~CalOptima shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24-hour a day, 7 days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility~~, at ~~all times~~least annually, notify its providers, including~~:~~

~~H.~~G. ~~CalOptima shall ~~ensure that appropriate~~ hospitals ~~are available and accessible to Members within~~, of this requirement through the provider ~~network to provide necessary high-risk pregnancy and delivery services.~~newsletter.

~~I.~~H. CalOptima's Quality Improvement Department shall document policies and procedures of CalOptima's network hospitals related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met~~, including, if applicable, specific language in network hospital subcontracts.~~ .

~~IV.~~III. PROCEDURE

~~A. CalOptima's Contracting department oversees and manages~~Hospitals shall ensure that the ~~Hospital contracting process in collaboration with CalOptima's Quality Improvement Department and Finance Departments~~discharged **Member** has ~~:~~

~~A. On an annual basis, CalOptima's Quality Improvement department shall monitor, via a signed attestation, and conduct an annual audit for validation of the attestation, of contracted hospitals' compliance with:~~

~~1. Applicable CalOptima policies and procedures;~~

~~B.~~A. ~~Emergency medication dispensing requirements of providing Members~~ access to at least a seventy-two (72-) hour supply of ~~covered outpatient or~~ any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

DRAFT 20190918QAC

~~a. In order to receive reimbursement for emergency supply medications, the hospital pharmacy shall submit a prior approval request for the emergency supply. The request must clearly state the request is for the emergency 72 hour medications.~~

~~b. On a quarterly basis, the CalOptima Grievance Appeals Resolution Services (GARS) department shall ensure any grievances related to the dispensing of the 72 hour drug supply are isolated and reported to the the GARS committee, Quality Improvement Committee (QIC) and Delegation Oversight Committee (DOC).~~

~~c. On a quarterly basis, the Quality Improvement department shall monitor and report any Potential Quality Issues (PQI) in relation to the 72 hour drug supply to the QIC and DOC.~~

~~d. CalOptima shall inform Members of their right to receive the 72 hour drug supply through the Member Handbook and at least annually through the Member Newsletter.~~

~~e. CalOptima shall, at least annually, notify its providers, including hospitals, of this requirement through the Provider Newsletter.~~

CalOptima's Pharmacy Department

~~2. For designated emergency service facility, the facility has one or more Physicians and one (1) Nurse on duty in the facility at all times.~~

~~3. Appropriate hospitals are available and accessible to Members within the provider network to provide necessary high-risk pregnancy and delivery services.~~

~~B. Oversight of Attestations~~

~~1. A random sample will be chosen, at a minimum, on an annual basis.~~

~~2. The Network Operations department shall validate compliance with the attested items.~~

~~3. On an annual basis, the results shall be reported to the Quality Improvement Committee (QIC) and Delegation Oversight Committee (DOC).~~

~~4. A Corrective Action Plan shall be issued in accordance with CalOptima Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions~~

~~C. Contracted hospitals shall provide required policies and procedures to CalOptima upon request.~~

~~D. CalOptima shall, request a random sample of Medication Dispensing logs on at least a semi-annual basis.~~

~~E. CalOptima shall provide track and trend results via a semi-annual report to the QIC and DOC.~~

~~C.~~B. ~~On a quarterly basis, CalOptima~~ shall monitor and report pharmacy emergency overrides at the point of sale for hospital discharge ~~at the Pharmacy and Therapeutics Committee~~.

1. On a daily ~~basis~~ basis, a CalOptima Pharmacist shall conduct medication reconciliation for **Members** discharged from the hospital including emergency room admissions and assist **Members** in obtaining necessary discharge-related medications, provide telephonic medication counseling for high-risk medications started upon hospital discharge, and screen for duplication in therapy, drug-drug interactions, and potential dosing errors.

DRAFT 20190918QAC

2. Upon a referral from a CalOptima **Transition of Care** Coach, a CalOptima Pharmacist shall review and address medication discrepancies and major medication-related problems for **Members** participating in the CalOptima **Transition of Care** Program. A CalOptima Pharmacist shall contact the **Member** to conduct discharge counseling, provide clinical recommendations to the ~~member~~**Member**, and notify the ~~member's~~**Member's** primary care provider of these recommendations. A CalOptima Pharmacist shall review the **Member's** discharge summary for the following:

   a. Discrepancies identified on the Medication Discrepancy Tool;

   b. Potential Drug-Drug interaction;

   c. Changes in medication regimen as a result of the hospitalization;

   d. New medication counseling;

   e. Medication access issues; and

   f. Medication adherence.

3. On a quarterly basis, findings will be reported to the Pharmacy and Therapeutics (P & T) Committee.

4. Quality of care issues identified by the CalOptima Pharmacy Department through the medication reconciliation and **Transition of Care** processes shall be reported to QI for investigation, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review.

C. CalOptima shall respond to **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply as described in CalOptima Policy HH.1102: CalOptima Member Complaint and shall conduct a review of the related grievance by a nurse pursuant to CalOptima Policy GG.1611: Potential Quality Issue Review.

D. On an annual basis, CalOptima's Quality Improvement Department shall monitor compliance through a random sample of CalOptima- and health network-contracted hospitals. The Quality Improvement Department shall request and review for compliance with this policy:

1. An attestation from the hospital attesting to adherence to this policy; and

2. Hospital policy demonstrating adherence to this policy.

E. Oversight Process

1. Semi-annually, **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply will be reviewed by the CalOptima Grievance Appeals Resolution Services (GARS) Department.

2. Semi-annually, the Quality Improvement Department shall monitor and report any **Potential Quality Issues (PQI)** in relation to the seventy-two (72)-hour covered outpatient drug supply to the **Quality Improvement (QI) Committee**.

3. Annually, the results of the monitoring from P & T and GARS Committees shall be reported to the (**QI) Committee**.

DRAFT 20190918QAC

4. A Corrective Action Plan shall be issued in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions for any hospital found to be out of compliance with this policy.

~~V.~~IV. ATTACHMENT(S)

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima ~~Pharmacy Management~~Contract with the Department of Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~A.~~D. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies~~.~~
~~B.~~E. CalOptima Policy ~~and Procedure HH.2002: Sanctions~~ GG.1600: Access and Availability Standards
F. CalOptima Policy ~~and Procedure~~GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
G. CalOptima Policy HH.2002Δ: Sanctions
~~C.~~H. CalOptima Policy HH.~~2005~~2005Δ: Corrective Action Plan
~~D. Department of Health Care Services Contract~~
I. CalOptima PolicyHH.1102, CalOptima Member Complaint
J. CalOptima Policy GG.1611: Potential Quality Issue Review
~~E.~~K. Section 1927(d)(5) of the Social Security Act
L. Welfare and Institutions Code §14185
M. Title 42 Code of Federal Regulations § 438.3(s)

~~VII.~~VI. REGULATORY AGENCY APPROVAL(S)

04/28/15:——— Department of Health Care Services

~~VIII.~~VII. BOARD ACTION(S)

~~Not Applicable~~

~~REVIEW/~~None to Date

~~IX.~~VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	11/01/2014	GG.1639Δ	Hospital Oversight	Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2015	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare

DRAFT 20190918QAC

				OneCare Connect PACE

1

DRAFT_20190918QAC

IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Medically Necessary	Reasonable and necessary services to protect life, to prevent 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.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Quality Improvement (QI) Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Service Area	The geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

DRAFT 20190910 OAC

Policy #:	GG.1639Δ
Title:	**Post-Hospital Discharge Medication Supply**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader
Effective Date:	11/01/2014
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

DRAFT 20190918QAC

I. PURPOSE

To describe the process by which CalOptima shall provide oversight of contracted hospitals to ensure that **Members** have access to seventy-two (72)-hour supply of covered outpatient drugs in an **emergency situation**.

II. POLICY

A. Hospitals shall ensure that discharged **Members** have access to at least a seventy-two (72) hour supply of any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

B. For the purpose of this policy, an emergency situation would include any covered outpatient drug needed for continuity of care that routinely require prior authorization, which would be delayed due to after-hours (nights, weekends and holidays), the 72-hour supply is an exception to the prior authorization processes.

C. The Quality Improvement Department shall monitor hospitals to ensure that a **Member** has access to at least a seventy-two (72)-hour emergency supply of a covered outpatient or **Medically Necessary** medications when prior authorization is not available, and when the medication is needed without delay to prevent the **Member's** condition from worsening.

D. Routine discharge prescriptions and prescriptions for an emergency supply of medication shall be filled at the **Member's** pharmacy, in accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies.

E. CalOptima's Pharmacy Department shall monitor **Members** recently discharged from the hospital and assist the **Member** or the **Member's** pharmacy with access to at least a seventy-two (72)-hour supply of **Medically Necessary** medications.

F. CalOptima's Customer Service Department shall inform **Members** of their right to receive the seventy-two (72)-hour covered outpatient drug supply through the **Member** Handbook and at least annually through the **Member** newsletter.

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

G. CalOptima's Provider Relations Department shall, at least annually, notify its providers, including hospitals, of this requirement through the provider newsletter.

H. CalOptima's Quality Improvement Department shall document policies and procedures of CalOptima's network hospitals related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met.

III. PROCEDURE

A. Hospitals shall ensure that the discharged **Member** has access to at least a seventy-two (72) hour supply of any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

B. CalOptima's Pharmacy Department shall monitor and report pharmacy emergency overrides at the point of sale for hospital discharge.

1. On a daily basis, a CalOptima Pharmacist shall conduct medication reconciliation for **Members** discharged from the hospital including emergency room admissions and assist **Members** in obtaining necessary discharge-related medications, provide telephonic medication counseling for high-risk medications started upon hospital discharge, and screen for duplication in therapy, drug-drug interactions, and potential dosing errors.

2. Upon a referral from a CalOptima **Transition of Care** Coach, a CalOptima Pharmacist shall review and address medication discrepancies and major medication-related problems for **Members** participating in the CalOptima **Transition of Care** Program. A CalOptima Pharmacist shall contact the **Member** to conduct discharge counseling, provide clinical recommendations to the **Member**, and notify the **Member's** primary care provider of these recommendations. A CalOptima Pharmacist shall review the **Member's** discharge summary for the following:

    a. Discrepancies identified on the Medication Discrepancy Tool;

    b. Potential Drug-Drug interaction;

    c. Changes in medication regimen as a result of the hospitalization;

    d. New medication counseling;

    e. Medication access issues; and

    f. Medication adherence.

3. On a quarterly basis, findings will be reported to the Pharmacy and Therapeutics (P & T) Committee.

4. Quality of care issues identified by the CalOptima Pharmacy Department through the medication reconciliation and **Transition of Care** processes shall be reported to QI for investigation, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review.

C. CalOptima shall respond to **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply as described in CalOptima Policy HH.1102: CalOptima Member Complaint

DRAFT_20190918QAC

and shall conduct a review of the related grievance by a nurse pursuant to CalOptima Policy GG.1611: Potential Quality Issue Review.

D. On an annual basis, CalOptima's Quality Improvement Department shall monitor compliance through a random sample of CalOptima- and health network-contracted hospitals. The Quality Improvement Department shall request and review for compliance with this policy:

1. An attestation from the hospital attesting to adherence to this policy; and

2. Hospital policy demonstrating adherence to this policy.

E. Oversight Process

1. Semi-annually, **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply will be reviewed by the CalOptima Grievance Appeals Resolution Services (GARS) Department.

2. Semi-annually, the Quality Improvement Department shall monitor and report any **Potential Quality Issues (PQI)** in relation to the seventy-two (72)-hour covered outpatient drug supply to the **Quality Improvement (QI) Committee**.

3. Annually, the results of the monitoring from P & T and GARS Committees shall be reported to the (**QI) Committee**.

4. A Corrective Action Plan shall be issued in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions for any hospital found to be out of compliance with this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
E. CalOptima Policy GG.1600: Access and Availability Standards
F. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima PolicyHH.1102, CalOptima Member Complaint
J. CalOptima Policy GG.1611: Potential Quality Issue Review
K. Section 1927(d)(5) of the Social Security Act
L. Welfare and Institutions Code §14185
M. Title 42 Code of Federal Regulations § 438.3(s)

VI. REGULATORY AGENCY APPROVAL(S)

DRAFT_20190918QAC

04/28/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	11/01/2014	GG.1639Δ	Hospital Oversight	Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2015	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare OneCare Connect PACE

DRAFT_20190918OC

IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Medically Necessary	Reasonable and necessary services to protect life, to prevent 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.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Quality Improvement (QI) Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Service Area	The geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

DRAFT_20190918QAC

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model Program and Merit-based Incentive Payment System (MIPS) Payment Adjustment

Contact

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

Recommended Action(s)

Approve modifications to the following Policies and Procedures:

A. GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program [Medi-Cal]
B. GG.1318: Coordination of Care for Hemophilia Members [Medi-Cal]
C. GG.1539: Authorization for Out-of-Network and Out-of-Area Services [MC, OC, OCC]
D. MA.3101: Claims Processing [OC, OCC, PACE]

Background and Discussion

As a County Organized Health System (COHS), CalOptima contracts with state and federal agencies to provide health care services to beneficiaries in Orange County. Periodically, CalOptima establishes new, or modifies existing, Policies and Procedures to implement new, or modified, laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated and subject to peer review. New and modified Policy and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, or programs are established. Most recently, the following have impacted CalOptima's Policies and Procedures:

Whole-Child Model

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. The California Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for COHS on a phased-in basis.

On November 9, 2018, DHCS delayed the implementation of Orange County's transition of the CCS program to WCM from January 1, 2019 to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible population and the complexity of our delegated delivery system, DHCS determined that more time is needed to ensure effective preparation and a robust number of CCS-paneled providers. On December 23, 2018, DHCS released All Plan Letter (APL) 18-023 California Children's Services Whole-Child Model Program, which superseded APL 18-011, originally published on June 7, 2018, and included clarifying language and new guidance regarding Neonatal Intensive Care Unit (NICU), High Risk Infant Follow-up (HRIF) program, pediatric palliative care, and continuity of care appeals.

Back to Agenda

On April 4, 2019, the CalOptima Board of Directors authorized modification of existing WCM-related Policies and Procedures to eliminate the age restriction for members who are diagnosed with Hemophilia, End Stage Renal Disease, or are identified as eligible for a transplant consistent with the DHCS-approved commencement date of the CalOptima WCM program to no sooner than July 1, 2019. Additional policies and procedure require modification due to the delayed WCM implementation date and regulatory guidance.

Below is a summary of the modified policies related to WCM:

A. ***GG.1101: California Children's Services*** **(CCS)/Whole-Child Model – Coordination with County CCS Program** defines the guidelines for coordination of care between CalOptima or a health network and the County California Children's Services (CCS) program for members eligible with the CCS program and transitioned into the WCM program, newly CCS-eligible members, or new CCS members enrolling in CalOptima, including identification and referral of members with CCS-eligible conditions. CalOptima revised this policy to ensure compliance with the DHCS APL 18-023: California Children's Services Whole-Child Model Program. With respect to WCM, the revisions address CalOptima's expanded responsibility for determining HRIF program eligibility, coordinating and authorizing HRIF services, and ensuring the provision of HRIF case management service in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model. The revisions also address the addition of CalOptima as a liaison between practitioners/Health Networks and the County for medical eligibility determination referrals.

B. ***GG.1318: Coordination of Care for Hemophilia Members*** defines the case management guidelines for coordination of care by CalOptima and its Health Networks for Members diagnosed with Hemophilia. CalOptima has revised the policy pursuant the DHCS APL 18-023: California Children's Services Whole-Child Model Program. The WCM implementation date has been revised in the policy and effectuates CalOptima's responsibility for care coordination for member diagnosed with Hemophilia and are less than twenty-one years of age.

C. ***GG.1539: Authorization for Out-of-Network and Out-of-Area Services*** describes requirements and process for authorization of out-of-network and out-of-area Covered Services for Members assigned to CalOptima Direct or a Health Network. CalOptima revised this policy with respect to Whole-Child Model to be compliant with the DHCS APL 18-023: California Children's Services Whole-Child Model. The revisions ensure WCM members rights to access out-of-network providers in order to obtain Medically Necessary Covered Services if they follow the appropriate process and CalOptima or a Health Network is unable to provide the needed service. The revisions ensure that CalOptima or a Health Network cannot deny out-of-network services based upon cost or location.

<u>Merit-based Incentive Payment System (MIPS) Adjustments</u>
The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) requires CMS to implement an incentive program, referred to as the Quality Payment Program; which provides two participation tracks for non-contracted (out-of-network) clinicians:

Back to Agenda

Advanced Alternative Payment Models (APMS) and Merit-based Incentive Payment System (MIPS). Guidance regarding APMS is forthcoming. Guidance regarding MIPS was first received on April 27, 2018 with subsequent updates on November 8, 2018 and January 8, 2019.

The MIPS was created to reform Medicare Part B payments by rewarding the delivery of high-quality patient care provided by non-contracted clinicians. CMS evaluates eligible clinicians and adjusts payment based upon following performance categories: Quality, Promoting Interoperability, Improvement Activities, and Cost. Evaluation is conducted on an annual basis and the maximum MIPS adjustment percentages increase year over year. The following table provides an overview of the positive and negative MIPS adjustments which can have a range of percentages with a maximum limit for each payment year from 2019-2022:

Performance Year	Payment Year	Maximum Limit for MIPS adjustment
January 1, 2017 - December 31, 2017	2019	+/-4 percent
January 1, 2018 - December 31, 2018	2020	+/-5 percent
January 1, 2019 - December 31, 2019	2021	+/-7 percent
January 1, 2020 - December 31, 2020	2022	+/-9 percent

Below is a summary of the modified policy related to MIPS payment adjustments:

A. ***MA.3101: Claims Processing*** outlines the criteria and process to ensure the timely and accurate processing and adjudication of claims in accordance with applicable statutory and regulatory guidelines for contracted and non-contracted providers. CalOptima revised this policy pursuant to the CalOptima review process to ensure alignment with current operations to include MIPS payment adjustments requirements for non-contracted providers, for both CalOptima and its Health Networks. This policy will apply to MIPS program requirements beginning January 2019 and beyond.

Fiscal Impact
The proposed revisions to CalOptima Policies GG.1101, GG.1318, GG.1539 and MA.3101 are operational and compliance-related in nature. Staff does not anticipate any additional fiscal impact to the CalOptima Consolidated FY 2019-20 Operating Budget, approved by the Board on June 6, 2019.

Rationale for Recommendation
The recommended actions will enable CalOptima to meet regulatory and business requirements of the Whole-Child Model program and MIPS payment adjustments.

Concurrence
Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program [Medi-Cal] (redline and clean)
2. GG.1318: Coordination of Care for Hemophilia Members [Medi-Cal] (redline and clean)
3. GG.1539: Authorization for Out-of-Network and Out-of-Area Services [MC, OC, OCC] (redline and clean)
4. MA.3101: Claims Processing [OC, OCC, PACE] (redline and clean)
5. Board Action April 4, 2019, Consider Actions Related to CalOptima's Whole-Child Model (WCM) Program
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. CMS HPMS Memo: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Back to Agenda

Policy #: GG.1101
Title: **California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 10/01/1995
~~Last Review Date:~~ ~~11/01/17~~
~~Last~~ Revised Date: ~~11/01/17~~07/01/2019

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a **Health Network** and the ~~County~~ **California Children's Services (CCS)** ~~for Children with Special~~program.

II. POLICY

A. Effective July 01, 2019, CalOptima shall implement ~~on~~ the Department of Health Care ~~Needs.~~Services (DHCS)-approved **Whole-Child Model (WCM)** program. CalOptima shall assume responsibility for **CCS** for **Members** who are eligible for the **California Children's Services (CCS)** program and transitioned into the **WCM** program, newly **CCS-eligible members**, or new **CCS members** enrolling in CalOptima, including the identification and referral of **Members** with **CCS-eligible C~~c~~onditions**.

~~II. POLICY~~

B. With respect to the **WCM** program, CalOptima and the **Health Networks** shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as the California DHCS guidance, including, but not limited to, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the **Health Networks** shall:

1. Use all current and applicable **CCS** ~~provides~~program guidelines, including **CCS** program regulations, **CCS** program information notices, and **CCS** numbered letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible Condition** in cases in which applicable **CCS** clinical guidelines do not exist.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the County **CCS** program for the coordination of **CCS** services to **Members**.

D. CalOptima shall convene a quarterly meeting between CalOptima and the local **CCS** p~~P~~rogram in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services ~~Program~~/Whole Child Model.

DRAFT

Back to Agenda

E. CalOptima or a **Health Network** shall assume responsibility for the **WCM** program as follows:

1. Authorization and payment of **CCS**-eligible medical services, including authorization activities, claims processing and payment, **Case Management**, and quality oversight and coordination of all Medi-Cal and **CCS**-covered services, as well as **Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)**, for enrolled **Members**.

2. Providing all supporting medical documentation and information needed for **CCS** annual medical eligibility redetermination and other medical determinations.

3. Providing all **Member** information in a Transfer Packet to the County **CCS** p~~P~~rogram to facilitate inter-county transfer in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

4. High Risk Infant Follow-Up (HRIF) program, including determining HRIF program eligibility, coordinating and authorizing HRIF services for **Members** in accordance with CCS N.L. 05-1016: High Risk Infant Follow-Up (HRIF) Program Services, or any superseding CCS N.L., and ensuring the provision of HRIF **Case Management**~~,~~ services in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services ~~Program~~/Whole Child Model.

F. County **CCS** Program WCM responsibilities, include but are not limited to:

1. **CCS** program eligibility determination, including responding to and tracking appeals related to **CCS** program medical eligibility determinations and redeterminations; and

~~1.~~2. Care coordination for Medical Therapy Program (MTP) services, receiving and processing referrals to the MTP (except for review and authorization of durable medical equipment, including custom and specialized durable medical equipment, and related supplies), physical and occupational therapy services provided at the Medical Therapy Units (MTU), medical therapy conference services, and financial assistance to **Members** under the age of twenty-one (21) who are eligible for ~~CCS services~~MTP.

3. Notify CalOptima ~~shall enter into a memorandum~~ of ~~understanding (MOU), or other agreement, with~~ a new **CCS-eligible** inter-county transfer **Member** via a Transfer Packet.

G. DHCS **WCM** responsibilities include but are not limited to:

1. Review and final determination of unresolved disagreements between CalOptima and the ~~local~~County **CCS** program ~~for the coordination of CCS services to Members.~~relative to **CCS** medical eligibility.

~~B.~~ If a **Member** has **Other Health Coverage (OHC),** CalOptima~~,~~ or a **Health Network**~~, or a Practitioner,~~ shall ~~identify Members who may have a CCS-Eligible Condition.~~

~~C.~~ consider the **OHC** plan as the **Member's** primary health plan. CalOptima~~,~~ or a **Health Network**~~, or a Practitioner, shall refer a Member to CCS within twenty-four (24) hours, or the next working day, after determining that~~ shall remain the ~~Member may have a CCS-Eligible Condition.~~

Back to Agenda

DRAFT

D. A Member's Primary Care Practitioner (PCP), Health Network, or Practitioner, shall refer the Member to CCS for Emergency Services that qualify under CCS within twenty-four (24) hours, or the next working day, after determining that the Member needs Emergency Services related to his or her CCS-Eligible Condition.

E. CalOptima or a Health Network is not responsible for the provision or payment of services authorized by CCS for the treatment of a CCS-Eligible Condition, after CCS determines that the Member is eligible for CCS.

a. CCS shall only reimburse CCS-paneled Providers and CCS-approved hospitals, for services authorized by CCS, for the treatment of a CCS-Eligible Condition.

F. CalOptima or a Health Network shall provide the following: secondary health plan

1. Provision and payment of Covered Services related to the identification, evaluation, and diagnosis of a CCS-Eligible Condition;

2. Covered Services unrelated to a Member's CCS-Eligible Condition after CCS determines that the Member is eligible for CCS;

3. Covered Services for a Member who has been referred to CCS, but is awaiting an eligibility determination, or authorization for service. The Covered Services may be related or unrelated to the Member's CCS-Eligible Condition; and

H. Covered Services for a Member if CCS does not approve eligibility,payer of last resort in accordance with Section III.E. of this policy.CalOptima Policy FF.2003: Coordination of Benefits.

G. CalOptima or a Health Network shall designate a case manager to serve as a liaison to CCS to help coordinate services with CCS.

I. CalOptima or a **Health Network** shall proactively collaborate with CCS to coordinate transition services for a Member reaching twenty-one (21**WCM Member** who loses Medi-Cal eligibility to the County **CCS** program for ongoing health care and **Case Management** services.

1. CalOptima or a **Health Network** shall notify the County **CCS** program in writing, within fifteen (15) calendar days, of **CCS**-eligible neonates, infants, and children up to three (3) years of age, from CCS to CalOptima Direct, a Health Network, or the Genetically Handicapped Persons Program (GHPP).that lose Medi-Cal coverage.

H. A Member or a Member's Authorized Representative shall have the right to decline enrollment in CCS after the Member is notified of his or her CCS eligibility.

III. PROCEDURE

A. A **Practitioner** shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential **CCS**-Eligible Conditions**eligible Conditions** in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a **Health Network** shall provide:

Back to Agenda

DRAFT

1. Training and resources to **Primary Care Physician** and other **Primary Care Providers** to ensure timely identification of **Members** with potential **CCS-eligible Conditions** and notification to the ~~-~~County **CCS** program;

2. Provision and payment~~may~~ of **Medically Necessary Covered Services** related to the identification, evaluation, and diagnosis of a **CCS-eligible Condition**;

3. **Medically Necessary Covered Services** whether related or unrelated to a **Member's CCS-eligible Condition**;

4. Authorization and reimbursement of only **CCS**-paneled physicians and **CCS**-approved facilities for the treatment of **CCS-eligible Conditions**, in accordance with **CCS** program requirements and CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

~~1.~~5. CalOptima or a **Health Network** shall identify ~~a Member~~**Members** who may have a **CCS-eligible Condition** through ~~a referral which may be made through,~~various means, including but ~~is~~ not limited to:

~~2. Utilization Management;~~

~~3. Case Management;~~

~~4. PCP;~~

~~5. Specialist;~~

~~6. Pharmacy; and~~

~~7. Disease Management.~~

a. Screening of all requests for service authorizations for Medi-Cal **Members** under the age of twenty-one (21) by a trained team of nurses and medical authorization assistants;

b. Screening of all **Members** referred for **Case Management, Disease Management**, and/-or **Population Health Management** services or who are currently enrolled in a **Case Management**, **Disease Management,** or **Population Health Management** program; and

c. Review of pharmacy data.

~~B.~~C. CalOptima~~, a Health Network, or a Practitioner,~~ shall refer a **Member** to ~~CCS~~the County **CCS** program for initial and annual medical eligibility determination after identifying ~~and determining~~ that the **Member's** medical condition may qualify him or her for **CCS**.

~~C.~~D. ~~CalOptima, a~~A **Health Network**~~, or a Practitioner,~~ shall refer a **Member** ~~to~~for initial and annual **CCS** medical eligibility determination through CalOptima by~~ completing the following steps:~~:

DRAFT

Back to Agenda

~~A. Contacting the Member's PCP and requesting the Member's Medical Records;~~

~~4.~~1. ~~Ensuring the completion of~~Completing a Service Authorization Request (SAR) form~~, identifying which services the Member may be eligible for, and~~ and submitting the ~~SAR to the Orange County CCS office~~request to CalOptima; and

2. Ensuring the submission of all supporting medical documentation and information needed ~~by CCS to~~ to determine **CCS** medical eligibility and to determine the **Medical Necessity** of the services requested.

3. CalOptima shall facilitate the **CCS** medical eligibility determination by the County **CCS** program by submitting the New Referral **CCS** GHPP Client Service Authorization Request (SAR) and supporting medical documentation to the County **CCS** program.

E. CalOptima shall refer a **Member** to the County CCS program within twenty-four (24) hours, or the next working day, after determining that the **Member** may have a **CCS-eligible Condition**, as described in Section III.D. of this policy.

F. CalOptima, a **Health Network**, or a **Practitioner** shall refer all **Members**, including new **Members**, newly **CCS-eligible Members**, and **WCM** transition **Members** who may have developed a new **CCS-Eligible Condition**, immediately to CalOptima for transmittal to the County **CCS** program for **CCS** eligibility determination, as set forth in Section III.D. of this policy, and not wait until the annual **CCS** medical eligibility determination period.

G. The County **CCS** program will provide confirmation or adverse determination of **CCS** medical eligibility to CalOptima in accordance with **CCS** program eligibility requirements.

1. CalOptima shall ensure notification of the **CCS** medical eligibility determination to the requesting **Health Network** within twenty-four (24) hours of receipt of the County **CCS** program~~'s~~ **CCS** medical eligibility determination.

H. Disagreements between CalOptima and the County **CCS** program regarding **CCS** medical eligibility determinations must be resolved by the County **CCS** program, in consultation with DHCS. The local **CCS** program shall communicate all resolved disputes in writing to CalOptima in a timely manner. Disputes between CalOptima and the County **CCS** program that are unable to be resolved will be referred by either entity to DHCS.

I. **Members** appealing a **CCS** eligibility determination must appeal to the County **CCS** program.

J. **Member** Grievances

1. CalOptima shall ensure **Members** are provided information on and are provided the same grievances, appeals and state fair hearing rights as provided under state and federal law and in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

K. Provider Grievances

DRAFT

Back to Agenda

1. CalOptima or a **Health Network** shall address and resolve **CCS** provider complaints, including but not limited to disputes or grievances concerning the processing of a payment or non-payment of a claim by **CalOptima** or **Health Network** in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process ~~the SAR~~to all of its **CCS** providers.

~~D. If a Member is approved for CCS:~~

~~1. A~~ CalOptima or a **Health Network** ~~case manager~~ shall ~~help~~proactively coordinate ~~the Member's CCS services.~~

~~2. A Member's PCP shall request authorization from CCS for CCS authorized~~ services~~.~~

~~E. If a Member is not approved~~ for ~~CCS:~~

~~1. A CalOptima, or Health Network, case manager may resubmit the Member's application, with additional information, for reconsideration. The application for reconsideration shall be reviewed and approved by a CalOptima or Health Network Medical Director prior to submission.~~

~~2. If a Member is denied CCS for a second (2nd) time, CalOptima, or a Health Network, shall provide, and pay for, the Member's Covered Services.~~

~~F. If CCS denies authorization because the Member does not have a CCS Eligible Condition, or the service is not a benefit under CCS, the Member's Practitioner shall submit the authorization request and a copy of the CCS denial letter to CalOptima's Utilization Management (UM) Department, or the Member's Health Network.~~

~~G. CCS shall contact a Member, and his or her family, one hundred eighty (180) calendar days prior to the date the Member reaches twenty-one (21) years of age to inform the Member that his or her enrollment in CCS will automatically terminate on the date the Member reaches twenty-one (21) years of age. CCS shall provide a copy of the notice to CalOptima, or the Member's Health Network, to help transition the Member's services from CCS to CalOptima Direct, a Health Network, or the GHPP.~~

L. ~~CalOptima, or a Member's Health Network, shall contact a Member at least one hundred twenty (120) calendar days prior to the~~a **WCM Member** reaching twenty-one (21) years of age ~~to help transition services from CCS to CalOptima Direct, a Health Network, or GHPP~~, including but not limited to those **Members** eligible for services with the Genetically Handicapped Persons program (GHPP), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services ~~program~~/Whole-Child Model.

M. CalOptima or a **Health Network** shall ensure the development of an **Individual Care Plan (ICP)**, **Case Management**, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services ~~program~~/Whole-Child Model.

N. CalOptima or a **Health Network** shall ensure access to out-of-network providers for eligible **Members** in order to obtain **Medically Necessary** services in accordance with CalOptima Policies

Back to Agenda

DRAFT

GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

O. CalOptima or a **Health Network** shall ensure the provision of the **Maintenance** and **T~~t~~ransportation** benefit for eligible **Members** and a **Member**'s family seeking transportation to a medical service related to the **Member's CCS-eligible Condition** in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

P. CalOptima and its **Health Network** shall provide appropriate preventive, mental health, developmental, and specialty **EPSDT** medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

Q. CalOptima shall ensure oversight of the functions and responsibilities, processes, and performance of a **Health Network**, including compliance with the requirements of the **WCM** program and network adequacy standards in accordance with CalOptima Policies GG.1619: Delegation Oversight and GG.1600: Access and Availability Standards.

IV. ATTACHMENT(S)

A. Application to Determine CCS Program Eligibility
B. New Referral CCS~~/~~ GHPP Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract for Health Care Services
~~A.~~B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. CalOptima Contract for Health Care Services~~
C. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
D. CalOptima Memorandum of Understanding with Orange County Health ~~Network Service Agreement~~Care Agency for Whole Child Model
~~E. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9~~
~~California Welfare and Institutions Code §§14093.06(b) and 14094.15(d)~~
E. CalOptima Policy FF.2003: Coordination of Benefits
F. CalOptima Policy GG.1116: Pediatric Preventive Services
G. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
H. CalOptima Policy GG.1330: Case Management – California Children's Services ~~-~~/Whole-Child Model
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1508: Authorization and Processing of Referrals
K. CalOptima Policy GG.1510: Appeals Process
L. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
M. CalOptima Policy GG.1547: Maintenance and Transportation
N. CalOptima Policy GG.1600: Access and Availability Standards
O. CalOptima Policy GG.1619: Delegation Oversight
P. CalOptima Policy HH.1101: CalOptima Provider Complaint

DRAFT

Back to Agenda

Q. CalOptima Policy HH.1102: Member Grievance
R. CalOptima Policy HH.1108: State Hearing Process and Procedures
S. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services
T. Department of Health Care Services (DHCS) All Plan Letter 18-023: California Children's Services Whole Child Model Program
U. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
V. Welfare and Institutions Code §§14093.06(b) and 14094.15(d)
~~A. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services~~

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/11/19: Department of Health Care Services
B. 11/02/18: Department of Health Care Services
~~A.~~C. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

A. 10/04/18:~~–~~ Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~ #	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	05/01/1999	GG.1101	California Children's Services	Medi-Cal
Revised	05/01/2000	GG.1101	California Children's Services	Medi-Cal
Revised	04/01/2007	GG.1101	California Children's Services	Medi-Cal
Revised	08/01/2009	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2014	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2015	GG.1101	California Children's Services	Medi-Cal
Revised	10/01/2016	GG.1101	California Children's Services	Medi-Cal
Revised	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/04/2018	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Reinstated	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	07/01/2019	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal

DRAFT

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.~~
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services ~~Eligible~~ eligible Conditions	~~Include, but are not limited to: chronic~~Chronic medical conditions ~~such as~~, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae~~.~~ as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~Members~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
~~Children with Special Health Care Needs~~Case Management	~~Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 438.208(c)(2), (c)(3), and (c)(4).~~A systematic approach to coordination of care for a member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for ~~Members~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

DRAFT

Term	Definition
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
~~Emergency Services~~Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	~~Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.~~A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide ~~Covered Services~~covered services to ~~Members~~members assigned to that Health Network.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Maintenance	The cost(s) for lodging (such as motel room, etc.) and food for the member, parent(s), or legal guardian(s) when needed to enable the member to access authorized services for a CCS-Eligible Condition.
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~~program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
~~Medical Record~~	~~Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member~~member~~, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.~~
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

DRAFT

Term	Definition
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a member, for the payment of the reasonable value of all or part of the health care benefits provided to a member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Population Health Management (PHM)	A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing ~~Covered Services.~~covered services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to ~~Members~~members and serves as the medical home for ~~Members~~members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For ~~Members~~members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model program, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic ~~in accordance with W & I Code 14182(b)(11).~~.
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Transportation	For purposes of this Policy, the cost(s) for the use of a private vehicle or public conveyance to provide the member access to authorized services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

DRAFT

1

DRAFT

Policy #:	GG.1101
Title:	**California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a **Health Network** and the County **California Children's Services (CCS)** program.

II. POLICY

A. Effective July 01, 2019, CalOptima shall implement the Department of Health Care Services (DHCS)-approved **Whole-Child Model (WCM)** program. CalOptima shall assume responsibility for **CCS** for **Members** who are eligible for the **California Children's Services (CCS)** program and transitioned into the **WCM** program, newly **CCS-eligible members**, or new **CCS members** enrolling in CalOptima, including the identification and referral of **Members** with **CCS-eligible Conditions**.

B. With respect to the **WCM** program, CalOptima and the **Health Networks** shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as the California DHCS guidance, including, but not limited to, All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the **Health Networks** shall:

1. Use all current and applicable **CCS** program guidelines, including **CCS** program regulations, **CCS** program information notices, and **CCS** numbered letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible Condition** in cases in which applicable **CCS** clinical guidelines do not exist.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the County **CCS** program for the coordination of **CCS** services to **Members**.

D. CalOptima shall convene a quarterly meeting between CalOptima and the local **CCS** program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services/Whole Child Model.

E. CalOptima or a **Health Network** shall assume responsibility for the **WCM** program as follows:

1. Authorization and payment of **CCS**-eligible medical services, including authorization activities, claims processing and payment, **Case Management**, and quality oversight and

DRAFT

Back to Agenda

coordination of all Medi-Cal and **CCS**-covered services, as well as **Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)**, for enrolled **Members**.

2. Providing all supporting medical documentation and information needed for **CCS** annual medical eligibility redetermination and other medical determinations.

3. Providing all **Member** information in a Transfer Packet to the County **CCS** program to facilitate inter-county transfer in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

4. High Risk Infant Follow-Up (HRIF) program, including determining HRIF program eligibility, coordinating and authorizing HRIF services for **Members** in accordance with CCS N.L. 05-1016: High Risk Infant Follow-Up (HRIF) Program Services, or any superseding CCS N.L., and ensuring the provision of HRIF **Case Management** services in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services/Whole Child Model.

F. County **CCS** Program WCM responsibilities, include but are not limited to:

1. **CCS** program eligibility determination, including responding to and tracking appeals related to **CCS** program medical eligibility determinations and redeterminations; and

2. Care coordination for Medical Therapy Program (MTP) services, receiving and processing referrals to the MTP (except for review and authorization of durable medical equipment, including custom and specialized durable medical equipment, and related supplies), physical and occupational therapy services provided at the Medical Therapy Units (MTU), medical therapy conference services, and financial assistance to **Members** under the age of twenty-one (21) who are eligible for MTP.

3. Notify CalOptima of a new **CCS-eligible** inter-county transfer **Member** via a Transfer Packet.

G. DHCS **WCM** responsibilities include but are not limited to:

1. Review and final determination of unresolved disagreements between CalOptima and the County **CCS** program relative to **CCS** medical eligibility.

H. If a **Member** has **Other Health Coverage (OHC)**, CalOptima or a **Health Network** shall consider the **OHC** plan as the **Member's** primary health plan. CalOptima or a **Health Network** shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

I. CalOptima or a **Health Network** shall proactively coordinate transition services for a **WCM Member** who loses Medi-Cal eligibility to the County **CCS** program for ongoing health care and **Case Management** services.

1. CalOptima or a **Health Network** shall notify the County **CCS** program in writing, within fifteen (15) calendar days, of **CCS**-eligible neonates, infants, and children up to three (3) years of age, that lose Medi-Cal coverage.

III. PROCEDURE

DRAFT

A. A **Practitioner** shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential **CCS-eligible Conditions** in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a **Health Network** shall provide:

1. Training and resources to **Primary Care Physician** and other **Primary Care Providers** to ensure timely identification of **Members** with potential **CCS-eligible Conditions** and notification to the County **CCS** program;

2. Provision and payment of **Medically Necessary Covered Services** related to the identification, evaluation, and diagnosis of a **CCS-eligible Condition**;

3. **Medically Necessary Covered Services** whether related or unrelated to a **Member's CCS-eligible Condition**;

4. Authorization and reimbursement of only **CCS**-paneled physicians and **CCS**-approved facilities for the treatment of **CCS-eligible Conditions**, in accordance with **CCS** program requirements and CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

5. CalOptima or a **Health Network** shall identify **Members** who may have a **CCS-eligible Condition** through various means, including but not limited to:

a. Screening of all requests for service authorizations for Medi-Cal **Members** under the age of twenty-one (21) by a trained team of nurses and medical authorization assistants;

b. Screening of all **Members** referred for **Case Management, Disease Management**, and/or **Population Health Management** services or who are currently enrolled in a **Case Management**, **Disease Management,** or **Population Health Management** program; and

c. Review of pharmacy data.

C. CalOptima shall refer a **Member** to the County **CCS** program for initial and annual medical eligibility determination after identifying that the **Member's** medical condition may qualify him or her for **CCS**.

D. A **Health Network** shall refer a **Member** for initial and annual **CCS** medical eligibility determination through CalOptima by:

1. Completing a Service Authorization Request (SAR) form and submitting the request to CalOptima; and

2. Ensuring the submission of all supporting medical documentation and information needed to determine **CCS** medical eligibility and to determine the **Medical Necessity** of the services requested.

3. CalOptima shall facilitate the **CCS** medical eligibility determination by the County **CCS** program by submitting the New Referral **CCS** GHPP Client Service Authorization Request (SAR) and supporting medical documentation to the County **CCS** program.

DRAFT

E. CalOptima shall refer a **Member** to the County CCS program within twenty-four (24) hours, or the next working day, after determining that the **Member** may have a **CCS-eligible Condition**, as described in Section III.D. of this policy.

F. CalOptima, a **Health Network**, or a **Practitioner** shall refer all **Members**, including new **Members**, newly **CCS-eligible Members**, and **WCM** transition **Members** who may have developed a new **CCS-Eligible Condition**, immediately to CalOptima for transmittal to the County **CCS** program for **CCS** eligibility determination, as set forth in Section III.D. of this policy, and not wait until the annual **CCS** medical eligibility determination period.

G. The County **CCS** program will provide confirmation or adverse determination of **CCS** medical eligibility to CalOptima in accordance with **CCS** program eligibility requirements.

1. CalOptima shall ensure notification of the **CCS** medical eligibility determination to the requesting **Health Network** within twenty-four (24) hours of receipt of the County **CCS** program **CCS** medical eligibility determination.

H. Disagreements between CalOptima and the County **CCS** program regarding **CCS** medical eligibility determinations must be resolved by the County **CCS** program, in consultation with DHCS. The local **CCS** program shall communicate all resolved disputes in writing to CalOptima in a timely manner. Disputes between CalOptima and the County **CCS** program that are unable to be resolved will be referred by either entity to DHCS.

I. **Members** appealing a **CCS** eligibility determination must appeal to the County **CCS** program.

J. **Member** Grievances

1. CalOptima shall ensure **Members** are provided information on and are provided the same grievances, appeals and state fair hearing rights as provided under state and federal law and in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

K. Provider Grievances

1. CalOptima or a **Health Network** shall address and resolve **CCS** provider complaints, including but not limited to disputes or grievances concerning the processing of a payment or non-payment of a claim by **CalOptima** or **Health Network** in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process to all of its **CCS** providers.

L. CalOptima or a **Health Network** shall proactively coordinate services for a **WCM Member** reaching twenty-one (21) years of age, including but not limited to those **Members** eligible for services with the Genetically Handicapped Persons program (GHPP), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

M. CalOptima or a **Health Network** shall ensure the development of an **Individual Care Plan (ICP)**, **Case Management**, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model.

DRAFT

N. CalOptima or a **Health Network** shall ensure access to out-of-network providers for eligible **Members** in order to obtain **Medically Necessary** services in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

O. CalOptima or a **Health Network** shall ensure the provision of the **Maintenance** and **Transportation** benefit for eligible **Members** and a **Member**'s family seeking transportation to a medical service related to the **Member's CCS-eligible Condition** in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

P. CalOptima and its **Health Network** shall provide appropriate preventive, mental health, developmental, and specialty **EPSDT** medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

Q. CalOptima shall ensure oversight of the functions and responsibilities, processes, and performance of a **Health Network**, including compliance with the requirements of the **WCM** program and network adequacy standards in accordance with CalOptima Policies GG.1619: Delegation Oversight and GG.1600: Access and Availability Standards.

IV. ATTACHMENT(S)

A. Application to Determine CCS Program Eligibility
B. New Referral CCS GHPP Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
D. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model
E. CalOptima Policy FF.2003: Coordination of Benefits
F. CalOptima Policy GG.1116: Pediatric Preventive Services
G. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
H. CalOptima Policy GG.1330: Case Management – California Children's Services/Whole-Child Model
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1508: Authorization and Processing of Referrals
K. CalOptima Policy GG.1510: Appeals Process
L. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
M. CalOptima Policy GG.1547: Maintenance and Transportation
N. CalOptima Policy GG.1600: Access and Availability Standards
O. CalOptima Policy GG.1619: Delegation Oversight
P. CalOptima Policy HH.1101: CalOptima Provider Complaint
Q. CalOptima Policy HH.1102: Member Grievance
R. CalOptima Policy HH.1108: State Hearing Process and Procedures
S. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services

DRAFT

T. Department of Health Care Services (DHCS) All Plan Letter 18-023: California Children's Services Whole Child Model Program
U. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
V. Welfare and Institutions Code §§14093.06(b) and 14094.15(d)

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/11/19: Department of Health Care Services
B. 11/02/18: Department of Health Care Services
C. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1101	California Children's Services	Medi-Cal
Revised	05/01/2000	GG.1101	California Children's Services	Medi-Cal
Revised	04/01/2007	GG.1101	California Children's Services	Medi-Cal
Revised	08/01/2009	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2014	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2015	GG.1101	California Children's Services	Medi-Cal
Revised	10/01/2016	GG.1101	California Children's Services	Medi-Cal
Revised	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/04/2018	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Reinstated	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	07/01/2019	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal

DRAFT

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 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.
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

DRAFT

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that Health Network.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Maintenance	The cost(s) for lodging (such as motel room, etc.) and food for the member, parent(s), or legal guardian(s) when needed to enable the member to access authorized services for a CCS-Eligible Condition.
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.
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.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a member, for the payment of the reasonable value of all or part of the health care benefits provided to a member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Population Health Management (PHM)	A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic.

DRAFT

Term	Definition
Primary Care Provider (PCP)	A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Transportation	For purposes of this Policy, the cost(s) for the use of a private vehicle or public conveyance to provide the member access to authorized services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

1

DRAFT

INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form **or** whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

Back to Agenda

• Disorders of the skin and subcutaneous tissue (severe hemangioma)
• Medically handicapping malocclusion (severely crooked teeth)
Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

• complete the application form on page 3 and return it to their county CCS office;
• give CCS all of the information requested so CCS can determine if the family qualifies;
• apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

• CCS must keep this information confidential.[2]

• CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes
1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

Back to Agenda

APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. Please type or print clearly.

A. Applicant Information

1. Name of Applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by

2. Date of birth (month, day, year)	3. Place of birth - county and state	Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

5. Gender	6. Race/Ethnicity	7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Primary Care Physician	10. Physician's phone number

B. Parent/Legal Guardian/Family Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name

13. Residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

14. Mailing address (if different from 13)	City	County	Zip Code

15. Home phone number	16. Cell phone number	17. Work phone number	18. What language do you speak at home?
( )	( )	( )	

19. Email address	20. Number of persons in family unit

21. Other Parent Name and Address if not living with the applicant

C. Health Insurance Information

22. Does the applicant have Medi-Cal? ☐ Yes ☐ No	23. If yes, what is the applicants Medi-Cal number?	24. Is there a share-of-cost? ☐ Yes ☐ No	25. If yes, what is the amount you pay per month? $

26a. Does the applicant have other health insurance? ☐ Yes ☐ No	26b. If yes, what is the name of the insurance plan or company?	26c. Policy or Plan Number

27. Type of insurance plan or company
☐ Preferred Provider Organization (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other: _____

28. Does the applicant have dental insurance? ☐ Yes ☐ No	29. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

_____I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of applicant by the CCS program.

_____I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

_____I certify that I have read and understand the information or have had it read to me.

_____I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date

Signature of witness (only if the person signed with a mark)	Date

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office. Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next Box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.

2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.

3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.

4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. Box.

5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).

6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.

8. **Suspected CCS condition or disability:** Write the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.

9. **Name of applicant's primary care physician:** Write the name of the applicant's physician.

10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).

12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.

13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. Box.

14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.

15. **Home phone number:** Please write the home phone number where you can be reached.

16. **Cell phone number:** Please write the cell phone number where you can be reached.

17. **Work phone number:** Please write the work phone number where you can be reached.

18. **Language(s) spoken:** Write the language you speak **at home**.

19. **Email address**: Write the email address for the parent or legal guardian.

20. **Number of persons in family unit:** Write the number of persons living in the same household.

21. **Other Parent Name and Address if not living with the applicant:** Write the name and address for a second contact person.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

22. If the applicant does not receive Medi-Cal, check "No" and go to number 26a. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number.

23. If you the applicant has Medi-Cal, enter the 14 digit Medi-Cal number.

24. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes".

25. If you pay a portion of the chare of cost, fill in the monthly amount paid.

26a. If the applicant does not have other health insurance, check "No" and go to number 28.

26b. If the applicant has health insurance, fill in the name of the insurance plan or company.

26c. If the applicant has health insurance, fill in the policy or plan number.

27. If the applicant has health insurance, check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.

28. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."

29. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

Back to Agenda

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)	City	State ZIP code
5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last	first	middle
9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)
12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address
18. Residence address (number, street) *(DO NOT USE P.O. BOX)*	City	State ZIP code
19. Mailing address (if different) (number, street, P.O. box number)	City	State ZIP code
20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
27. Enrolled in commercial insurance plan ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

28.
Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10: _____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached ☐ Yes	36. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days

Additional Services Requested from Other Health Care Provider

40. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address (number, street)	City	State	ZIP code

Description of services	Procedure code	Units	Quantity
Addi ional information			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.

27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would l ke the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.

Policy #: GG.1318
Title: **Coordination of Care for Hemophilia Members**
Department: Medical Affairs
Section: Case Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/2006
~~Last Review Date:~~ ~~04/01/18~~
~~Last~~ Revised Date: ~~04/01/18~~10/03/2019

DRAFT_20191003BOD_Concurrent DHCS Review

I. PURPOSE

This policy defines the case management guidelines for coordination of care by CalOptima and its Health Networks for Members diagnosed with Hemophilia.

II. POLICY

A. This policy shall apply to Medi-Cal Members age twenty-one (21) and over, until implementation of the Whole-Child Model program, at which time it shall apply to Medi-Cal Members of any age.

~~A.~~B. CalOptima is responsible for providing case management to a CalOptima Direct ~~Direct~~ Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia, in accordance with the provisions of this policy.

~~B.~~C. If a Health Network Member, except a Kaiser Member, ~~is at least twenty-one (21) years of age and is at least twenty-one (21) years of age and~~ is diagnosed with Hemophilia, CalOptima shall transition such Member to CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

~~C.~~D. A CalOptima Direct ~~Direct~~ Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia shall receive care from a Federal Hemophilia Treatment Center, in accordance with the provisions of this policy.

E. A CalOptima Direct ~~Direct~~ Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia shall receive Hemophilia factor from a Pharmacy that is registered as a covered entity in the 340B Drug Pricing Program.

~~The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services approved Whole Child Model program.~~
~~D.~~

III. PROCEDURE

A. A Provider is responsible for diagnosing a Member with Hemophilia.

B. Upon receipt of notice of a Member who is ~~at least twenty-one (21) years of age and at least twenty-one (21) years of age and~~ diagnosed with Hemophilia, a Health Network (except Kaiser Health Foundation) shall:

Back to Agenda

1. Notify CalOptima's Case Management Department via secure email within five (5) business days after identification of such Member; and

2. Provide Case Management to the Member until the Member is effectively transitioned to CalOptima Direct.

C. Upon receipt of a written notice from a Health Network as set forth in Section III.B of this policy:

1. CalOptima's Case Management Department shall open a case for oversight until the Member transitions to CalOptima Direct;

2. CalOptima's Case Manager shall submit a Change of Network Request (CONR) to CalOptima's Medi-Cal Enrollment and Reconciliation Department inbox to request Health Network assignment to CalOptima Direct (COD);

3. CalOptima's Medi-Cal Enrollment and Reconciliation Department shall transition the Member to CalOptima Direct as set forth in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct; and

4. CalOptima shall notify the Member of the transition to CalOptima Direct within five (5) business days after receipt of notice from the Health Network.

D. CalOptima shall provide case management and care coordination to a Member who is not a Kaiser Member and is ~~at least twenty-one (21) years of age and~~ ~~at least twenty-one (21) years of age and~~ diagnosed with Hemophilia as follows:

1. CalOptima's Case Management Department shall contact the Member by telephone within (10) business days after transition to CalOptima Direct to identify any questions or concerns that the Member may have.

2. CalOptima's Case Management Department shall verify that the Member is connected to the Center for Comprehensive Care and Diagnosis of Inherited Blood Disorders, the Orange County Federal Hemophilia Treatment Center.

3. A CalOptima case manager shall:

a. Follow the Member's progress during any hospital admission and coordinate with the facility case manager to ensure that all discharge needs are met;

b. Provide ongoing communication with the Member after discharge from any hospital admission, as the severity and complexity of the case requires, to identify any issues and to assist in coordinating follow-up care;

c. Continue to coordinate with the Federal Hemophilia Treatment Center and provide authorizations as needed for follow-up care; and

d. Close the case according to case closure criteria.

IV. ATTACHMENT(S)

Not Applicable

DRAFT_20191003BOD_Concurrent DHCS Review

Back to Agenda

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/29/16: Department of Health Care Services
B. 04/14/14: Department of Health Care Services
C. 03/10/14: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/2006	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2014	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2016	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	03/01/2017	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	04/01/2018	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	10/03/2019	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal

DRAFT_20191003BOD_Concurrent DHCS Review

Back to Agenda

IX. GLOSSARY

Term	Definition
340B Drug Pricing Program	Program established pursuant to section 340B of the Public Health Service Act, which limits the cost of covered outpatient drugs to covered entities as defined by 340B(a)(4) of the Public Health Service Act.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Care Management and Coordination	A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.
Contract	The written instrument between CalOptima and physicians, hospitals, health maintenance organizations (HMOs), or other entities. Contract shall include any Memorandum of Understanding entered into by CalOptima that are binding on the Health Network in which a physician participates, the Department of Health Care Services (DHCS) Medi-Cal Managed Care Policy Division Policy Letters, Contract Interpretations, and Financial Bulletins issued pursuant to the Contract.
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.
Federal Hemophilia Treatment Center	A provider that is part of a regional network of comprehensive hemophilia diagnostic treatment centers established and contracted through the Special Projects of Regional and National Significance (SPRANS) under 42 U.S.C., Section 701(a)(2).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Hemophilia	Hemophilia A, B, C, or Von Willebrand disease. Hemophilia does not include any other acquired factor deficiencies including, but not limited to, defibrination syndrome, acquired coagulation factor deficiency, and hemorrhagic disorder due to intrinsic circulating anticoagulants.
Kaiser Member	A Member who is enrolled in, or receives all Covered Services, from Kaiser Health Foundation, Incorporated.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration, who is enrolled in a CalOptima program.

DRAFT_20191003_PCC_Required DHCS Review

Back to Agenda

Policy #:	GG.1318
Title:	**Coordination of Care for Hemophilia Members**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2006
Revised Date:	10/03/2019

DRAFT_20191003BOD_Concurrent DHCS Review

I. PURPOSE

This policy defines the case management guidelines for coordination of care by CalOptima and its Health Networks for Members diagnosed with Hemophilia.

II. POLICY

A. This policy shall apply to Medi-Cal Members age twenty-one (21) and over, until implementation of the Whole-Child Model program, at which time it shall apply to Medi-Cal Members of any age.

B. CalOptima is responsible for providing case management to a CalOptima Direct Member who is diagnosed with Hemophilia, in accordance with the provisions of this policy.

C. If a Health Network Member, except a Kaiser Member, is diagnosed with Hemophilia, CalOptima shall transition such Member to CalOptima Direct, in accordance with CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.

D. A CalOptima Direct Member who is diagnosed with Hemophilia shall receive care from a Federal Hemophilia Treatment Center, in accordance with the provisions of this policy.

E. A CalOptima Direct Member who is diagnosed with Hemophilia shall receive Hemophilia factor from a Pharmacy that is registered as a covered entity in the 340B Drug Pricing Program.

III. PROCEDURE

A. A Provider is responsible for diagnosing a Member with Hemophilia.

B. Upon receipt of notice of a Member who is diagnosed with Hemophilia, a Health Network (except Kaiser Health Foundation) shall:

1. Notify CalOptima's Case Management Department via secure email within five (5) business days after identification of such Member; and

2. Provide Case Management to the Member until the Member is effectively transitioned to CalOptima Direct.

C. Upon receipt of a written notice from a Health Network as set forth in Section III.B of this policy:

1. CalOptima's Case Management Department shall open a case for oversight until the Member transitions to CalOptima Direct;

Back to Agenda

2. CalOptima's Case Manager shall submit a Change of Network Request (CONR) to CalOptima's Medi-Cal Enrollment and Reconciliation Department inbox to request Health Network assignment to CalOptima Direct (COD);

3. CalOptima's Medi-Cal Enrollment and Reconciliation Department shall transition the Member to CalOptima Direct as set forth in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct; and

4. CalOptima shall notify the Member of the transition to CalOptima Direct within five (5) business days after receipt of notice from the Health Network.

D. CalOptima shall provide case management and care coordination to a Member who is not a Kaiser Member and is diagnosed with Hemophilia as follows:

1. CalOptima's Case Management Department shall contact the Member by telephone within (10) business days after transition to CalOptima Direct to identify any questions or concerns that the Member may have.

2. CalOptima's Case Management Department shall verify that the Member is connected to the Center for Comprehensive Care and Diagnosis of Inherited Blood Disorders, the Orange County Federal Hemophilia Treatment Center.

3. A CalOptima case manager shall:

a. Follow the Member's progress during any hospital admission and coordinate with the facility case manager to ensure that all discharge needs are met;

b. Provide ongoing communication with the Member after discharge from any hospital admission, as the severity and complexity of the case requires, to identify any issues and to assist in coordinating follow-up care;

c. Continue to coordinate with the Federal Hemophilia Treatment Center and provide authorizations as needed for follow-up care; and

d. Close the case according to case closure criteria.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct

VI. REGULATORY AGENCY APPROVAL(S)

A. 03/29/16: Department of Health Care Services
B. 04/14/14: Department of Health Care Services
C. 03/10/14: Department of Health Care Services

DRAFT_20191003_DD_Concurrent DHCS Review

Back to Agenda

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2014	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	01/01/2016	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	03/01/2017	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	04/01/2018	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal
Revised	10/03/2019	GG.1318	Coordination of Care for Hemophilia Members	Medi-Cal

DRAFT_20191003BOD_Contained DHCS Review

Back to Agenda

IX. GLOSSARY

Term	Definition
340B Drug Pricing Program	Program established pursuant to section 340B of the Public Health Service Act, which limits the cost of covered outpatient drugs to covered entities as defined by 340B(a)(4) of the Public Health Service Act.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Care Management and Coordination	A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.
Contract	The written instrument between CalOptima and physicians, hospitals, health maintenance organizations (HMOs), or other entities. Contract shall include any Memorandum of Understanding entered into by CalOptima that are binding on the Health Network in which a physician participates, the Department of Health Care Services (DHCS) Medi-Cal Managed Care Policy Division Policy Letters, Contract Interpretations, and Financial Bulletins issued pursuant to the Contract.
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.
Federal Hemophilia Treatment Center	A provider that is part of a regional network of comprehensive hemophilia diagnostic treatment centers established and contracted through the Special Projects of Regional and National Significance (SPRANS) under 42 U.S.C., Section 701(a)(2).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Hemophilia	Hemophilia A, B, C, or Von Willebrand disease. Hemophilia does not include any other acquired factor deficiencies including, but not limited to, defibrination syndrome, acquired coagulation factor deficiency, and hemorrhagic disorder due to intrinsic circulating anticoagulants.
Kaiser Member	A Member who is enrolled in, or receives all Covered Services, from Kaiser Health Foundation, Incorporated.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration, who is enrolled in a CalOptima program.

DRAFT_20191003_POLICY_Current DHCS Review

Back to Agenda

Policy #:	GG.1539
Title:	**Authorization for Out-of-Network and Out-of-Area Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/2015
~~Last Review Date:~~	~~08/01/18~~
~~Last~~ Revised Date:	~~08/01/18~~10/03/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes ~~CalOptima's~~ requirements and process for authorization of **Out-of-Network** and **Out-of-Area Covered Services**~~.~~ for **Members** assigned to **CalOptima Direct** or a **Health Network**.

II. POLICY

A. If CalOptima delegates Utilization Management ~~(UM)~~ activities to a **Health Network**, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the **Health Network** shall be responsible~~, subject to CalOptima's approval,~~ for authorization determinations for **Member** referrals for **Covered Services**:

1. **Out-of-Network**~~;~~ for Medi-Cal, OneCare Connect, and~~-~~/or OneCare, as applicable; and

2. **Out-of-Area**, as directed by the **Health Network**~~.~~ ~~–~~, for Medi-Cal, OneCare Connect, and/or One Care, as applicable.

B. CalOptima or a **Health Network** may authorize **Out-of-Network** and **Out-of-Area Covered Services**, as applicable, if a **Member**, due to his or her medical condition, requires:

1. **Covered Services** from a **Non-Contracted Provider**;

2. Specialty care that is not available within the network; and/or

~~2.~~3. Tertiary ~~Facility~~facility specialty care that is not available within the network~~;~~.

~~3. Specialty care that is not available within the network;~~

~~4. Continuity of Care~~ CalOptima or a **Health Network** shall process requests for ~~special medical needs, such as End-Stage Renal Disease (ESRD), while traveling;~~

~~5. Urgent Care Service, while traveling; and~~

~~6. Emergency Services from a Non-Contracted Provider.~~

~~C. CalOptima may deny any request for post-service authorization of~~ **Covered Services** ~~provided to a Member Out-of-Network, or Out-of-Area, based on lack of documentation of Medical Necessity, or failure to meet criteria outlined in Section II.B. of this policy.~~

DRAFT

Back to Agenda

D. A Member shall notify his or her Primary Care Physician (PCP) within seventy-two (72) hours after accessing Out-of-Network, or Out-of-Area, Emergency Services.

E.A. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member** transitioning from traditional Fee-For-Service (FFS), another Managed Care Plan, or California Children's Services (CCS) program into the Whole Child Model (WCM) program, with his or her out-of-network nursing facility, Primary Care Physician (PCP), or Specialty Care Provider, in accordance with CalOptima Policies GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima, MA.6021a: Continuity of Care for New Members, and CMC.6021a: Continuity of Care for New Members.

III. PROCEDURE

F.C. When requesting an authorization, a Provider or Practitioner, including Specialty Practitioners, shall adhere to the responsibilities outlined in CalOptima Policy GG.1113: Specialty Practitioner Responsibilities.1508: Authorization and Processing of Referrals.

G.D. CalOptima's Utilization Management DepartmentCalOptima or a **Health Network** shall review all requests and notices for Out-of-Area **Covered Services** for a **Member** utilizing criteria described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

E. CalOptima or a **Health Network** shall process requestsensure that **Members** eligible with the Whole-Child Model (WCM) program are provided accurate information on how to request and seek approval for **Out-of-Network Covered Services**, in accordance with CalOptima Policy.

H.F. **Covered Services** not subject to prior authorization are set forth in CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

G. CalOptima or a **Health Network** shall review any request for post-service authorization of **Covered Services** provided to a **Member** when submitted 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.

H. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member** transitioning from traditional Fee-For-Service (FFS), another Medi-Cal Managed Care Plan, or **California Children's Services (CCS)** program into the **WCM** program, in accordance with CalOptima Policies GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima Services, MA.6021a: Continuity of Care for New Members, and CMC.6021a: Continuity of Care for New Members, and GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program.

III. PROCEDURE services that do not require a Prior Authorization,

A. For **Covered Services**, network **Providers**, including **Specialty Care Practitioners**, shall refer the **Member** to a another network **Provider** (contracted **Provider**,), unless such a **Provider** of the required type is unavailable in-network. Referrals to an outOrange County **Out-of-**networkNetwork **Provider** shall be processed in accordance with Section III.C of this

DRAFT

Back to Agenda

Policy.policy. Referrals to an **Out-of-Area Provider** shall be processed in accordance with Section III.B of this policy.

1. For **Sensitive Services**, **Members** may access any **Provider**, including those who are outOut-of-networkNetwork, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

B. Authorization for **Out-of-**Network services**Area Covered Services**:

1. For OneCare Connect and Medi-Cal only, upon determination that a **Member** requires **Out-of-Area Covered Services** Out-of-Area, the referring **Practitioner** shall request authorization from the Member's **Health Network**.
, or CalOptima
1. For OneCare, a Member's Health Network shall notify the CalOptima Utilization Management Department within one (1) working day after identifying the Member's need for Out-of-Network Covered Services.

a. A Member's Health Network shall notify the **CalOptima** Utilization Management Department within twenty-four (24) hours after the Health Network receives notice of a OneCare Member's admission to an Out-of-Network acute care facility.

B. **Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for Out-of-Area Covered Services;
CalOptima Direct
1. For OneCare Connect and Medi-Cal only, upon determination that a Member requires Covered Services Out-of-Area, the referring Practitioner shall request authorization from the Member's Health NetworkCalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

a. Upon notice of a **Member's** acute admission to an Out-of-Area facility, the Member's **Health Network,** or CalOptima's case management nurse for **CalOptima Direct Members**, shall conduct concurrent review by telephone until the **Member** is discharged.

b. Prior to a **Member's** discharge from an **Out-of-Area** facility, the Member's **Health Network**, or CalOptima Utilization Management Department for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

2. For OneCare, upon determination that a **Member** requires **Out-of-Area Covered Services** Out-of-Area, the referring **Practitioner** shall request authorization from CalOptima's Utilization Management (UM) Department, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

Back to Agenda

a. If a Member's **Health Network** receives notification of a **Member's** admission to an **Out-of-Area** facility for **Covered Services**, the **Health Network** shall notify the CalOptima Utilization Management Department within twenty-four (24) hours.

b. Upon notice of a Member's acute admission to an **Out-of-Area** facility, a CalOptima case management nurse shall conduct concurrent review ~~by telephone~~ until the **Member** is discharged in accordance with CalOptima Policy GG.1501: Inpatient Length of Stay Assignment~~.~~.

c. Prior to a Member's discharge from an **Out-of-Area** facility, the CalOptima Utilization Management ~~(UM)~~ Department and the Member's **Health Network** shall ~~be responsible for ensuring~~coordinate the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

C. Authorization for **Out-of-Network Covered Services**

1. For Medi-Cal, One Care, and OneCare Connect, upon determination that a **Member** requires **Covered Services Out-of-Network**, the referring **Practitioner** shall request authorization from the **Member's Health Network**, or CalOptima for **CalOptima Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508: Authorization and Processing of Referrals, and GG.1501: Inpatient Length of Stay Assignment.

a. Upon notice of a **Member's** acute admission to an **Out-of-Network** facility, the **Member's Health Network**, or CalOptima for **CalOptima Direct Members**, shall conduct concurrent review until the **Member** is discharged.

b. Prior to a **Member's** discharge from an **Out-of-Network** facility, the Member's **Health Network** or CalOptima, for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's Covered Services** throughout the post-discharge and transition to community-based care period, by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

2. Whole-Child Model Program

a. For the **WCM** program, **CCS-eligible Members** and **CCS**-paneled **Providers** shall follow CalOptima or **Health Network's** authorization policies and procedure to obtain appropriate approvals prior to accessing an **Out-of-Network CCS Provider**;

b. CalOptima or a **Health Network** shall allow **CCS**-eligible **Members** access to **Out-of-Network CCS Providers** in order to obtain **Medically Necessary Covered Services** related to the **Members' CCS-eligible Condition**, if:

DRAFT

Back to Agenda

i. CalOptima or a **Health Network** has no specialist that treats the **CCS-Eligible Condition** within the network;

ii. In-network **Providers** are unable to meet timely access standards, as described in CalOptima Policy GG.1600: Access and Availability Standards; or

iii. **WCM Continuity of Care** requirements are applicable to the **WCM Member** at the time the service is provided, as outlined in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

c. CalOptima or a **Health Network** cannot deny **Out-of-Network Covered Services** based upon cost or location.

d. CalOptima or a **Health Network** shall ensure transportation is provided for **CCS**-eligible **Members** obtaining **Out-of-Network Covered Services** in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy CMC.6021a: Continuity of Care for New Members
H. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program
~~H.~~I. CalOptima Policy GG.1113 Specialty Practitioner Responsibilities
~~I.~~J. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
~~J.~~K. CalOptima Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima
L. CalOptima Policy GG.1500 Authorization and Processing of Referrals
M. CalOptima Policy GG.1501: Inpatient Length of Stay Assignment
~~K.~~N. CalOptima Policy GG.1505: Transportation Emergency, Non-Emergency, and Non-Medical
~~L.~~O. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~M.~~P. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
~~N.~~Q. CalOptima Policy GG.1541: Utilization Management Delegation
R. CalOptima Policy GG.1547: Maintenance and Transportation
S. CalOptima Policy GG.1600: Access and Availability Standards
~~O.~~T. CalOptima Policy MA.1001: Glossary of Terms

Back to Agenda

~~P.~~U. CalOptima Policy MA.6021a: Continuity of Care for New Members
V. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	10/01/2005	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	09/01/2008	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	11/01/2015	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	06/01/2017	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect

DRAFT

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS program to treat a CCS-Eligible Condition.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing Provider relationship.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).

Term	Definition
Emergency Service	Those covered inpatient and outpatient services required that are 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), a ~~hysician~~ physician under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide ~~Covered Services~~covered services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Out-of-Area	Covered ~~services~~Services provided outside the County of Orange by an appropriate~~,~~ Qualified Health Care Professional.
Out-of-Network	Covered ~~services~~Services provided by a non-contracted~~,~~ and appropriate~~,~~ Qualified Health Care Professional ~~qualified health care professional~~.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

DRAFT

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).
Provider	For purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or entity that furnished Covered Services and is licensed or certified to do so.
Qualified Health Care Professional	A Primary Care Physician (PCP), specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, or condition.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Provider or Specialty Care Practitioner	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

DRAFT

Policy #:	GG.1539
Title:	**Authorization for Out-of-Network and Out-of-Area Services**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	11/01/2015
Revised Date:	10/03/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes requirements and process for authorization of **Out-of-Network** and **Out-of-Area Covered Services** for **Members** assigned to **CalOptima Direct** or a **Health Network**.

II. POLICY

A. If CalOptima delegates Utilization Management activities to a **Health Network**, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the **Health Network** shall be responsible for authorization determinations for **Member** referrals for **Covered Services**:

1. **Out-of-Network** for Medi-Cal, OneCare Connect, and/or OneCare, as applicable; and

2. **Out-of-Area**, as directed by the **Health Network**, for Medi-Cal, OneCare Connect, and/or One Care, as applicable.

B. CalOptima or a **Health Network** may authorize **Out-of-Network** and **Out-of-Area Covered Services**, as applicable, if a **Member**, due to his or her medical condition, requires:

1. **Covered Services** from a **Non-Contracted Provider**;

2. Specialty care that is not available within the network; and/or

3. Tertiary facility specialty care that is not available within the network.

C. CalOptima or a **Health Network** shall process requests for **Covered Services** in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

D. CalOptima or a **Health Network** shall review all requests and notices for **Covered Services** for a **Member** utilizing criteria described in CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines.

E. CalOptima or a **Health Network** shall ensure that **Members** eligible with the Whole-Child Model (WCM) program are provided accurate information on how to request and seek approval for **Out-of-Network Covered Services**.

DRAFT

Back to Agenda

F. **Covered Services** not subject to prior authorization are set forth in CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

G. CalOptima or a **Health Network** shall review any request for post-service authorization of **Covered Services** provided to a **Member** when submitted 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.

H. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member** transitioning from traditional Fee-For-Service (FFS), another Medi-Cal Managed Care Plan, or **California Children's Services (CCS)** program into the **WCM** program, in accordance with CalOptima Policies GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima Services, MA.6021a: Continuity of Care for New Members, and CMC.6021a: Continuity of Care for New Members, and GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program.

III. PROCEDURE

A. For **Covered Services**, network **Providers**, including **Specialty Care Practitioners**, shall refer the **Member** to another network **Provider** (contracted **Provider**), unless a **Provider** of the required type is unavailable in-network. Referrals to an Orange County **Out-of-Network Provider** shall be processed in accordance with Section III.C of this policy. Referrals to an **Out-of-Area Provider** shall be processed in accordance with Section III.B of this policy.

1. For **Sensitive Services**, **Members** may access any **Provider**, including those who are **Out-of-Network**, as outlined in CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.

B. Authorization for **Out-of-Area Covered Services**:

1. For OneCare Connect and Medi-Cal only, upon determination that a **Member** requires **Out-of-Area Covered Services**, the referring **Practitioner** shall request authorization from the Member's **Health Network**, or CalOptima for **CalOptima Direct Members,** 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.

a. Upon notice of a **Member's** acute admission to an Out-of-Area facility, the Member's**Health Network,** or CalOptima's case management nurse for **CalOptima Direct Members**, shall conduct concurrent review until the **Member** is discharged.

b. Prior to a **Member's** discharge from an **Out-of-Area** facility, the Member's **Health Network**, or CalOptima Utilization Management Department for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

Back to Agenda

2. For OneCare, upon determination that a **Member** requires **Out-of-Area Covered Services**, the referring **Practitioner** shall request authorization from CalOptima's Utilization Management Department in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

    a. If a Member's **Health Network** receives notification of a **Member's** admission to an **Out-of-Area** facility for **Covered Services**, the **Health Network** shall notify the CalOptima Utilization Management Department within twenty-four (24) hours.

    b. Upon notice of a Member's acute admission to an **Out-of-Area** facility, a CalOptima case management nurse shall conduct concurrent review until the **Member** is discharged in accordance with CalOptima Policy GG.1501: Inpatient Length of Stay Assignment.

    c. Prior to a Member's discharge from an **Out-of-Area** facility, the CalOptima Utilization Management Department and the Member's **Health Network** shall coordinate the provision of a **Member's** medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

        i. Performing appropriate discharge planning; and

        ii. Coordinating post-hospitalization services, as needed.

C. Authorization for **Out-of-Network Covered Services**

1. For Medi-Cal, One Care, and OneCare Connect, upon determination that a **Member** requires **Covered Services Out-of-Network**, the referring **Practitioner** shall request authorization from the **Member's Health Network**, or CalOptima for **CalOptima Direct Members,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508: Authorization and Processing of Referrals, and GG.1501: Inpatient Length of Stay Assignment.

    a. Upon notice of a **Member's** acute admission to an **Out-of-Network** facility, the **Member's Health Network**, or CalOptima for **CalOptima Direct Members**, shall conduct concurrent review until the **Member** is discharged.

    b. Prior to a **Member's** discharge from an **Out-of-Network** facility, the Member's **Health Network** or CalOptima, for **CalOptima Direct Members**, shall be responsible for ensuring the provision of a **Member's Covered Services** throughout the post-discharge and transition to community-based care period, by:

        i. Performing appropriate discharge planning; and

        ii. Coordinating post-hospitalization services, as needed.

2. Whole-Child Model Program

    a. For the **WCM** program, **CCS-eligible Members** and **CCS**-paneled **Providers** shall follow CalOptima or **Health Network's** authorization policies and procedure to obtain appropriate approvals prior to accessing an **Out-of-Network CCS Provider**;

DRAFT

Back to Agenda

b. CalOptima or a **Health Network** shall allow **CCS**-eligible **Members** access to **Out-of-Network CCS Providers** in order to obtain **Medically Necessary Covered Services** related to the **Members' CCS-eligible Condition**, if:

i. CalOptima or a **Health Network** has no specialist that treats the **CCS-Eligible Condition** within the network;

ii. In-network **Providers** are unable to meet timely access standards, as described in CalOptima Policy GG.1600: Access and Availability Standards; or

iii. **WCM Continuity of Care** requirements are applicable to the **WCM Member** at the time the service is provided, as outlined in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

c. CalOptima or a **Health Network** cannot deny **Out-of-Network Covered Services** based upon cost or location.

d. CalOptima or a **Health Network** shall ensure transportation is provided for **CCS**-eligible **Members** obtaining **Out-of-Network Covered Services** in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy CMC.6021a: Continuity of Care for New Members
H. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program
I. CalOptima Policy GG.1113 Specialty Practitioner Responsibilities
J. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network
K. CalOptima Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima
L. CalOptima Policy GG.1500 Authorization and Processing of Referrals
M. CalOptima Policy GG.1501: Inpatient Length of Stay Assignment
N. CalOptima Policy GG.1505: Transportation Emergency, Non-Emergency, and Non-Medical
O. CalOptima Policy GG.1508: Authorization and Processing of Referrals
P. CalOptima Policy GG.1535: Utilization Review Criteria and Guidelines
Q. CalOptima Policy GG.1541: Utilization Management Delegation
R. CalOptima Policy GG.1547: Maintenance and Transportation
S. CalOptima Policy GG.1600: Access and Availability Standards
T. CalOptima Policy MA.1001: Glossary of Terms

Back to Agenda

U. CalOptima Policy MA.6021a: Continuity of Care for New Members
V. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	09/01/2008	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	11/01/2015	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6004	Authorization for Out-of-Area Services	OneCare
Revised	06/01/2017	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect

DRAFT

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical provider that is paneled by the CCS program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS program to treat a CCS-Eligible Condition.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing Provider relationship.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).
Emergency Service	Those covered inpatient and outpatient services required that are 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), a physician 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.
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	An enrollee-beneficiary of a CalOptima program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Out-of-Area	Covered Services provided outside the County of Orange by an appropriate Qualified Health Care Professional.
Out-of-Network	Covered Services provided by a non-contracted and appropriate Qualified Health Care Professional.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182(b)(11).

DRAFT

Term	Definition
Provider	For purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or entity that furnished Covered Services and is licensed or certified to do so.
Qualified Health Care Professional	A Primary Care Physician (PCP), specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, or condition.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Provider or Specialty Care Practitioner	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

1

DRAFT

CalOptima
A Public Agency
Better. Together.

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

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE Fax to (714) 246-8579 ☐ RETRO Fax to (714) 246-8579

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

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

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

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

Client Index # (CIN): _____ Name of ICF/SNF (if applicable): _____

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____	Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____
Address: Phone: _____ Fax:	Address: Phone: _____ Fax:
Office Contact: _____ Physician's Signature: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to (714) 338-3137. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.***

☐ Inpatient Facility ☐Outpatient Facility ☐ SNF Estimated Length of Stay: _____

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

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE — FOR CalOptima USE ONLY

STATUS		Authorization Number #:	
☐ Approved	☐ Alternative Treatment	Signature:	Date:
☐ Not a Covered Benefit	☐ Modified	Comments:	
☐ Not Medically Indicated	Affiliated Health Plan:	Phone:	

Revised 6/12/14

Back to Agenda

Policy ~~#:~~:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/2005
Revised Date:	~~04/01/2019~~10/03/2019
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a **Health Network*** in accordance with applicable statutory~~-~~, and regulatory ~~guidelines~~requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for **Covered Services*** rendered to a **Member** in accordance with the standard allowances set by CalOptima ~~fee schedules~~Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted **Provider**.

B. A **Provider** shall submit a claim for **Covered Services** rendered on, or after, January 1, 2010 as follows:

1. A **Non-Contracted Provider** shall submit a claim for **Covered Services** rendered to a **Member** within one (1) calendar year after the date of service.

2. A contracted **Provider** shall submit a claim for **Covered Services** rendered to a **Member** within the time frame specified in the contracted **Provider** agreement. If the contracted Provider agreement does not specify a time frame, the contracted **Provider** shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a **Health Network** shall make timely and reasonable payment for the following **Covered Services** provided to a **Member** by a **Non-Contracted Provider**:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the **Member's** health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. **Emergency Services** - Emergency medical services *do not* require **Prior Authorization**. If ~~no~~it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of ~~ER admission~~an inpatient admission from the ER ~~is~~ on file for the room and board charges, ~~the examiner~~CalOptima or a **Health Network** must~~-~~ pay the emergency triage fee and request **Medical Records**;

3. Urgently needed services;

DRAFT

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

Back to Agenda

4. ~~Post~~Authorized post-stabilization care services;

5. Renal dialysis services when the **Member** is temporarily out-of-area and cannot reasonably access a contracted **Provider** for such **Covered Services**;

6. Denied **Covered Services** ~~denied which~~that are ~~found~~determined in the **Appeal** processes ~~as described~~ in CalOptima ~~Policies CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, CMC.9005: Payment Appeal, MA.9003: Standard Appeal, MA.9004: Expedited Appeal, and MA.9005: Payment Appeal,~~policies to be services the **Member** was entitled to have furnished, or paid for, by CalOptima or a **Health Network**; and

~~7. Specialty care provided outside of the network, but at in-network cost-sharing, in order to satisfy all Medicare Part A and Part B benefits. That is, if a **Member** requires a very specialized **Covered Service** that is not provided by the physicians in the network,~~ CalOptima or a Health Network shall ~~arrange for that service to be provided by a qualified **Non-Contracted**~~provide Medically Necessary, Covered Services to a Member through an out-of-network Provider~~.~~

~~D.~~ when CalOptima ~~may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims.~~ or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima ~~may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.~~

7. Policy EE.1141Δ: CalOptima Provider Contracts.

~~E.~~D. CalOptima or a **Health Network** shall pay, or deny, a claim as follows:

1. Contracted **Providers**

   a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted **Provider**, or portion thereof, in accordance with the ~~time frames specified in~~timeframes, terms, and conditions of the ~~contracted~~ Provider ~~agreement.~~ Agreement.

2. **Non-Contracted Providers**

   a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all **Clean Claim**s from **Non-Contracted Providers** within thirty (30) calendar days after the date of receipt.

   b. CalOptima or a Health Network shall pay, or deny, all other claims from **Non-Contracted Providers** within sixty (60) calendar days after the date of receipt.

   c. If CalOptima or a Health Network fails to pay a **Clean Claim** from a **Non-Contracted Provider** within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima or a Health Network shall reimburse a **Non-Contracted Provider** at the Medicare Fee Schedule for Medicare Part B professional services.

DRAFT

Back to Agenda

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the **Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS)** for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by **CMS** in the MIPS adjustment data files.

i. CalOptima or a Health Network may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retroactive adjustment to paid claims.

ii. CalOptima or a Health Network are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

~~F.~~E. If CalOptima or a **Health Network** denies payment of a **Clean Claim**, CalOptima or a Health Network shall notify the **Member** with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

   a. The specific reasons for the payment denial;

   b. Inform the **Member** of his or her right to request an **Appeal**;

   c. Describe the **Appeal**s process, time frames, and other elements; and

   d. Inform the **Member** of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered ~~by CalOptima,~~under the Medicare program, **,** but is covered by and payable under a **Member's** Medi-Cal coverage, CalOptima or a **Health Network** shall not send the **Member** a Notice of Denial of Payment.

~~G.~~F. The CalOptima Claims Administration Department or a **Health Network** shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

~~H.~~G. CalOptima or a **Health Network** shall identify payers that are primary to Medicare, shall determine the amounts payable ~~to~~by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

~~I.~~H. **Provider** Appeal and Grievance

1. A **Provider** may **Appeal** a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

DRAFT

Back to Agenda

2. A **Provider** may file a **Grievance** in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a **Health Network** receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. **Invalid/Incomplete Claims**

1. If CalOptima or a Health Network receives an Invalid, or Incomplete, Claim, it shall notify the **Provider** no later than ten (10) working days after the date of receipt, in writing, with a request for the missing, or invalid, information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, ~~CalOptima~~CalOptima's or a **Health Network** notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an **Invalid/Incomplete Claim**, the **Provider** shall have no rights to **Appeal** such denial.

C. **Non-Clean Claims**

1. If CalOptima or a **Health Network** receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a **Health Network** shall notify a **Provider** of a **Non-Clean Claim** no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a **Health Network** requests reasonably relevant information from a **Provider** in addition to information that the **Provider** submits with a claim, CalOptima or a **Health Network** shall provide a written explanation of the necessity for such request.

3. Contracted/**Non-Contracted Providers**:

a. If CalOptima or a **Health Network** does not receive the requested information within forty-five (45) calendar days after it receives the claim, ~~the claim examiner~~CalOptima or a **Health Network** shall- send a second (2nd) letter to the contracted/**Non-Contracted Provider** requesting such information.

b. If CalOptima or a **Health Network** does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a **Health Network** shall review the claim with the information available and shall make a determination to pay, or deny, the claim.

4. ~~The claims processor~~ CalOptima or a **Health Network** shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

DRAFT

5. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to provide requested **Medical Record**s or other information, it shall process any dispute arising from the denial of such claim as a **Provider Grievance**, in accordance with Section II.I. of this Policy.

6. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the **Provider's** submission of a **Grievance** in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a **Health Network** shall have the right to accept and adjudicate the claim.

2. CalOptima or a **Health Network** may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a **Health Network** may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. Record Maintenance

1. CalOptima or a **Health Networks** shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a **Clean Claim**, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a **Health Networks** took such action, in the same manner that the **Provider** submitted the claim.

2. CalOptima or a **Health Networks** shall maintain all **Member Medical Record**s and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NDMCP; OMB Approval 0938-0829 (Expires: 01/31/2020) H5433_UM17_3a (Rev 8/30/17)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~B.~~C. CalOptima PACE Program Agreement
~~C.~~D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
~~D.~~E. CalOptima Policy CMC.9003: Standard Appeal
~~E.~~F. CalOptima Policy CMC.9004: Expedited Appeal
~~F.~~G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
~~G.~~I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
~~H.~~J. CalOptima Policy MA.3103: Coordination of Benefits
~~I.~~K. CalOptima Policy MA.9003: Standard Appeal
~~J.~~L. CalOptima Policy MA.9004: Expedited Appeal
~~K.~~M. CalOptima Policy MA.9005: Payment Appeal

Back to Agenda

DRAFT

~~L.~~N. CalOptima Policy MA.9006: Provider Complaint Process
~~M.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~N.~~O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
~~O.~~P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
~~P.~~Q. Patient Protection and Affordable Care Act, §6404
~~Q.~~R. Title 31, United States Code (U.S.C.), §3902(a)
~~R.~~S. Title 42, Code of Federal Regulations (C.F.R.), §410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), ~~and~~ 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

DRAFT

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE

DRAFT

IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.

DRAFT

Term	Definition
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.

DRAFT

Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/2005
Revised Date:	10/03/2019
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a **Health Network*** in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for **Covered Services** rendered to a **Member** in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted **Provider**.

B. A **Provider** shall submit a claim for **Covered Services** rendered on, or after, January 1, 2010 as follows:

1. A **Non-Contracted Provider** shall submit a claim for **Covered Services** rendered to a **Member** within one (1) calendar year after the date of service.

2. A contracted **Provider** shall submit a claim for **Covered Services** rendered to a **Member** within the time frame specified in the contracted **Provider** agreement. If the contracted Provider agreement does not specify a time frame, the contracted **Provider** shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a **Health Network** shall make timely and reasonable payment for the following **Covered Services** provided to a **Member** by a **Non-Contracted Provider**:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the **Member's** health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. **Emergency Services** - Emergency medical services *do not* require **Prior Authorization**. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a **Health Network** must pay the emergency triage fee and request **Medical Records**;

3. Urgently needed services;

DRAFT

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

Back to Agenda

4. Authorized post-stabilization care services;

5. Renal dialysis services when the **Member** is temporarily out-of-area and cannot reasonably access a contracted **Provider** for such **Covered Services**;

6. Denied **Covered Services** that are determined in the **Appeal** processes in CalOptima policies to be services the **Member** was entitled to have furnished, or paid for, by CalOptima or a **Health Network**; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a **Health Network** shall pay, or deny, a claim as follows:

1. Contracted **Providers**

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted **Provider**, or portion thereof, in accordance with the timeframes, terms, and conditions of the Provider Agreement.

2. **Non-Contracted Providers**

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all **Clean Claim**s from **Non-Contracted Providers** within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from **Non-Contracted Providers** within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a **Clean Claim** from a **Non-Contracted Provider** within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a **Non-Contracted Provider** at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the **Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS)** for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by **CMS** in the MIPS adjustment data files.

i. CalOptima or a Health Network may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retroactive adjustment to paid claims.

DRAFT

Back to Agenda

ii. CalOptima or a Health Network are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

E. If CalOptima or a **Health Network** denies payment of a **Clean Claim**, CalOptima or a Health Network shall notify the **Member** with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the **Member** of his or her right to request an **Appeal**;

c. Describe the **Appeal**s process, time frames, and other elements; and

d. Inform the **Member** of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, **,** but is covered by and payable under a **Member's** Medi-Cal coverage, CalOptima or a **Health Network** shall not send the **Member** a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a **Health Network** shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a **Health Network** shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. **Provider** Appeal and Grievance

1. A **Provider** may **Appeal** a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. A **Provider** may file a **Grievance** in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a **Health Network** receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. **Invalid/Incomplete Claims**

DRAFT

Back to Agenda

1. If CalOptima or a Health Network receives an Invalid, or Incomplete, Claim, it shall notify the **Provider** no later than ten (10) working days after the date of receipt, in writing, with a request for the missing, or invalid, information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a **Health Network** notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an **Invalid/Incomplete Claim**, the **Provider** shall have no rights to **Appeal** such denial.

C. **Non-Clean Claims**

1. If CalOptima or a **Health Network** receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a **Health Network** shall notify a **Provider** of a **Non-Clean Claim** no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a **Health Network** requests reasonably relevant information from a **Provider** in addition to information that the **Provider** submits with a claim, CalOptima or a **Health Network** shall provide a written explanation of the necessity for such request.

3. Contracted/**Non-Contracted Providers**:

   a. If CalOptima or a **Health Network** does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a **Health Network** shall send a second (2nd) letter to the contracted/**Non-Contracted Provider** requesting such information.

   b. If CalOptima or a **Health Network** does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a **Health Network** shall review the claim with the information available and shall make a determination to pay, or deny, the claim.

4. CalOptima or a **Health Network** shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to provide requested **Medical Record**s or other information, it shall process any dispute arising from the denial of such claim as a **Provider Grievance**, in accordance with Section II.I. of this Policy.

6. If CalOptima or a **Health Network** denies a claim based on a **Provider's** failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the **Provider's** submission of a **Grievance** in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a **Health Network** shall have the right to accept and adjudicate the claim.

2. CalOptima or a **Health Network** may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of

DRAFT

Back to Agenda

professional and/or facility claims. CalOptima or a **Health Network** may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. Record Maintenance

1. CalOptima or a **Health Networks** shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a **Clean Claim**, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a **Health Networks** took such action, in the same manner that the **Provider** submitted the claim.

2. CalOptima or a **Health Networks** shall maintain all **Member Medical Record**s and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NDMCP; OMB Approval 0938-0829 (Expires: 01/31/2020) H5433_UM17_3a (Rev 8/30/17)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement
D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
J. CalOptima Policy MA.3103: Coordination of Benefits
K. CalOptima Policy MA.9003: Standard Appeal
L. CalOptima Policy MA.9004: Expedited Appeal
M. CalOptima Policy MA.9005: Payment Appeal
N. CalOptima Policy MA.9006: Provider Complaint Process
O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
Q. Patient Protection and Affordable Care Act, §6404
R. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), §410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

DRAFT

Back to Agenda

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE

DRAFT

Back to Agenda

IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.

DRAFT

Back to Agenda

Term	Definition
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.

1

DRAFT

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Payment

Date:

Member number:
Claim number:

Name:

Your request was denied

We've denied the payment of medical services/items listed below requested by you or your doctor [ ]:

Why did we deny your request?

We denied the payment of medical services/items listed above because:

You have the right to appeal our decision

You have the right to ask OneCare (HMO SNP) to review our decision by asking us for an appeal**.**

Appeal: Ask OneCare (HMO SNP) for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-877-412-2734 to learn how to name your representative. TTY users call 1-800-735-2929. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with OneCare (HMO SNP)

Step 1: You, your representative, or your doctor [*provider*] must ask us for an appeal *or State Fair Hearing*. Your *written* request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Mail, fax, or deliver your appeal *or call us*.

For a Standard Appeal: Address: Attention: Grievance and Appeals Resolution Services
CalOptima
505 City Parkway West
Orange, CA 92868

Phone: 1-877-412-2734 Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-877-412-2734 Fax: 1-714-246-8562

What happens next?

If you ask for an appeal and we continue to deny your request for *payment of* a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get help & more information

- OneCare (HMO SNP) Toll Free: 1-877-412-2734 TTY users call: 1-800-735-2929

24 hours, 7 days a week.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116

Sincerely,

Claims Administration
OneCare

cc: Member File

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:
Claim number:

Name:

Your request was denied

We've denied the payment of medical services/items listed below requested by you or your doctor [*provider*]:

[service] [service dates]

Why did we deny your request?

We denied the payment of medical services/items listed above because:

[Remarks]

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

How to keep your services while we review your case: *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-855-705-8823 to learn how to name your representative. TDD/TTY users call 1-800-735-2929. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with OneCare Connect

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**.

Fast (Expedited) Appeal *– We'll give you a decision on a fast appeal as expeditiously as your condition requires, and always within* ***72 hours*** *after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal.*

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. *If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.*

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Address: OneCare Connect
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

For a Fast (Expedited) Appeal: Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562}

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for {*payment of*} a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of this notice. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TDD: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: [*insert name*]

Get help & more information

- Call **OneCare Connect** at 1-855-705-8823, 24 hours, 7 days a week. TDD/TTY users call 1-800-735-2929. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-888-HMO-9050.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- If this notice is about your In-Home Supportive Services (IHSS) benefits, call your **local county social services office** for help. The phone number is 1-714-825-3000 and 1-800-281-9799.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. You can get this information for free in other languages. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-855-705-8823 (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-705-8823 (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝
1-800-735-2929):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
(**1-800-735-2929**: TTY الهاتف النصي/خط الاتصال لضعاف السمع) **1-855-705-8823**

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-855-705-8823 (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-855-705-8823 (TTY: 1-800-735-2929)**.

CalOptima PACE
13300 Garden Grove Blvd
Garden Grove, CA 92843
(714) 468-1100
TDD/TTY: (714) 468-1063

{Date}

{Participant's Name or Representative}
{C/o Participant's Name}
{Address}

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr/s {Name}:

Your request of [insert date] for [insert brief description of requested service or payment for service]

Has been: __**Denied** __**Deferred** __**Modified** for the reason(s) indicated below:

- ❑ Is not medically necessary
- ❑ Requested services will not improve or contribute to sustaining your health
- ❑ An alternative service is provided to meet your care needs
- ❑ Did not meet authorization criteria
- ❑ Is not a benefit of the PACE Program
- ❑ Requires additional information or consult
- ❑ Requested service has potentially negative health and safety issues
- ❑ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:
_____
_____

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your Social Worker or our Quality Assurance Department at (714) 468-1100 who will explain these processes to you. For the hearing impaired (TTY/TDD), please call (714) 468-1063.

Sincerely,

[First Initial and last name of Examiner
Claims Administration

CONFIDENTIAL

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at **CalOptima PACE** share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. **CalOptima PACE** will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When **CalOptima PACE** decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever **CalOptima PACE** denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If you

CONFIDENTIAL

Back to Agenda

request and expedited appeal, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

*Note: For **CalOptima PACE** participants enrolled in Medi-Cal – **CalOptima PACE** will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and **CalOptima PACE** denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.
2. You can make your appeal either verbally(in person or by telephone) or in writing; ask any PACE Program staff of the center you attend to help you start the process. CalOptima PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by **the Quality Assurance Department** who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our **Quality Assurance Department** at **714-468-1100 or our toll-free number at (855) 785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call **(714) 468-1063**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Quality Assurance Department
   CalOptima PACE
   13300 Garden Grove Blvd
   Garden Grove, CA 92843

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For and expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

CONFIDENTIAL

Back to Agenda

6. The reconsideration of **CalOptima PACE** decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon **CalOptima PACE** completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, **CalOptima PACE** will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:
If we decide fully in your favor on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

CONFIDENTIAL

Back to Agenda

The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if **CalOptima PACE** wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **Medicare Medi-Cal program or both,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

CONFIDENTIAL

Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: (800)-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: (800)-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from **CalOptima PACE**.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in **Orange County**, if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, **CalOptima PACE** will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Back to Agenda

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14524-1302
Telephone: (585) 348-3300
Facsimile: (585) 425-5292

CONFIDENTIAL

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

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

Contact

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

Recommended Actions

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

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

Background

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis.

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

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

Back to Agenda

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

Discussion

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

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

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

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

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

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

Back to Agenda

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DD.2006: Enrollment In/ Eligibility with CalOptima (redline and clean versions)
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process (redline and clean versions)
3. GG.1125: Cancer Clinical Trials (redline and clean versions)
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices (redline and clean versions)
5. Board Action December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. DHCS All Plan Letter 18-011 California Children's Services Whole-Child Model Program

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

Back to Agenda

Medi-Cal CalOptima A Public Agency Better. Together.

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

5. At the time of initial enrollment in CalOptima, a **Member** with a non-Orange County z~~Z~~ip c~~C~~ode, or invalid address information from the State.

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

DRAFT

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

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

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

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

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

   a. Is diagnosed with hemophilia;

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

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

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

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

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

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

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

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

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

Back to Agenda

DRAFT

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

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

III. PROCEDURE

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

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

~~B.~~

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

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

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

Back to Agenda

DRAFT

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

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

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

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

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

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

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

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

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

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

Back to Agenda

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

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

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

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

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

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

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

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

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

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

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

DRAFT

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

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

IV. ATTACHMENT(S)

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVAL(S)

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

VII. BOARD ACTION(S)

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

Back to Agenda

DRAFT

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

VIII. REVIEW/REVISION HISTORY

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

DRAFT

~~X.~~IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a ~~Member~~member is eligible to receive Medi-Cal ~~Covered Services~~covered services.
California Children's Services Program	~~For the purposes of this policy, the~~The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~persons~~individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the ~~Member~~member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~Members~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A ~~Member~~member who receives all ~~Covered Services~~covered services through CalOptima Direct.
CalOptima Direct Administrative (COD~~-~~A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for ~~Members~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division ~~of~~Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of ~~Covered Services.~~covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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

DRAFT

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

DRAFT

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

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

    a. Is diagnosed with hemophilia;

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

DRAFT

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

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

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

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

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

IV. ATTACHMENT(S)

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVAL(S)

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

DRAFT

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

VII. BOARD ACTION(S)

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

VIII. REVIEW/REVISION HISTORY

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

DRAFT

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A member who receives all covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

DRAFT

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

1

DRAFT

CalOptima
A Public Agency
Better. Together.

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

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

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

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

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

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

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

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

Client Index # (CIN): _____

Referring Provider:

Provider NPI#: _____ **TIN#:** _____

Medi-Cal ID#: _____

Address: **Phone:** _____

Fax: _____

Office **Contact:** _____

Physician's Signature: _____

Diagnosis: _____ **ICD-9:** _____

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

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

☐ **Inpatient** ☐ **Outpatient**

Estimated Length of Stay: _____

Letter of Agreement (LOA) Requested

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

List ALL procedures requested along with the appropriate CPT/HCPCS

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

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

Back to Agenda

CalOptima
A Public Agency
Better. Together.

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

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

Name: CIN #: Phone No: ( ) -

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

Primary Care Physician: Phone No: ( ) -

Treating Specialists: Phone No: ( ) -

Is Member currently in Case Management?

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

Planned Admissions or scheduled surgeries:

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

Ordering Physician: Phone No: ( ) -

Date of Procedure: - - Type of Procedure:

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

What factor is utilized?

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

Ordering Physician: Phone No: ( ) -

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

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

If yes:

Hospital:

Diagnosis:

RX

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

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of person completing this form: Date: - -

PLEASE SEND A COPY OF ALL OPEN AUTHORIZATIONS

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

Form Approved
OMB No. 0938-0046

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

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

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

2. Medicare Claim Number

3. Social Security Number

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

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

6. Phone Number *(including area code)*

7. Sex ☐ Male ☐ Female

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

9. Country/Area of Origin or Ancestry

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

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

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

13. Height INCHES OR CENTIMETERS

14. Dry Weight POUNDS OR KILOGRAMS

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

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

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

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

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

18. Prior to ESRD therapy:

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

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

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

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility

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

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

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

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

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

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

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

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

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

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

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

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

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

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

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

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

E. PHYSICIAN IDENTIFICATION

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

PHYSICIAN ATTESTATION

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

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

53. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

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

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

G. PRIVACY STATEMENT

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

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

For whom should this form be completed:

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

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

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

Initial

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

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

Re-entitlement

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

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

Supplemental

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

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

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

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

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

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

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

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

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

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

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

DISTRIBUTION OF COPIES:

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

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

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

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

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

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

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

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

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

None—Patient has no medical insurance plan.

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

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

NOTE: For amputee patients, enter actual dry weight.

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

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

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

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

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

*Drug dependence means dependent on illicit drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Self-dialysis Training Patients (Medicare Applicants Only)

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

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

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

Policy #:	DD.2008
Title:	**Health Network and CalOptima Community Network Selection Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/1995
~~Last Review Date:~~	~~06/01/18~~
~~Last~~ Revised Date:	~~06/01/18~~04/04/2019

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

III. PROCEDURE

Back to Agenda

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

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

   a. Introductory/welcome letter;

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

   c. Health Information Form;

   d. CalOptima **Member** Handbook;

   e. CalOptima **Member** Identification Card;

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

   g. **Health Network** report card;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

      ii. A Health Network based on Auto Assignment.

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

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

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

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

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

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

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

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

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

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

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

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

        i. Cystic Fibrosis;

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

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

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

DRAFT

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

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

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

DRAFT

VIII. ~~REVIEW/~~REVISION HISTORY

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

DRAFT

IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~ individuals under the age of twenty-one (21) years who have CCS ~~Eligible Conditions~~eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the ~~Members~~members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-Eligible Conditions	~~Conditions~~Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations~~, Section 41800~~ sections 41515.2 through ~~4187.6 including, but not limited to:~~ ~~1. Infectious and parasitic diseases;~~ ~~2. Neoplasms;~~ ~~3. Endocrine, nutritional, and metabolic diseases;~~ ~~4. Disease of blood and blood-forming organs;~~ ~~5. Diseases of the nervous system;~~ ~~6. Diseases of the eye;~~ ~~7. Diseases of the ear and mastoid process;~~ ~~8. Diseases of the circulatory system;~~ ~~9. Diseases of the respiratory system;~~ ~~10. Diseases of the digestive system;~~ ~~11. Diseases of the genitourinary system;~~ ~~12. Complications of pregnancy, childbirth, and puerperium;~~ ~~13. Diseases of the skin and subcutaneous tissue;~~ ~~14. Diseases of the musculoskeletal and connective tissue;~~ ~~15. Congenital anomalies;~~ ~~16. Certain causes of Perinatal morbidity and mortality; and Accidents, poisonings, violence, and immunization reactions~~41518.9..
Continuity of Care	Services provided to a ~~Member~~member rendered by an out-of-network provider with whom the ~~Member~~member has pre-existing provider relationship.

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

1

DRAFT

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

DRAFT

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

Back to Agenda

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

    a. Introductory/welcome letter;

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

    c. Health Information Form;

    d. CalOptima **Member** Handbook;

    e. CalOptima **Member** Identification Card;

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

    g. **Health Network** report card;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

        ii. A Health Network based on Auto Assignment.

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

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

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

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

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

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

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

DRAFT

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

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

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

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

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

i. Cystic Fibrosis;

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

iii. Spina Bifida; or

iv. Muscular Dystrophy.

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
C. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
E. CalOptima Policy GG.1101: California Children's Services
F. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
G. CalOptima Policy GG.1325: Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima
H. Contract for Health Care Services
I. Medi-Cal Managed Care Division (MMCD) All-Plan Letter (APL) 03-002: SB 87 Medi-Cal Contact Information Release Form
J. Title 22, California Code of Regulations, §§50188, 51006, and 51301 et seq.

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	02/20/1997	DD.1102	Health Plan Selection Process	Medi-Cal
Revised	07/01/2004	DD.1114	Request from Members of Same Household to Enroll in Different Health Networks	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2004	DD.1109	Health Network Selection and Health Network Obligations for Members	Medi-Cal
Revised	01/01/2007	DD.2008	Health Network Selection Process	Medi-Cal
Revised	01/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	12/01/2011	DD.2008	Health Network Selection Process	Medi-Cal
Revised	03/01/2015	DD.2008	Health Network Selection Process	Medi-Cal
Revised	04/01/2016	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2017	DD.2008	Health Network Selection Process	Medi-Cal
Revised	06/01/2018	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal
Revised	04/04/2019	DD.2008	Health Network and CalOptima Community Network (CCN) Selection Process	Medi-Cal

1

DRAFT

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.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9..
Continuity of Care	Services provided to a member rendered by an out-of-network provider with whom the member has pre-existing provider relationship.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51310 of Title 22, CCR), which shall be covered for members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Family Linked Member	A member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another member who is in his or her family and who resides in the same household.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that health network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	A primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes covered services.

1

DRAFT

PRI-037-105

CalOptima
A Public Agency
Better. Together.

HEALTH NETWORK (HN) SELECTION FORM

Last:	First:	ID #:	PCP Last Name or Clinic Name:	PCP First Name:	PCP or Clinic ID:	HN ID*

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

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

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

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

E-mail Address:

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

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

Back to Agenda

Dear Member:

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

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

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

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

If you have questions or need help in choosing a health network, please call CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TTY/TDD users can call **1-800-735-2929**. You can also visit our website at www.caloptima.org.

Medi-Cal
CalOptima
A Public Agency
Better. Together.
www.caloptima.org

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

[HEALTH_NETWORK]   [HN_PHONE]

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

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

Medi-Cal
CalOptima
A Public Agency
Better. Together.
www.caloptima.org

** VOID **

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

Medi-Cal
CalOptima
A Public Agency
Better. Together.
www.caloptima.org

** VOID **

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

Medi-Cal
CalOptima
A Public Agency
Better. Together.
www.caloptima.org

** VOID **

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

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

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

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

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

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

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

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

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

Policy #: GG.1125
Title: **Cancer Clinical Trials**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 11/01/02
~~Last Review Date:~~ ~~08/01/17~~
~~Last~~ Revised Date: ~~08/01/17~~TBD

Applicable to: ☒ Medi-Cal
☒ OneCare
☒ OneCare Connect

I. PURPOSE

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

II. POLICY

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

B. Routine patient care costs:

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

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

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

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

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

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

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

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

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

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

Back to Agenda

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

A. A Provider~~,~~ or Practitioner~~,~~ shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. DHCS California Children's~~'~~ Services (CCS) Numbered Letter (NL) ~~37-1992~~ 37-1292: Coverage of Experimental and/or Investigational Services
~~C.~~D. CalOptima Health Network Service Agreement
~~D.~~E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~E.~~F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~G. Health and Safety Code, §1370.6
~~G.~~H. Medicare National Coverage Determination 100-03, July 9, 2007

Back to Agenda

~~H.~~I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

Back to Agenda

IX. GLOSSARY

Term	Definition
California Children Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006.: Enrollment in/Eligibility with CalOptima Direct.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.

Back to Agenda

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

I. PURPOSE

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

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein..

B. Routine patient care costs:

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

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

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

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

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

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

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

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

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

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

Back to Agenda

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

A. A Provider or Practitioner shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. DHCS California Children's Services (CCS) Numbered Letter (NL) 37-1292: Coverage of Experimental and/or Investigational Services
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health and Safety Code, §1370.6
H. Medicare National Coverage Determination 100-03, July 9, 2007
I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.

Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	~~08/01/17~~04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima~~,~~ or a Health Network~~,~~ shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima~~,~~ or a Health Network~~,~~ shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima~~,~~ or a Health Network~~, shall not~~ will review for Medical Necessity and, if indicated, will authorize the purchase of ~~a Medically Necessary car seat~~an AOPD for children that ~~is otherwise available through the~~are not California ~~Children~~Children's Services ~~Program~~ (CCS~~) or CCS~~)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program ~~for a Member who is eligible for services through~~.

G. No sooner than the ~~CCS Program~~Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

Back to Agenda

A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria:

i. The Member shall be over four (4) years of age;

ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

iii. The Member shall meet at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

c) The Member has a skeletal deformity that requires total postural support for safe transportation.

c. Related Considerations

i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria

i. The Member shall be over four (4) years of age;

ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

iii. The Member shall at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

~~B. CalOptima and its Health Networks shall refer medically eligible CCS Members to the CCS program for consideration of AOPD under the EPSDT Service program.~~

~~C.~~B. A request for reimbursement of an AOPD shall be accompanied by:

~~1. A current physician prescription;~~

1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy~~,~~ or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy~~.~~ and includes:

~~D. CalOptima and its Health Networks shall monitor the outcome of CCS referrals for CCS authorization.~~

a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

Back to Agenda

A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) /Whole -Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~98-06~~18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)~~Numbered Letters 01-0298 and 09-0598~~
H. Department of Health Services (DHCS) All Plan Letter (APL) ~~14-017~~18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal ~~Beneficiaries~~Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

Back to Agenda

IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.

1

Back to Agenda

Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
Revised Date:	04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima or a Health Network shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima or a Health Network shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for children that are not California Children's Services (CCS)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program.

G. No sooner than the Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

Back to Agenda

A. CalOptima and its Health Networks shall utilize the following criteria when determining the Medical Necessity of an AOPD:

1. Car Seats

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria:

i. The Member shall be over four (4) years of age;

ii. The Member shall be either over forty (40) pounds, or over forty (40) inches in height; and

iii. The Member shall meet at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control or sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment; or

c) The Member has a skeletal deformity that requires total postural support for safe transportation.

c. Related Considerations

i. The Member's height, width, or physical deformity precludes use of a commercially available car seat.

ii. A harness, or vest, will not provide the Member with enough stability to remain in proper alignment or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own an appropriate vehicle to allow transport in a wheelchair.

2. Harnesses or Vests

a. Medical Necessity: The Member requires maximal to moderate postural support to maintain a safe sitting position during transportation.

b. Criteria

i. The Member shall be over four (4) years of age;

ii. The Member shall be over forty (40) pounds or over forty (40) inches in height; and

iii. The Member shall at least one (1) of the following criteria:

a) The Member has a moderate to minimal trunk control sitting ability, moderate to minimal lateral head control, and requires total postural support;

b) The Member is at risk for breathing complications as a result of poor trunk control or alignment;

c) The Member has a skeletal deformity that requires total postural support for safe transportation; or

d) The Member requires transportation in other than an upright position due to deformity or surgical corrections.

c. Related Considerations

i. The Member's physical deformity or trunk instability precludes use of a standard seat belt or commercially available vest, or harness.

ii. A standard seat belt, or commercially available vest/harness, will not provide the Member with enough stability to remain in proper alignment, or allow for safe transport.

iii. The Member cannot be transported in a wheelchair because the family does not own appropriate vehicle to allow transport in a wheelchair.

B. A request for reimbursement of an AOPD shall be accompanied by:

1. A current prescription provided by the physician of the appropriate specialty for treating the child's condition that the device is intended to address;

a. For children whose CCS-Eligible Condition is the condition necessitating the AOPD, the prescribing physician shall be CCS-paneled.

2. A current medical report that justifies the Medical Necessity of the item requested; and

3. A current physical therapy or occupational therapy, assessment that addresses the criteria as defined in Section III.A. of this policy and includes:

a. Physical findings;

b. Functional status related to the DME item requested; and

c. A home, school and community accessibility assessment, if indicated.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. California Children's Services Guide for Purchase of Durable Medical Equipment (DME)
B. California Children's Services (CCS) Numbered Letter (NL) 17-1199: Automobile Orthopedic Positioning Devices (AOPDs)
C. California Children's Services (CCS) Numbered Letter (NL) 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
D. California Vehicle Code, §27360

E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023: California Children Services Whole Child Model Program (supersedes APL 18-011)
H. Department of Health Services (DHCS) All Plan Letter (APL) 18-007: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of Twenty-One
I. Title 22, California Code of Regulations (CCR), §§ 51321 and 51160

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	05/01/2007	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	11/01/2015	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	10/01/2016	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	08/01/2017	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal
Revised	04/04/2019	GG.1515	Criteria for Medically Necessary Automobile Orthopedic Positioning Devices	Medi-Cal

IX. GLOSSARY

Term	Definition
Automobile Orthopedic Positioning Devices (AOPDs)	A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima	For purposes of this policy, CalOptima shall include both CalOptima Direct and CalOptima Community Network (CCN).
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Durable Medical Equipment (DME)	Durable Medical Equipment is any equipment that is prescribed by a licensed practitioner to meet the medical equipment needs of the patient that: (a) can withstand repeated use; (b) is used to serve a medical purpose; (c) is not useful to an individual in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the patient's home.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT includes periodic screening that includes at a minimum a comprehensive health and developmental history (including assessment of both physical and mental health development); an unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors; and health education (including anticipatory guidance), vision, dental, and hearing services. In addition, other necessary health care, diagnostic services, treatment and measures described in Title 42, US Code, Section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Necessity or Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.

1

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

Back to Agenda

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Back to Agenda

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

Back to Agenda

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

Back to Agenda

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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

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

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

Back to Agenda

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Back to Agenda

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

Back to Agenda

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

Back to Agenda

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Back to Agenda

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Back to Agenda

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Back to Agenda

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

Back to Agenda

A Public Agency

CalOptima

Better. Together.

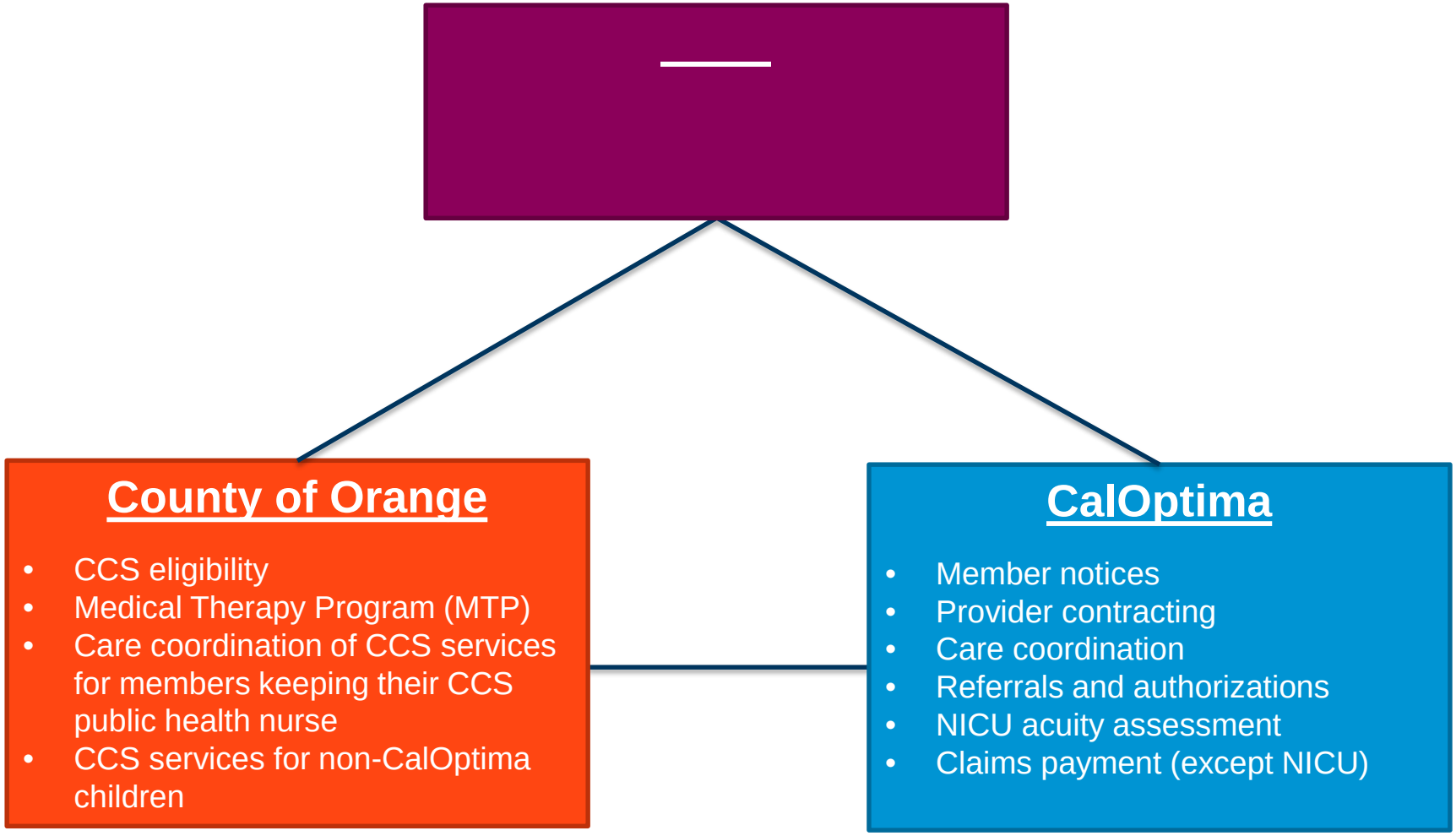
Background

Back to Agenda

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

Implementation Plan Elements

Back to Agenda

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

Back to Agenda

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

Back to Agenda

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Back to Agenda

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

Back to Agenda

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

Back to Agenda

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

Back to Agenda

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Back to Agenda

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

DRAFT

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

DRAFT

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

DRAFT

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

DRAFT

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

DRAFT

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

DRAFT

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

DRAFT

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Back to Agenda

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Back to Agenda

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

Back to Agenda

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

Back to Agenda

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Back to Agenda

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:
- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:
- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

Back to Agenda

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

Back to Agenda

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program. This APL supersedes APL 18-011.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

Back to Agenda

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP serves as the primary vehicle for ensuring collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

Back to Agenda

When a CCS-eligible member moves from one county to another, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP, as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program must communicate all resolved disputes in writing to the MCP. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;

Back to Agenda

- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

Back to Agenda

The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

---

[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

Back to Agenda

centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

Back to Agenda

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

---

[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Back to Agenda

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

Back to Agenda

redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

---

[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   Risk Assessment
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

Back to Agenda

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

Individual Care Plan
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

WCM Transitioning Members
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

---

[24] See APL 17-006, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf
[25] See APL 17-006
[26] See CCS N.L. 03-0810, which is available at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl030810.pdf
[27] APL 17-010 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf

F. Out-of-Network Access

MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.[28] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[29] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[30]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS fee-for-service rates, unless the provider and the MCP enter into

---

[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

Back to Agenda

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

---

[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

Back to Agenda

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program. This APL supersedes APL 18-011.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

Back to Agenda

determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP). WCM counties participating with the MTP will continue to receive a separate allocation for this program and are responsible for care coordination of MTP services.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices. Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[6]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/Pediatric Intensive Care Unit/Neonatal Intensive Care Unit (NICU)

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures,

[6] See the WCM CCS N.L. Category List. is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Index-Category-List-June2018.xls

and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP serves as the primary vehicle for ensuring collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template and must be consistent with the requirements of SB 586. MCPs are required to submit an executed MOU to DHCS 105 days prior to implementation. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization, including administrative functions, from the county CCS program to the MCPs.[8] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensuring C.O.C. and services for members who are in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for C.O.C. of already approved service authorization requests, as required by this APL and applicable state and federal laws.

[7] See footnote 5. The MOU template can be found on the CCS WCM website.
[8] See footnote 4. WIC Section 14094.7(d)(4)(C).

Back to Agenda

When a CCS-eligible member moves from one county to another, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP, as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program must communicate all resolved disputes in writing to the MCP. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL removes or limits existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

[9] See footnote 4. WIC Section 14093.06(b).
[10] Unresolved disputes must be referred to: CCSRedesign@dhcs.ca.gov
[11] See footnote 4. WIC Section 14094.15(d).

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new CCS members enrolling in the MCP, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level through:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

   <u>New Members and Newly CCS-Eligible Members Determined High Risk</u>
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   <u>Risk Assessment</u>
   The risk assessment process must address:

   - General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;

Back to Agenda

- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

Back to Agenda

The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

---

[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

Back to Agenda

centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

Back to Agenda

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

---

[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing Unbudgeted Operating Expenditures For Royalty Fees For Use Of The American Medical Association Current Procedural Terminology Codes

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

Recommended Actions
Authorize unbudgeted Operating expenditures and appropriate the funds within the Medi-Cal program administrative expenses category in an additional amount not to exceed $30,000 from existing reserves for an increase to Other Operating Expenses-Software Maintenance for royalty fees for use of the American Medical Association (AMA) Current Procedural Terminology (CPT) codes.

Background/Discussion
Annually, all health plans and healthcare delivery organizations must pay royalty fees for use of the standard CPT codes as defined and provided exclusively by the AMA. These are commonly referred to as procedure codes. The license for CPT codes may be obtained directly from the AMA or from a third-party vendor. CalOptima licenses the CPT codes from Optum, since all other CalOptima code sets and standards are also licensed through Optum. For the CPT codes, Optum charges no markup as they generate revenue from the other code sets they supply.

CalOptima staff included $27,000 in the Board-approved FY2019-20 operating budget for this item. This budget amount was based on historical licensing fees paid to Optum for the use of all code sets including the AMA CPT codes. However, the AMA licensing methodology for CPT codes changes for CalOptima effective November 1, 2019. The prior licensing model required the reporting of "users" of each "product" (e.g., a claims system) to calculate royalties due. However, an attached letter from the AMA from early April 2019 to all health plans states "*In order to provide a licensing model that better aligns with the objective metrics and electronic products used by health plans, the AMA is introducing the Health Plan Licensing Royalty Model…Based on extensive market feedback, the unit of licensure for the Health Plan Licensing Royalty Model is per member per year (PMPY).*" Also attached is a document provided by the AMA explaining the new model

The new model has been simplified and is based on the volume of members supported by core systems (e.g., claims, customer service, care management, etc.). Ultimately, a rate per member per year has been established to calculate the annual royalty. For CalOptima, this rate will be for the volume of members managed directly. The delegated health networks that handle core systems processing for CalOptima members (and others) will be subject to licensing and royalties for all of their members, including the assigned CalOptima members.

The notice from the AMA explaining the licensing change was received during April 2019 after the original budget was submitted. Initially, Optum had applied the royalty fee per member to the total population of CalOptima membership, representing a significant increase from prior pricing. However,

staff has been working with Optum to explain the delegated model. As a result, Optum has determined that CalOptima is responsible for royalty fees only for CalOptima's non-delegated membership.

The Fiscal Year (FY) 2019-20 budgeted amount for all code sets is $27,600. This included an anticipated increase for use of the code sets for in-house Behavioral Health Services. Based on the new licensing model, and the agreed upon volume of membership, this request is to allocate an additional $30,000 for the FY 2019-20 royalties. The CPT royalties represent $38,920 of the total; the other code sets represent approximately $18,000. This additional amount was not budgeted. Per the terms of the licensing agreement, the AMA has the right to modify the licensing terms annually. The use of standard CPT codes is required; they are produced by and only licensable through the AMA.

Fiscal Impact
The recommended action to authorize operating expenditures and appropriate funds within the Medi-Cal program administrative expense category in an additional amount not to exceed $30,000 is unbudgeted. As proposed, an allocation of up to $30,000 from existing reserves will fund this action.

Rationale for Recommendation
Approval of the proposed action is recommended to ensure that CalOptima remains in compliance with the terms of its licensure of AMA CPT codes.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1 – AMA Optum HP End User Letter
2 – AMA HP Licensing Model Overview

/s/ Michael Schrader — *9/23/2019*
Authorized Signature — **Date**

AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
t (312) 464-5000

American Medical Association
330 N. Wabash Avenue
Chicago, IL 606011

Dear CPT Licensee:

As part of an ongoing initiative to ensure fairness and consistency in licensure for use of the CPT® Data File, the AMA is implementing a new Health Plan Licensing Royalty Model in 2018, which will be used to calculate royalties for use of the CPT® Data File by health plans in connection with various electronic systems. This letter is intended to provide information concerning the new Health Plan Licensing Royalty Model as it will impact how you calculate and report CPT® royalties to the AMA or your authorized distributor.

This initiative began in 2015 and 2016 when the AMA developed and deployed a model to streamline licensing the CPT® Data File for use with electronic health records and other designated HIT applications in hospital and ambulatory settings. In 2017, the model was required for reporting "Users" and calculating royalties. The AMA received positive feedback for the model's fairness and use of objective industry metrics.

Through 2017 and 2018, the AMA continued efforts to examine the electronic products used by health plans, including deep analysis of products reported by customers that directly licensed the CPT® Data File from the AMA. Further, the AMA sought to understand how health plans were applying the definition of "User" (the unit of licensure) and determining the number of Users of the CPT® Data File for certain HIT applications. Through this work, the AMA confirmed that the long-standing "User" definition did not work well for health plans and that a new model of licensure was needed.

In order to provide a licensing model that better aligns with the objective metrics and electronic products used by health plans, the AMA is introducing the Health Plan Licensing Royalty Model – a method of calculating royalties for use of the CPT Data File by health plans. As in prior years, royalties are required for each electronic product that utilizes or benefits from the CPT Data File. Under the new model, electronic products are classified into Systems Arrays. The Health Plan Licensing Royalty Model and its underlying Systems Arrays were developed with extensive input from external expert consultants. Based on extensive market feedback the unit of licensure for the Health Plan Licensing Royalty Model is per member per year (PMPY). Initial feedback on this model is that it is both straightforward to use and provides a consistent and transparent method to determine appropriate royalties.

The AMA has designated the Health Plan Licensing Royalty Model as the standard for determining royalties for health plans. Further, authorized distributors are working with the AMA to determine which of their products that use the CPT® Data File require use of this model. This change will be effective for use of the CPT 2019 Data File which was published in September 2018.

The AMA has provided additional tools (e.g., Health Plan Licensing Royalty Model Data Worksheet; 2019 Health Plan Model Tool Kit, including Frequently Asked Questions) to authorized distributors to assist in their implementation of the model with their clients. Please work with your authorized distributor to ensure that you are in compliance with your license for CPT® content.

Regards,

AMA CPT Licensing & Intellectual Property

Health Plan Licensing Royalty Model

Overview

In 2018, the American Medical Association (AMA) is implementing the Health Plan Licensing Royalty Model ("Health Plan Model"), which will be used to calculate royalties for use of the CPT® Data File by health plans. Over the past several years, the AMA has gathered input from health plan stakeholders, and it's clear licensing CPT for their electronic systems based on "User" counts is challenging. The AMA developed the new Health Plan Model to provide an objective, easy to understand and apply method for licensure that aligns with health plan use of CPT.

Why is the AMA changing the royalty model for health plan licensees?
The AMA spent considerable effort over the last several years to understand how health plans were applying the definition of "User" (the unit of licensure) for the HIT applications used in health plan environments. Through this work, the AMA confirmed that the long-standing "User" definition did not work well for health plans and that a new model of licensure was needed.

The AMA used the following principles to guide the development of the new model:

Reflect existing use of CPT®, drive innovation and scale with rapidly evolving HIT landscape	**Respond to customer feedback about CPT® User based royalty models**	**Improve fairness and consistency in reporting licensure for use of CPT®**
Use verifiable and auditable definitions to assess use of CPT® and improve reporting and compliance	**Reduce administrative reporting burdens**	**Provide tools to improve education**

What is the Health Plan Model?
The Health Plan Model is a method of calculating royalties for use of the CPT Data File by health plans. Under the new model, electronic products are classified into "Systems Arrays." Each Systems Array has a corresponding royalty rate and the unit of licensure is Member. Annual royalties for CPT are based on the number of Members served by a product within a Systems Array multiplied by the royalty rate.

Royalty Rate x # of Members

Additional considerations in the new model include whether the electronic product is a "Core Product" or a "Supporting Product," and whether electronic products are integrated. Royalty rates may vary depending on these variables.

Which electronic products are subject to CPT royalties?
Any electronic product that uses CPT as follows is a "Covered Product" under the Health Plan Model and it must have an appropriate CPT license:

1. Imports, exports, displays, accesses, uses, or manipulates the CPT Data File; or
2. accesses, uses, or manipulates the CPT Data File to produce or enable an output (data, reports, or the like) that could not have been created without the CPT Data File, even though the CPT Data File may not be visible or directly accessible; or
3. makes use of an input or output that relies on or could not have been created without the CPT Data File even though the CPT Data File may not be visible or directly accessible.

How do licensees determine royalties for electronic products that require a CPT license?
The AMA has a set of tools to help licensees apply the Health Plan Model to all Covered Products, including a data collection Worksheet. Covered Products are categorized into Systems Arrays, which represent electronic products used to perform key functions in health plan operations. These Covered Products are then further classified as Core Products that meet specific functional criteria to accomplish substantial aspects of a Systems Array, or Supporting Products, as described in more detail below. Royalty rates vary based on (i) Systems Array, and (ii) whether the Covered Product is a Core Product or a Supporting Product.

These materials are for educational and informational purposes only. Terms and conditions applicable to the Health Plan Licensing Royalty Model and your entity's license of one or more CPT products are set forth solely in your entity's executed CPT license agreement with the AMA.

© 2018 American Medical Association. All rights reserved.

Health Plan Licensing Royalty Model

Overview

The following are the expected number of Core Products in each Systems Array for any given Member population.

Systems Array	Expected number of Core Products (per Member population)
Claims Processing	1
Customer Service	1
Data Management, Reporting & Analytics	4
Fraud, Waste & Abuse	1
Medical Management	2
Provider Network Management	2

For licensing purposes, no Covered Product may be reported as a Supporting Product within a Systems Array until the expected number of Core Products are reported for the same Systems Array and the same Member population. Further, once the expected number of Core Products in a given Systems Array for a given Member population has been reported, each additional Covered Product in that Systems Array serving the same Member population shall be reported as a Supporting Product.

How can we determine if our technology vendor is licensing CPT on our behalf?
The AMA will evaluate the information provided by the health plan in the data collection Worksheet, and will work with each CPT Data File distributor to identify and eliminate any duplicative royalties for any Covered Product that is licensed by an authorized distributor of CPT who pays royalties on behalf of its clients.

How are royalties calculated for Covered Products that support a portion of membership, such as different lines of business?
CPT royalties are calculated by multiplying the Systems Array royalty rate by the total number of Members served by that Systems Array. For example, a health plan may have one claims system that serves both its 100,000-Member commercial business and its 50,000-Member administrative services only ("ASO") business. The health plan also has a claim editor for validating claims only for its ASO line of business. Royalties would be calculated for the claims system by multiplying the royalty rate by the 150,000 Members, and for the claim editor by multiplying the royalty rate by the 50,000 Members.

Are a license and applicable royalties required for electronic products that support business functions that have been outsourced to a third party, such as claims processing or customer service call center?
Yes, these are required if such outsourced services constitute a Covered Product. Your account team or CPT Data File distributor will work with you to determine whether a service provider or technology vendor has appropriately licensed the CPT Data File, or if a new license agreement is required.

How are royalties calculated for multiple Core Products in a single Systems Array?
For Customer Service, Medical Management or Provider Network Management Systems Arrays, if there are two Core Products from the same vendor within the same Systems Array, only one would be considered a Core Product and one would be considered an integrated product/electronic system for purposes of calculating the applicable royalty.

These materials are for educational and informational purposes only. Terms and conditions applicable to the Health Plan Licensing Royalty Model and your entity's license of one or more CPT products are set forth solely in your entity's executed CPT license agreement with the AMA.

© 2018 American Medical Association. All rights reserved.

Board of Directors Meeting
October 3, 2019

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

OneCare Connect Member Advisory Committee (OCC MAC) members held a special meeting on August 22, 2019 and approved their 2019-20 meeting schedule. Members also selected and recommended Patty Mouton for OCC MAC Chair and Gio Corzo for Vice Chair .

Michael Schrader, Chief Executive Officer (CEO) provided OCC MAC members with an update on CalOptima's Strategic Plan. In addition to the CEO Report, members received a Chief Medical Officer (CMO) update by David Ramirez, M.D., a Federal and State Legislative report, as well as a verbal report on the Health Homes Program that will begin on January 1, 2019.

Edwin Poon, Ph.D., Director, Behavioral Health presented on the transition of OCC MAC members from Magellan Healthcare to CalOptima which will also become effective January 1, 2019. Members also received the annual Healthcare Effectiveness Data and Information Set (HEDIS) report from Quality Analytics.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on their current activities.

Board of Directors Meeting
October 3, 2019

Provider Advisory Committee (PAC) Update

September 12, 2019

PAC dedicated this meeting to hear a presentation from Tim Reilly, Founder and Partner of Pacific Health Consulting Group. Pacific Health Consulting Group has been contracted to review the CalOptima Delivery System.

PAC heard two public comments at this meeting in addition to comments from health networks and hospital representatives. PAC members also had some questions regarding reviewing the Network Strategy before it is presented to the Board in November 2019.

PAC also received a Federal and State Legislative update from Government Affairs.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

CalOptima
A Public Agency
Better. Together.

Health Homes Program Update

Board of Directors Meeting

October 3, 2019

Tracy Hitzeman, Executive Director, Clinical Operations

TC Roady, Director, Office of Compliance

Candice Gomez, Executive Director, Program Implementation

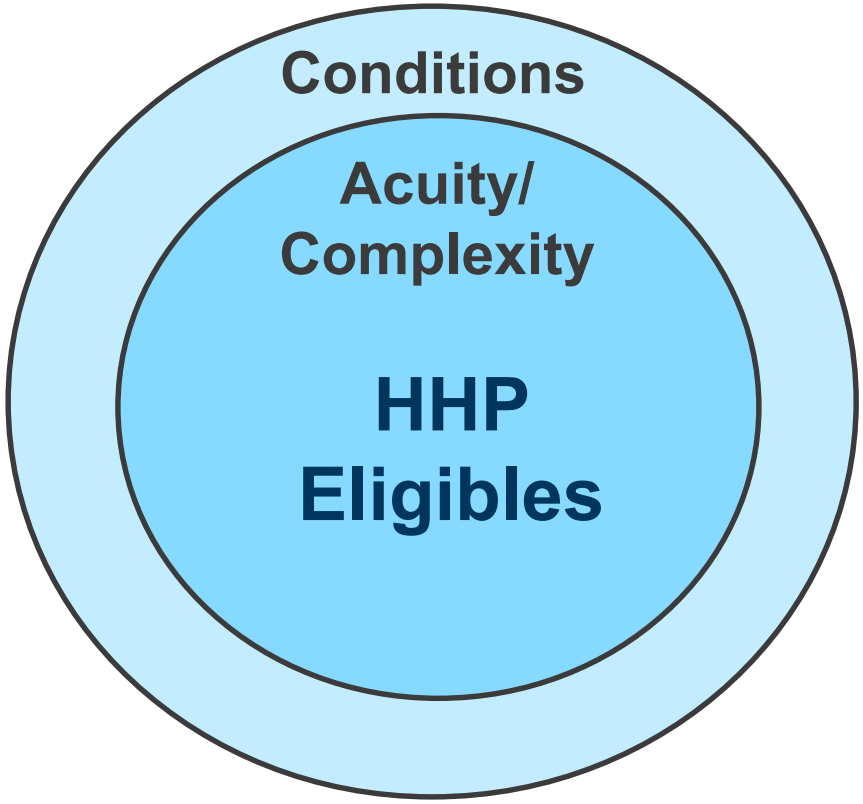
Health Homes Program (HHP)

- HHP is a clinical program that manages and coordinates care for the highest risk Medi-Cal members

- HHP is operated by managed care plans, which choose whether to participate in the program
  - Community-Based Care Management Entities (CB-CMEs) engage beneficiaries and provide care management and care coordination services
  - Managed care plans and CB-CMEs also connect members to community and social service resources, including housing

HHP Member Eligibility

- Medi-Cal members eligible for HHP must meet condition and acuity criteria
  - Conditions/combination of conditions specified by DHCS
    - Chronic physical conditions; or
    - Substance use disorder; or
    - Serious mental illness (SMI)
  - Acuity/complexity:
    - Three specified conditions; or
    - One inpatient stay; or
    - Three ED visits in year; or
    - Chronic homelessness



CalOptima Eligibility and Projected Enrollment

- Number of eligible members: 30,000
  - Chronic conditions only
  - Behavioral health only
  - Combination
- Possible opt-in rate of 10%–25%: 3,000–7,500 members
  - Number of homeless (approximately 10% of eligible members are homeless): 300–750 members
- Enrollment comparisons
  - Inland Empire Health Plan (January 2019 go-live): 10%
  - Kern Health Systems (July 2019 go-live): 25%
  - DHCS projection: 20%

HHP Core Services

HHP In-Person Services

- In-person services provided by CalOptima, the health networks or a vendor include:
  - Health Needs Assessment completion
  - Care coordination activities
  - Accompaniment to key medical appointments
  - Housing navigation and sustainability
- Vendor
  - Health network may elect to use services provided by the CalOptima vendor
    - Accompaniment to key medical appointments
    - Housing navigation and sustainability
  - Vendor will extend the same contract terms to CalOptima and the health networks

Permitted CB-CME Provider Types

- 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

CalOptima
A Public Agency
Better. Together.

COHS Plans' Experiences With HHP

- CalOptima is the only County Organized Health System (COHS) participating in HHP

Plan	Status
CalOptima	Only COHS participating in HHP
CenCal Health	Did not elect to participate
Central California Alliance for Health	Withdrew from participation citing programmatic and funding concerns
Gold Coast Health Plan	Did not elect to participate
Health Plan of San Mateo	Withdrew from participation citing trouble finding providers willing to participate as CB-CMEs
Partnership Health Plan	Withdrew from participation citing programmatic and funding concerns

Other Plans' Experiences With HHP

		Status	Notes
			• Using 20 CB-CME providers of varying types, including community clinics • Provided startup funding/grants to CB-CMEs • L.A. Care is primarily a delegated network
			• Using 50 CB-CME providers of varying types, including community clinics • Provided startup funding/grants to CB-CMEs • Also using 10 IEHP Care Teams as CB-CMEs for members who can't access other CB-CME providers for various reasons, such as contracting restrictions • IEHP enrollment is split between delegated IPAs and a direct network

Delivery Model Considerations

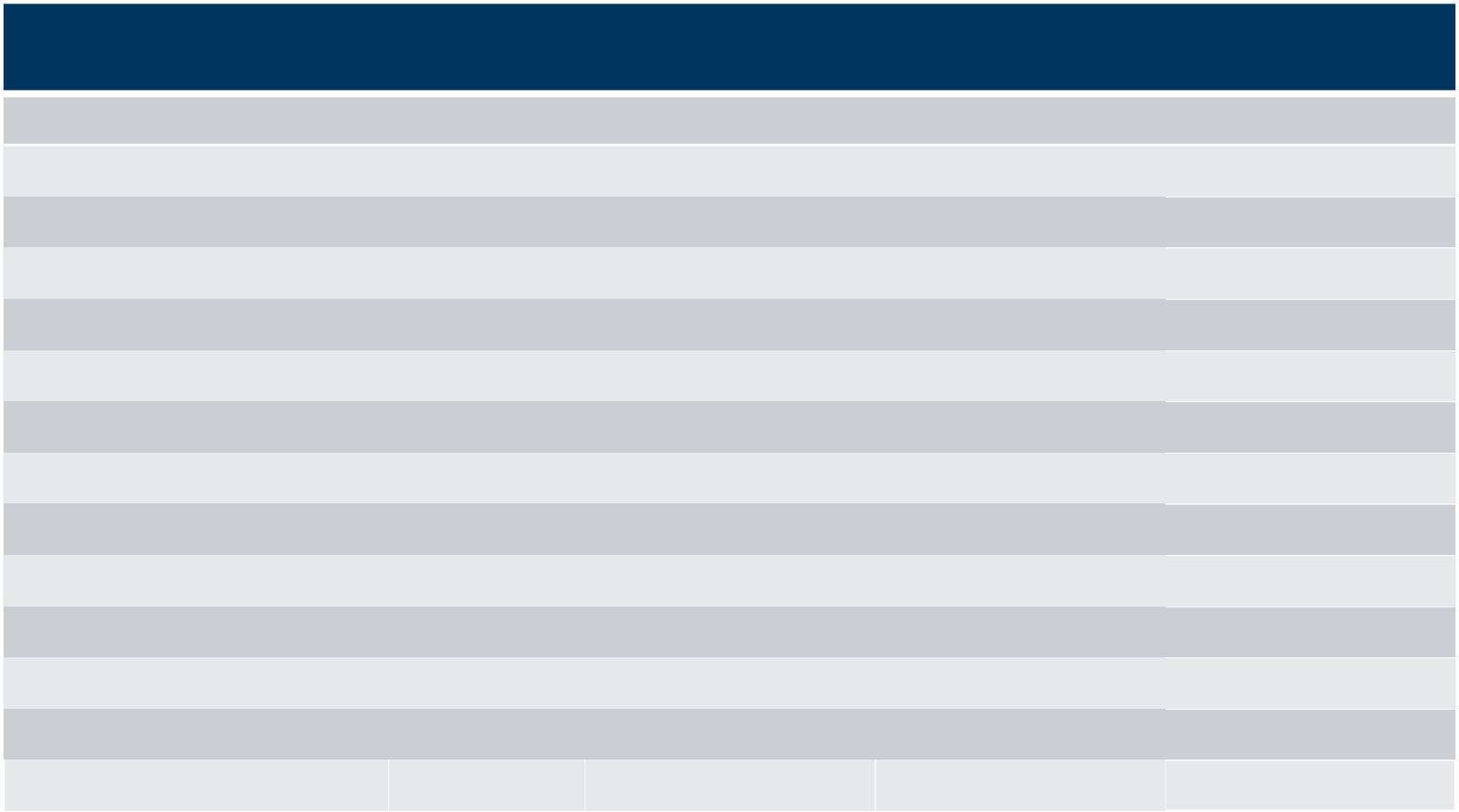
- Key factors
  - Per DHCS, members must have the ability to participate in HHP without changing health networks or PCPs
  - CB-CME must have access to all member information (e.g., records of ED visits, hospital stays, primary and specialty care, medications, care plans, community referrals, etc.)

- CalOptima member assignment
  - For primary care, 20% are assigned to a community clinic, 80% are not assigned to a community clinic
  - Majority of CalOptima members (80%) are assigned to a health network, including CalOptima Community Network

Delivery Model Considerations (Cont.)

- Leverage existing delivery system vs. build from scratch
  - Members can participate in HHP without needing to change their health network or PCP, consistent with DHCS guidance
  - Health networks have access to all member information (e.g., records of ED visits, hospital stays, primary and specialty care, medications, care plans, community referrals, etc.)
  - CalOptima HHP rates are a modest supplement to standard capitation, which already includes care management activities
  - Startup time is reduced due to health networks' existing information systems, standard workflows and experienced staff

Potential HHP Members by Health Network (August 2019)



Note: Member count may not include members overlapping with health networks within the same month

Outreach and Engagement Priorities

- CalOptima will prioritize outreach to HHP-eligible members based on:
  - Members who could benefit the most from increased care management, such as those with emerging risk for compounding health conditions
  - Members who are more likely to opt-in to HHP
  - Members who are experiencing homelessness

CalOptima
A Public Agency
Better. Together.

Outreach and Engagement Strategies

- For members experiencing homelessness, strategies include:
  - Personal care coordinator presence at shelters, recuperative care and known community “hot spots”
  - Education about HHP eligibility and referrals to Whole-Person Care (WPC) partners, hospitals and community organizations
  - Telephone contact when a valid number is known
  - Consideration for in-person contact at a hospital for frequently hospitalized members

HHP/WPC Collaboration

- CalOptima is partnering with Orange County's WPC program to:
  - Develop criteria and a systematic approach to identify HHP-eligible members within the WPC population
  - Develop training for WPC providers to proactively identify members who meet HHP eligibility criteria and refer them to CalOptima for HHP eligibility approval
  - Leverage the services already developed by WPC for the HHP population
  - Align housing supportive services for HHP, WPC and Housing for a Healthy California

HHP/WPC Collaboration (Cont.)

- WPC program:
  - Cannot duplicate services for beneficiaries also in HHP
    - Care coordination provided through HHP

- CalOptima staff will continue to collaborate with Orange County Health Care Agency, health networks and other stakeholders for Phase 2 of HHP, serving members with ~~SUD~~ Serious Mental Illness (SMI) diagnoses, ~~SMI and homelessness,~~ consistent with DHCS requirements

Rev. 10/3/19

Board Presentations Regarding HHP

- Use CalOptima Community Network (CCN) or health networks electing to participate as HHP CB-CMEs
  - September 12, 2018: Quality Assurance Committee
  - September 18, 2018: Finance and Audit Committee
- State feedback that members must be able to participate in HHP without needing to change networks or PCPs
  - March 7, 2019: Full Board
- Use all health networks, including CCN as CB-CMEs
  - May 15, 2019: Quality Assurance Committee (cancelled due to lack of quorum)
  - May 16, 2019: Finance and Audit Committee
  - June 27, 2019: Full Board
  - August 1, 2019: Full Board (continued due to lack of quorum)
  - September 5, 2019: Full Board (continued due to lack of quorum)

HHP Next Steps

September 2019

- CalOptima submission of revised program design to DHCS
- Transition from design to operational readiness meetings with health networks
- RFP vendor selection

October 2019

- Board Action (Continued from August and September 2019 meetings based on lack of quorum): Health network contract amendment, County Memorandum of Understanding (MOU) and vendor selection for housing-related services and accompaniment
- CalOptima readiness evaluation of our health networks as the CB-CMEs

November 2019

- DHCS deliverables due November 1, related to contracted CB-CME network certification
- State vendor (Harbage) conducts HHP awareness training for community stakeholders
- Continued health network and CalOptima vendor readiness activities and training
- All Medi-Cal member notices mailed for December 1 receipt

HHP Next Steps (Cont.)

December 2019

- Conclude health network readiness for CB-CME activities for Phase 1 go-live (chronic conditions)
- Community and provider education and engagement

January 2020

- HHP go-live for members with chronic conditions
- Outreach and engagement activities for HHP-eligible members begin
- Prepare for Phase 2 (SMI) DHCS deliverables

July 2020

- HHP go-live for members with SMI
- SMI member engagement

CalOptima A Public Agency Better. Together.

Post-Implementation Opportunities

- CalOptima could approach DHCS to request flexibility to add additional CB-CMEs following implementation

- Considerations for new CB-CMEs
  - Avoid duplication of services between existing and new CB-CMEs
  - Cannot force members to change PCPs or health networks
  - Consider startup costs
  - Must have ability to interface with various care management systems with health networks
  - Must have contracts and data sharing agreements with health networks

Program Future

Initiative Name	Primary Objectives	Lead Entity	Outlook	Notes
HHP	• Improve care coordination for high-risk Medi-Cal members • Community-based approach that accounts for SDOH • Improve outcomes and decrease expenses for participants	Managed Care Plan	Uncertain—continued state funding is contingent on HHP saving at least as much money as it costs to run	
WPC	• Coordination of physical health, and behavioral health, and social services in a patient-centered manner • Goals of improved health and well-being through more efficient and effective use of resources • Enhanced coordination and data-sharing among care entities, especially in service to homeless individuals			DHCS has stated that "sustainability path" for WPC efforts are through Enhanced Care Management (ECM) and In-Lieu-of Services (ILOS) under California Advancing and Innovating Medi-Cal (CalAIM)

Program Future (Cont.)

Initiative Name	Primary Objectives	Lead Entity	Outlook	Notes
CalAIM	DHCS effort to implement overarching policy changes over many years, with the objectives of: • Simplifying and streamlining delivery systems • Identifying and managing member risk and needs through population health management • Improving quality and delivery system transformation through value-based initiatives and payment reform			DHCS is considering use of ECM and ILOS to afford flexibility to managed care plans to address community-specific needs, such as recuperative care

CalOptima's Mission

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

CalOptima
A Public Agency
Better. Together.

Medi-Cal

OneCare (HMO SNP)

OneCare Connect

PACE

A Public Agency

CalOptima

Better. Together.

Financial Summary

August 2019

Board of Directors Meeting

October 3, 2019

Nancy Huang

Interim Chief Financial Officer

FY 2019-20: Consolidated Enrollment

August 2019 MTD

Overall enrollment was 762,032 members

- Actual higher than budget 10,937 members or 1.5% due to over 9,300 members from prior year (PY) retro adjustments in TANF Child
  - ➢ Medi-Cal favorable variance to budget of 10,977 members or 1.5%
    - Temporary Assistance for Needy Families (TANF) favorable variance of 11,832 members
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,348 members
    - Medi-Cal Expansion (MCE) unfavorable variance of 1,330 members
    - Whole Child Model (WCM) unfavorable variance of 896 members
    - Long-Term Care (LTC) favorable variance of 23 members
  - ➢ OneCare Connect unfavorable variance to budget of 86 members or 0.6%
- 6,139 increase from July
  - Medi-Cal increase of 6,281 members
  - OneCare Connect decrease of 167 members
  - OneCare increase of 15 members
  - PACE increase of 10 members

CalOptima A Public Agency Better. Together.

FY 2019-20: Consolidated Enrollment (cont.)

August 2019 YTD

Overall enrollment was 1,517,925 member months

- Actual higher than budget 14,008 members or 0.9% due to over 9,300 in prior year retro adjustments in TANF Child
  - Medi-Cal favorable variance of 13,977 members or 0.9%
    - TANF favorable variance of 16,085 members
    - MCE unfavorable variance of 2,498 members
    - SPD favorable variance of 2,407 members
    - WCM unfavorable variance of 2,011 members
    - LTC unfavorable variance of 6 members
  - OneCare Connect unfavorable variance of 45 members or 0.2%
  - OneCare favorable variance of 85 members or 2.8%
  - PACE unfavorable variance of 9 members or 1.3%

FY 2019-20: Consolidated Revenues

August 2019 MTD

- Actual higher than budget $3.1 million or 1.0%
  - ➢ Medi-Cal favorable to budget $2.0 million or 0.8%
    - Favorable volume variance of $4.0 million, PY enrollment adjustment impact was $1.2 million
    - Unfavorable price variance of $2.0 million
  - ➢ OneCare Connect favorable to budget $0.9 million or 3.7%
    - Unfavorable volume variance of $0.1 million
    - Favorable price variance of $1.0 million
  - ➢ OneCare favorable to budget $166.4 thousand or 10.0%
    - Favorable volume variance of $54.4 thousand
    - Favorable price variance of $111.9 thousand
  - ➢ PACE favorable to budget $17.3 thousand or 0.6%
    - Unfavorable volume variance of $23.3 thousand
    - Favorable price variance of $40.6 thousand

FY 2019-20: Consolidated Revenues (cont.)

August 2019 YTD

- Actual higher than budget $5.2 million or 0.9%
  - ➢ Medi-Cal favorable to budget $2.8 million or 0.5%
    - Favorable volume variance of $5.1 million
    - Unfavorable price variance of $2.4 million due to:
      - $6.0 million of PY revenue
      - Offset by $6.1 million of WCM revenue and $1.0 million of Hepatitis C revenue
      - OneCare Connect favorable to budget $2.0 million or 4.1%
    - Unfavorable volume variance of $0.1 million
    - Favorable price variance of $2.0 million due to favorable Medicare capitation rates

FY 2019-20: Consolidated Medical Expenses

August 2019 MTD

- Actual higher than budget $2.5 million or 0.9%
  - ➢ Medi-Cal unfavorable variance of $1.8 million or 0.7%
    - Unfavorable volume variance of $3.8 million
    - Favorable price variance of $2.0 million
      - Prescription Drug expenses favorable variance of $6.6 million due to YTD true-up
      - Professional Claims expenses unfavorable variance of $5.5 million
      - Facilities expenses unfavorable variance of $3.4 million
      - Reinsurance and Other expenses favorable variance of $2.2 million
      - Medical Management expenses favorable variance of $1.0 million
    - Due to claim lag and limited information available, most of WCM medical expenses were estimated based on budget assumptions in August 2019
  - ➢ OneCare Connect unfavorable variance of $0.9 million or 4.0%
    - Favorable volume variance of $0.1 million
    - Unfavorable price variance of $1.1 million

FY 2019-20: Consolidated Medical Expenses (cont.)

August 2019 YTD

- Actual higher than budget $10.1 million or 1.8%
  - ➢ Medi-Cal unfavorable variance of $8.8 million or 1.7%
    - Unfavorable volume variance of $4.9 million
    - Unfavorable price variance of $4.0 million
      - Professional Claims expenses unfavorable variance of $8.2 million
      - Facilities expenses unfavorable variance of $3.9 million
      - Reinsurance and Other expenses favorable variance of $4.2 million
      - Medical Management expenses favorable variance of $2.2 million
      - Provider Capitation expenses favorable variance of $1.3 million
  - ➢ OneCare Connect unfavorable variance of $1.6 million or 3.4%
    - Favorable volume variance of $0.1 million
    - Unfavorable price variance of $1.7 million

Medical Loss Ratio (MLR)

- August 2019 MTD: Actual: 95.4% Budget: 95.6%
- August 2019 YTD: Actual: 96.4% Budget: 95.6%

CalOptima A Public Agency Better. Together.

FY 2019-20: Consolidated Administrative Expenses

August 2019 MTD

- Actual lower than budget $2.2 million or 17.0%
  - Salaries, wages and benefits: favorable variance of $1.9 million
  - Other categories: favorable variance of $0.3 million

August 2019 YTD

- Actual lower than budget $4.2 million or 15.8%
  - Salaries, wages and benefits: favorable variance of $2.5 million
  - Other categories: favorable variance of $1.7 million

Administrative Loss Ratio (ALR)

- August 2019 MTD: Actual: 3.6% Budget: 4.4%
- August 2019 YTD: Actual: 3.7% Budget: 4.4%

FY 2019-20: Change in Net Assets

August 2019 MTD

- $9.1 million change in net assets
- $7.7 million favorable to budget
  - Higher than budgeted revenue of $3.1 million
  - Higher than budgeted medical expenses of $2.5 million
  - Lower than budgeted administrative expenses of $2.2 million
  - Higher than budgeted investment and other income of $4.9 million

August 2019 YTD

- $7.1 million change in net assets
- $4.7 million favorable to budget
  - Higher than budgeted revenue of $5.2 million
  - Higher than budgeted medical expenses of $10.1 million
  - Lower than budgeted administrative expenses of $4.2 million
  - Higher than budgeted investment and other income of $5.4 million

Enrollment Summary: August 2019

Month-to-Date					Year-to-Date			
Actual*	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
65,468	65,320	148	0.2%	Aged	130,720	130,508	212	0.2%
561	615	(54)	(8.8%)	BCCTP	1,127	1,230	(103)	(8.4%)
45,085	43,831	1,254	2.9%	Disabled	89,995	87,697	2,298	2.6%
296,340	286,213	10,127	3.5%	TANF Child	587,913	573,820	14,093	2.5%
89,326	87,621	1,705	1.9%	TANF Adult	177,722	175,730	1,992	1.1%
3,427	3,404	23	0.7%	LTC	6,802	6,808	(6)	(0.1%)
233,801	235,131	(1,330)	(0.6%)	MCE	467,675	470,173	(2,498)	(0.5%)
12,044	12,940	(896)	(6.9%)	WCM	23,869	25,880	(2,011)	(7.8%)
746,052	**735,075**	**10,977**	**1.5%**	**Medi-Cal**	**1,485,823**	**1,471,846**	**13,977**	**0.9%**
14,090	**14,176**	**(86)**	**(0.6%)**	**OneCare Connect**	**28,347**	**28,392**	**(45)**	**(0.2%)**
1,545	**1,496**	**49**	**3.3%**	**OneCare**	**3,075**	**2,990**	**85**	**2.8%**
345	**348**	**(3)**	**(0.9%)**	**PACE**	**680**	**689**	**(9)**	**(1.3%)**
762,032	**751,095**	**10,937**	**1.5%**	**CalOptima Total**	**1,517,925**	**1,503,917**	**14,008**	**0.9%**

*Note--August actuals include approximately 9,300 prior year retro adjustments

CalOptima
A Public Agency
Better. Together.

Financial Highlights: August 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
762,032	751,095	10,937	1.5%	Member Months	1,517,925	1,503,917	14,008	0.9%
300,911,724	297,802,512	3,109,213	1.0%	Revenues	600,482,352	595,332,013	5,150,339	0.9%
287,092,707	284,573,505	(2,519,202)	(0.9%)	Medical Expenses	579,023,910	568,956,858	(10,067,052)	(1.8%)
10,925,355	13,163,860	2,238,505	17.0%	Administrative Expenses	22,282,759	26,477,395	4,194,636	15.8%
2,893,662	**65,147**	**2,828,516**	**4341.8%**	**Operating Margin**	**(824,317)**	**(102,240)**	**(722,077)**	**-706.3%**
6,161,158	1,250,000	4,911,158	392.9%	Non Operating Income (Loss)	7,908,956	2,500,000	5,408,956	216.4%
9,054,820	**1,315,147**	**7,739,673**	**588.5%**	**Change in Net Assets**	**7,084,639**	**2,397,760**	**4,686,879**	**195.5%**
95.4%	95.6%	0.2%		Medical Loss Ratio	96.4%	95.6%	(0.9%)	
3.6%	4.4%	0.8%		Administrative Loss Ratio	3.7%	4.4%	0.7%	
1.0%	0.0%	0.9%		Operating Margin Ratio	(0.1%)	(0.0%)	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima A Public Agency Better. Together.

Consolidated Performance Actual vs. Budget: August 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
3.5	1.6	1.9	Medi-Cal	0.3	3.1	(2.8)
(1.0)	(1.5)	0.5	OCC	(1.9)	(3.1)	1.2
0.1	(0.1)	0.3	OneCare	0.5	(0.3)	0.7
0.3	0.1	0.2	PACE	0.3	0.2	0.1
2.9	**0.1**	**2.8**	**Operating**	**(0.8)**	**(0.1)**	**(0.7)**
6.2	1.3	4.9	Inv./Rental Inc, MCO tax	7.9	2.5	5.4
6.2	**1.3**	**4.9**	**Non-Operating**	**7.9**	**2.5**	**5.4**
9.1	**1.3**	**7.7**	**TOTAL**	**7.1**	**2.4**	**4.7**

CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: August 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	500,207	233,801	12,044	746,052	14,090	1,545	345	762,032
REVENUES								
Capitation Revenue	144,728,872	$ 103,099,664	$ 23,610,052	$ 271,438,587	$ 24,919,671	$ 1,828,503	$ 2,724,963	$ 300,911,724
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	144,728,872	103,099,664	23,610,052	271,438,587	24,919,671	1,828,503	2,724,963	300,911,724
MEDICAL EXPENSES								
Provider Capitation	39,534,412	45,225,166	10,226,827	94,986,405	10,914,029	462,094		106,362,528
Facilities	25,347,646	23,916,857	3,437,707	52,702,210	4,665,655	439,947	529,945	58,337,757
Ancillary	-	-	-	-	648,221	31,857	-	680,079
Professional Claims	19,800,750	8,121,939	1,235,720	29,158,409	-	-	669,213	29,827,622
Prescription Drugs	12,945,897	20,233,771	5,279,468	38,459,136	5,645,784	546,699	210,415	44,862,035
MLTSS	33,807,350	2,753,756	583,573	37,144,679	1,332,719	21,013	35,871	38,534,283
Medical Management	2,098,125	1,329,843	142,216	3,570,184	1,010,892	27,513	697,672	5,306,261
Quality Incentives	847,060	471,935	304,283	1,623,277	277,220		4,313	1,904,810
Reinsurance & Other	529,949	460,850	32,400	1,023,199	102,346		151,788	1,277,333
Total Medical Expenses	134,911,190	102,514,116	21,242,194	258,667,499	24,596,867	1,529,123	2,299,217	287,092,707
Medical Loss Ratio	93.2%	99.4%	90.0%	95.3%	98.7%	83.6%	84.4%	95.4%
GROSS MARGIN	**9,817,682**	**585,548**	**2,367,858**	**12,771,089**	**322,804**	**299,380**	**425,746**	**13,819,017**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				5,589,855	666,166	71,542	124,619	6,452,182
Professional fees				186,706	(20,619)	30,000	249	196,336
Purchased services				884,484	210,733	18,775	5,309	1,119,301
Printing & Postage				203,265	17,452	4,014	9	224,739
Depreciation & Amortization				398,581			2,092	400,673
Other expenses				2,172,074	(59,380)		2,626	2,115,320
Indirect cost allocation & Occupancy				(142,262)	519,792	35,589	3,685	416,804
Total Administrative Expenses				9,292,703	1,334,144	159,920	138,589	10,925,355
Admin Loss Ratio				3.4%	5.4%	8.7%	5.1%	3.6%
INCOME (LOSS) FROM OPERATIONS				3,478,386	(1,011,340)	139,460	287,157	2,893,662
INVESTMENT INCOME								6,161,295
TOTAL GRANT INCOME				(151)				(151)
OTHER INCOME				15				15
CHANGE IN NET ASSETS				**$ 3,478,249**	**$ (1,011,340)**	**$ 139,460**	**$ 287,157**	**$ 9,054,820**
BUDGETED CHANGE IN NET ASSETS				1,551,552	(1,463,642)	(115,560)	92,797	1,315,147
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,926,698	$ 452,302	$ 255,020	$ 194,360	$ 7,739,673

CalOptima
A Public Agency
Better. Together.

Consolidated Revenue & Expense: August 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	994,279	467,675	23,869	1,485,823	28,347	3,075	680	1,517,925
REVENUES								
Capitation Revenue	288,281,881	$ 206,762,933	$ 46,753,003	$ 541,797,817	$ 49,671,748	$ 3,646,712	$ 5,366,075	$ 600,482,352
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	288,281,881	206,762,933	46,753,003	541,797,817	49,671,748	3,646,712	5,366,075	600,482,352
MEDICAL EXPENSES								
Provider Capitation	78,349,942	89,688,224	20,376,852	188,415,019	22,203,179	945,018		211,563,216
Facilities	49,014,752	46,257,509	6,676,438	101,948,698	7,937,428	759,021	1,589,524	112,234,671
Ancillary	-	-	-	-	1,375,332	103,758	-	1,479,090
Professional Claims	36,203,524	16,483,439	2,430,540	55,117,503	-	-	1,089,546	56,207,049
Prescription Drugs	34,900,401	42,554,614	12,938,413	90,393,428	11,362,010	1,040,869	424,888	103,221,195
MLTSS	67,805,427	5,544,830	1,149,792	74,500,049	2,836,199	18,537	61,525	77,416,310
Medical Management	4,125,572	2,344,561	533,401	7,003,534	2,161,186	84,442	1,347,621	10,596,784
Quality Incentives	1,697,668	944,670	372,193	3,014,531	551,420		8,862	3,574,813
Reinsurance & Other	1,197,215	1,009,442	41,373	2,248,031	252,127		230,625	2,730,783
Total Medical Expenses	273,294,502	204,827,290	44,519,001	522,640,793	48,678,881	2,951,645	4,752,591	579,023,910
Medical Loss Ratio	94.8%	99.1%	95.2%	96.5%	98.0%	80.9%	88.6%	96.4%
GROSS MARGIN	**14,987,379**	**1,935,644**	**2,234,001**	**19,157,024**	**992,867**	**695,067**	**613,484**	**21,458,441**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				12,509,092	1,440,293	106,750	281,264	14,337,399
Professional fees				278,653	(21,469)	30,000	249	287,433
Purchased services				1,718,644	367,820	35,535	26,511	2,148,510
Printing & Postage				520,406	67,537	(4,865)	728	583,806
Depreciation & Amortization				799,840			4,184	804,024
Other expenses				3,324,766	(22,251)		5,038	3,307,553
Indirect cost allocation & Occupancy				(304,057)	1,039,584	71,178	7,327	814,032
Total Administrative Expenses				18,847,345	2,871,515	238,599	325,301	22,282,759
Admin Loss Ratio				3.5%	5.8%	6.5%	6.1%	3.7%
INCOME (LOSS) FROM OPERATIONS				309,679	(1,878,648)	456,469	288,183	(824,317)
INVESTMENT INCOME								7,909,093
TOTAL GRANT INCOME				(151)				(151)
OTHER INCOME				15				15
CHANGE IN NET ASSETS				**$ 309,543**	**$ (1,878,648)**	**$ 456,469**	**$ 288,183**	**$ 7,084,639**
BUDGETED CHANGE IN NET ASSETS				3,136,969	(3,107,483)	(290,187)	158,461	2,397,760
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,827,426)	$ 1,228,835	$ 746,656	$ 129,722	$ 4,686,879

CalOptima
A Public Agency
Better. Together.

Balance Sheet:
As of August 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$243,527,228	Accounts Payable	$7,138,624
Investments	667,764,921	Medical Claims liability	739,416,951
Capitation receivable	312,080,181	Accrued Payroll Liabilities	12,631,264
Receivables - Other	38,585,030	Deferred Revenue	62,426,886
Prepaid expenses	6,641,243	Deferred Lease Obligations	31,794
		Capitation and Withholds	131,031,756
Total Current Assets	**1,268,598,602**	**Total Current Liabilities**	**952,677,275**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	8,814,963		
505 City Parkway West	50,489,717		
	96,391,045		
Less: accumulated depreciation	(47,718,929)		
Capital assets, net	48,672,116	Other (than pensions) post employment benefits liability	24,948,553
Other Assets		Net Pension Liabilities	23,386,495
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,001,012,324**
Cash and Cash Equivalents	2,473,277		
Long-term Investments	561,713,310	Deferred Inflows	
Total Board-designated Assets	564,186,586	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	622,685,499	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**1,939,956,218**	TNE	93,332,612
Deferred Outflows		Funds in Excess of TNE	849,294,897
Contributions	686,962	**TOTAL NET POSITION**	942,627,509
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,951,046,667**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,951,046,667**

CalOptima
A Public Agency
Better. Together.

Board Designated Reserve and TNE Analysis
As of August 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	154,696,265				
	Tier 1 - Logan Circle	153,368,808				
	Tier 1 - Wells Capital	153,900,688				
Board-designated Reserve		461,965,760	334,693,548	518,133,330	127,272,213	(56,167,570)
TNE Requirement	Tier 2 - Logan Circle	102,220,826	93,332,612	93,332,612	8,888,214	8,888,214
	Consolidated:	564,186,586	428,026,159	611,465,942	136,160,427	(47,279,356)
	Current reserve level	*1.85*	*1.40*	*2.00*		


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

UNAUDITED FINANCIAL STATEMENTS

August 2019

Back to Agenda

Table of Contents

Back to Agenda

August 31, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $9.1 million, $7.7 million favorable to budget
- Operating surplus is $2.9 million, with a surplus in non-operating income of $6.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $7.1 million, $4.7 million favorable to budget
- Operating deficit is $0.8 million, with a surplus in non-operating income of $7.9 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
3.5	1.6	1.9	Medi-Cal	0.3	3.1	(2.8)
(1.0)	(1.5)	0.5	OCC	(1.9)	(3.1)	1.2
0.1	(0.1)	0.3	OneCare	0.5	(0.3)	0.7
0.3	0.1	0.2	PACE	0.3	0.2	0.1
2.9	**0.1**	**2.8**	**Operating**	**(0.8)**	**(0.1)**	**(0.7)**
6.2	1.3	4.9	Inv./Rental Inc, MCO tax	7.9	2.5	5.4
6.2	**1.3**	**4.9**	**Non-Operating**	**7.9**	**2.5**	**5.4**
9.1	**1.3**	**7.7**	**TOTAL**	**7.1**	**2.4**	**4.7**

CalOptima - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
762,032	751,095	10,937	1.5%	Member Months	1,517,925	1,503,917	14,008	0.9%
300,911,724	297,802,512	3,109,213	1.0%	Revenues	600,482,352	595,332,013	5,150,339	0.9%
287,092,707	284,573,505	(2,519,202)	(0.9%)	Medical Expenses	579,023,910	568,956,858	(10,067,052)	(1.8%)
10,925,355	13,163,860	2,238,505	17.0%	Administrative Expenses	22,282,759	26,477,395	4,194,636	15.8%
2,893,662	**65,147**	**2,828,516**	**4341.8%**	**Operating Margin**	**(824,317)**	**(102,240)**	**(722,077)**	**-706.3%**
6,161,158	1,250,000	4,911,158	392.9%	Non Operating Income (Loss)	7,908,956	2,500,000	5,408,956	216.4%
9,054,820	**1,315,147**	**7,739,673**	**588.5%**	**Change in Net Assets**	**7,084,639**	**2,397,760**	**4,686,879**	**195.5%**
95.4%	95.6%	0.2%		Medical Loss Ratio	96.4%	95.6%	(0.9%)	
3.6%	4.4%	0.8%		Administrative Loss Ratio	3.7%	4.4%	0.7%	
1.0%	0.0%	0.9%		Operating Margin Ratio	(0.1%)	(0.0%)	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima
Financial Dashboard
For the Two Months Ended August 31, 2019

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	746,052	735,075	10,977	1 5%
OneCare Connect	14,090	14,176	(86)	(0 6%)
OneCare	1,545	1,496	49	3 3%
PACE	345	348	(3)	(0 9%)
Total	762,032	751,095	10,937	1 5%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 3,478	$ 1,552	$ 1,926	124 1%
OneCare Connect	(1,011)	(1,464)	453	30 9%
OneCare	139	(116)	255	219 8%
PACE	287	93	194	208 6%
505 Bldg	-	-	-	0 0%
Investment Income & Other	6,161	1,250	4,911	392 9%
Total	$ 9,054	$ 1,315	$ 7,739	588 5%

MLR	Actual	Budget	% Point Var
Medi-Cal	95 3%	95 3%	0 1
OneCare Connect	98 7%	98 4%	(0 3)
OneCare	83 6%	98 0%	14 4

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,293	$ 10,979	$ 1,686	15 4%
OneCare Connect	1,334	1,849	514	27 8%
OneCare	160	149	(11)	(7 5%)
PACE	139	187	49	26 1%
Total	$ 10,925	$ 13,164	$ 2,239	17 0%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	929	1,145	217
OneCare Connect	172	200	28
OneCare	9	9	0
PACE	71	91	20
Total	1,180	1,445	265

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	803	642	162
OneCare Connect	82	71	11
OneCare	174	161	13
PACE	5	4	1
Total	1,064	877	187

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	1,485,823	1,471,846	13,977	0 9%
OneCare Connect	28,347	28,392	(45)	(0 2%)
OneCare	3,075	2,990	85	2 8%
PACE	680	689	(9)	(1 3%)
Total	1,517,925	1,503,917	14,008	0 9%

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 310	$ 3,137	$ (2,827)	(90 1%)
OneCare Connect	(1,879)	(3,107)	1,228	39 5%
OneCare	456	(290)	746	257 2%
PACE	288	158	130	82 3%
505 Bldg	-	-	-	0 0%
Investment Income & Other	7,909	2,500	5,409	216 4%
Total	$ 7,084	$ 2,398	$ 4,686	195 4%

MLR	Actual	Budget	% Point Var
Medi-Cal	96 5%	95 3%	(1 1)
OneCare Connect	98 0%	98 7%	0 7
OneCare	80 9%	99 7%	18 8

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 18,847	$ 22,097	$ 3,249	14 7%
OneCare Connect	2,872	3,706	834	22 5%
OneCare	239	299	60	20 1%
PACE	325	377	51	13 6%
Total	$ 22,283	$ 26,477	$ 4,195	15 8%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,840	2,291	451
OneCare Connect	372	400	27
OneCare	12	19	7
PACE	140	181	41
Total	2,364	2,890	526

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	807	642	165
OneCare Connect	76	71	5
OneCare	255	161	94
PACE	5	4	1
Total	1,143	878	265

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended August 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	762,032		751,095		10,937	
REVENUE						
Medi-Cal	$ 271,438,587	$ 363.83	$ 269,393,894	$ 366.48	$ 2,044,694	$ (2.65)
OneCare Connect	24,919,671	1,768.61	24,038,800	1,695.86	880,871	72.75
OneCare	1,828,503	1,183 50	1,662,130	1,111.05	166,373	72.45
PACE	2,724,963	7,898.44	2,707,688	7,780.71	17,275	117.73
Total Operating Revenue	300,911,724	394.88	297,802,512	396.49	3,109,213	(1.61)
MEDICAL EXPENSES						
Medi-Cal	258,667,499	346.72	256,863,217	349.44	(1,804,282)	2.72
OneCare Connect	24,596,867	1,745.70	23,653,899	1,668.71	(942,968)	(76.99)
OneCare	1,529,123	989.72	1,628,914	1,088.85	99,791	99.13
PACE	2,299,217	6,664.40	2,427,475	6,975.50	128,258	311.10
Total Medical Expenses	287,092,707	376.75	284,573,505	378.88	(2,519,202)	2.13
GROSS MARGIN	13,819,017	18.13	13,229,007	17.61	590,011	0.52
ADMINISTRATIVE EXPENSES						
Salaries and benefits	6,452,182	8.47	8,360,935	11.13	1,908,753	2.66
Professional fees	196,336	0.26	443,468	0.59	247,132	0.33
Purchased services	1,119,301	1.47	1,233,276	1.64	113,975	0.17
Printing & Postage	224,739	0.29	565,630	0.75	340,891	0.46
Depreciation & Amortization	400,673	0.53	457,866	0.61	57,193	0.08
Other expenses	2,115,320	2.78	1,716,776	2.29	(398,544)	(0.49)
Indirect cost allocation & Occupancy expense	416,804	0.55	385,909	0.51	(30,895)	(0.04)
Total Administrative Expenses	10,925,355	14.34	13,163,860	17.53	2,238,505	3.19
INCOME (LOSS) FROM OPERATIONS	2,893,662	3.80	65,147	0.09	2,828,516	3.71
INVESTMENT INCOME						
Interest income	3,000,053	3.94	1,250,000	1.66	1,750,053	2.28
Realized gain/(loss) on investments	417,842	0.55	-	-	417,842	0.55
Unrealized gain/(loss) on investments	2,743,399	3.60	-	-	2,743,399	3.60
Total Investment Income	6,161,295	8.09	1,250,000	1.66	4,911,295	6.43
TOTAL GRANT INCOME	(151)	-	-	-	(151)	-
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**9,054,820**	**11.88**	**1,315,147**	**1.75**	**7,739,673**	**10.13**
MEDICAL LOSS RATIO	**95.4%**		**95.6%**		**0 2%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.4%**		**0 8%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	1,517,925		1,503,917		14,008	
REVENUE						
Medi-Cal	$ 541,797,817	$ 364.64	$ 539,035,185	$ 366.23	$ 2,762,632	$ (1.59)
OneCare Connect	49,671,748	1,752.28	47,697,518	1,680.02	1,974,230	72.26
OneCare	3,646,712	1,185.92	3,236,613	1,082.48	410,099	103.44
PACE	5,366,075	7,891.29	5,362,697	7,783.30	3,378	107.99
Total Operating Revenue	600,482,352	395.59	595,332,013	395.85	5,150,339	(0.26)
MEDICAL EXPENSES						
Medi-Cal	522,640,793	351.75	513,801,550	349.09	(8,839,243)	(2.66)
OneCare Connect	48,678,881	1,717.25	47,099,333	1,658.95	(1,579,548)	(58.30)
OneCare	2,951,645	959.88	3,228,271	1,079.69	276,626	119.81
PACE	4,752,591	6,989.10	4,827,704	7,006.83	75,113	17.73
Total Medical Expenses	579,023,910	381.46	568,956,858	378.32	(10,067,052)	(3.14)
GROSS MARGIN	21,458,441	14.13	26,375,155	17.53	(4,916,713)	(3.40)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	14,337,399	9.45	16,844,512	11.20	2,507,113	1.75
Professional fees	287,433	0.19	905,603	0.60	618,170	0.41
Purchased services	2,148,510	1.42	2,466,552	1.64	318,042	0.22
Printing & Postage	583,806	0.38	1,131,260	0.75	547,454	0.37
Depreciation & Amortization	804,024	0.53	915,732	0.61	111,708	0.08
Other expenses	3,307,553	2.18	3,440,896	2.29	133,343	0.11
Indirect cost allocation & Occupancy expense	814,032	0.54	772,840	0.51	(41,192)	(0.03)
Total Administrative Expenses	22,282,759	14.68	26,477,395	17.61	4,194,636	2.93
INCOME (LOSS) FROM OPERATIONS	(824,317)	(0.54)	(102,240)	(0.07)	(722,077)	(0.47)
INVESTMENT INCOME						
Interest income	6,003,681	3.96	2,500,000	1.66	3,503,681	2.30
Realized gain/(loss) on investments	694,180	0.46	-	-	694,180	0.46
Unrealized gain/(loss) on investments	1,211,233	0.80	-	-	1,211,233	0.80
Total Investment Income	7,909,093	5.21	2,500,000	1.66	5,409,093	3.55
TOTAL GRANT INCOME	(151)	-	-	-	(151)	-
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**7,084,639**	**4.67**	**2,397,760**	**1.59**	**4,686,879**	**3.08**
MEDICAL LOSS RATIO	**96.4%**		**95.6%**		**(0.9%)**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.4%**		**0.7%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended August 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	500,207	233,801	12,044	746,052	14,090	1,545	345	762,032
REVENUES								
Capitation Revenue	144,728,872	$ 103,099,664	$ 23,610,052	$ 271,438,587	$ 24,919,671	$ 1,828,503	$ 2,724,963	$ 300,911,724
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	144,728,872	103,099,664	23,610,052	271,438,587	24,919,671	1,828,503	2,724,963	300,911,724
MEDICAL EXPENSES								
Provider Capitation	39,534,412	45,225,166	10,226,827	94,986,405	10,914,029	462,094		106,362,528
Facilities	25,347,646	23,916,857	3,437,707	52,702,210	4,665,655	439,947	529,945	58,337,757
Ancillary	-	-	-	-	648,221	31,857	-	680,079
Professional Claims	19,800,750	8,121,939	1,235,720	29,158,409	-	-	669,213	29,827,622
Prescription Drugs	12,945,897	20,233,771	5,279,468	38,459,136	5,645,784	546,699	210,415	44,862,035
MLTSS	33,807,350	2,753,756	583,573	37,144,679	1,332,719	21,013	35,871	38,534,283
Medical Management	2,098,125	1,329,843	142,216	3,570,184	1,010,892	27,513	697,672	5,306,261
Quality Incentives	847,060	471,935	304,283	1,623,277	277,220		4,313	1,904,810
Reinsurance & Other	529,949	460,850	32,400	1,023,199	102,346		151,788	1,277,333
Total Medical Expenses	134,911,190	102,514,116	21,242,194	258,667,499	24,596,867	1,529,123	2,299,217	287,092,707
Medical Loss Ratio	93 2%	99 4%	90 0%	95 3%	98 7%	83 6%	84 4%	95 4%
GROSS MARGIN	**9,817,682**	**585,548**	**2,367,858**	**12,771,089**	**322,804**	**299,380**	**425,746**	**13,819,017**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				5,589,855	666,166	71,542	124,619	6,452,182
Professional fees				186,706	(20,619)	30,000	249	196,336
Purchased services				884,484	210,733	18,775	5,309	1,119,301
Printing & Postage				203,265	17,452	4,014	9	224,739
Depreciation & Amortization				398,581			2,092	400,673
Other expenses				2,172,074	(59,380)		2,626	2,115,320
Indirect cost allocation & Occupancy				(142,262)	519,792	35,589	3,685	416,804
Total Administrative Expenses				9,292,703	1,334,144	159,920	138,589	10,925,355
Admin Loss Ratio				3 4%	5 4%	8 7%	5 1%	3 6%
INCOME (LOSS) FROM OPERATIONS				3,478,386	(1,011,340)	139,460	287,157	2,893,662
INVESTMENT INCOME								6,161,295
TOTAL GRANT INCOME				(151)				(151)
OTHER INCOME				15				15
CHANGE IN NET ASSETS				**$ 3,478,249**	**$ (1,011,340)**	**$ 139,460**	**$ 287,157**	**$ 9,054,820**
BUDGETED CHANGE IN NET ASSETS				1,551,552	(1,463,642)	(115,560)	92,797	1,315,147
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,926,698	$ 452,302	$ 255,020	$ 194,360	$ 7,739,673

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	994,279	467,675	23,869	1,485,823	28,347	3,075	680	1,517,925
REVENUES								
Capitation Revenue	288,281,881	$ 206,762,933	$ 46,753,003	$ 541,797,817	$ 49,671,748	$ 3,646,712	$ 5,366,075	$ 600,482,352
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	288,281,881	206,762,933	46,753,003	541,797,817	49,671,748	3,646,712	5,366,075	600,482,352
MEDICAL EXPENSES								
Provider Capitation	78,349,942	89,688,224	20,376,852	188,415,019	22,203,179	945,018		211,563,216
Facilities	49,014,752	46,257,509	6,676,438	101,948,698	7,937,428	759,021	1,589,524	112,234,671
Ancillary	-	-	-	-	1,375,332	103,758	-	1,479,090
Professional Claims	36,203,524	16,483,439	2,430,540	55,117,503	-	-	1,089,546	56,207,049
Prescription Drugs	34,900,401	42,554,614	12,938,413	90,393,428	11,362,010	1,040,869	424,888	103,221,195
MLTSS	67,805,427	5,544,830	1,149,792	74,500,049	2,836,199	18,537	61,525	77,416,310
Medical Management	4,125,572	2,344,561	533,401	7,003,534	2,161,186	84,442	1,347,621	10,596,784
Quality Incentives	1,697,668	944,670	372,193	3,014,531	551,420		8,862	3,574,813
Reinsurance & Other	1,197,215	1,009,442	41,373	2,248,031	252,127		230,625	2,730,783
Total Medical Expenses	273,294,502	204,827,290	44,519,001	522,640,793	48,678,881	2,951,645	4,752,591	579,023,910
Medical Loss Ratio	94 8%	99 1%	95 2%	96 5%	98 0%	80 9%	88 6%	96 4%
GROSS MARGIN	**14,987,379**	**1,935,644**	**2,234,001**	**19,157,024**	**992,867**	**695,067**	**613,484**	**21,458,441**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				12,509,092	1,440,293	106,750	281,264	14,337,399
Professional fees				278,653	(21,469)	30,000	249	287,433
Purchased services				1,718,644	367,820	35,535	26,511	2,148,510
Printing & Postage				520,406	67,537	(4,865)	728	583,806
Depreciation & Amortization				799,840			4,184	804,024
Other expenses				3,324,766	(22,251)		5,038	3,307,553
Indirect cost allocation & Occupancy				(304,057)	1,039,584	71,178	7,327	814,032
Total Administrative Expenses				18,847,345	2,871,515	238,599	325,301	22,282,759
Admin Loss Ratio				3 5%	5 8%	6 5%	6 1%	3 7%
INCOME (LOSS) FROM OPERATIONS				309,679	(1,878,648)	456,469	288,183	(824,317)
INVESTMENT INCOME								7,909,093
TOTAL GRANT INCOME				(151)				(151)
OTHER INCOME				15				15
CHANGE IN NET ASSETS				**$ 309,543**	**$ (1,878,648)**	**$ 456,469**	**$ 288,183**	**$ 7,084,639**
BUDGETED CHANGE IN NET ASSETS				3,136,969	(3,107,483)	(290,187)	158,461	2,397,760
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,827,426)	$ 1,228,835	$ 746,656	$ 129,722	$ 4,686,879

CalOptima - Consolidated

Enrollment Summary

For the Two Months Ended August 31, 2019

Month-to-Date					Year-to-Date			
Actual*	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
65,468	65,320	148	0.2%	Aged	130,720	130,508	212	0.2%
561	615	(54)	(8.8%)	BCCTP	1,127	1,230	(103)	(8.4%)
45,085	43,831	1,254	2.9%	Disabled	89,995	87,697	2,298	2.6%
296,340	286,213	10,127	3.5%	TANF Child	587,913	573,820	14,093	2.5%
89,326	87,621	1,705	1.9%	TANF Adult	177,722	175,730	1,992	1.1%
3,427	3,404	23	0.7%	LTC	6,802	6,808	(6)	(0.1%)
233,801	235,131	(1,330)	(0.6%)	MCE	467,675	470,173	(2,498)	(0.5%)
12,044	12,940	(896)	(6.9%)	WCM	23,869	25,880	(2,011)	(7.8%)
746,052	**735,075**	**10,977**	**1.5%**	**Medi-Cal**	**1,485,823**	**1,471,846**	**13,977**	**0.9%**
14,090	**14,176**	**(86)**	**(0.6%)**	**OneCare Connect**	**28,347**	**28,392**	**(45)**	**(0.2%)**
1,545	**1,496**	**49**	**3.3%**	**OneCare**	**3,075**	**2,990**	**85**	**2.8%**
345	**348**	**(3)**	**(0.9%)**	**PACE**	**680**	**689**	**(9)**	**(1.3%)**
762,032	**751,095**	**10,937**	**1.5%**	**CalOptima Total**	**1,517,925**	**1,503,917**	**14,008**	**0.9%**

*Note--August actuals include approximately 9,300 prior year retro adjustments

Enrollment (By Network)

162,896	163,038	(142)	(0.1%)	HMO	326,150	326,432	(282)	(0.1%)
211,247	210,897	350	0.2%	PHC	422,744	422,489	255	0.1%
187,219	188,431	(1,212)	(0.6%)	Shared Risk Group	376,363	377,342	(979)	(0.3%)
184,690	172,709	11,981	6.9%	Fee for Service	360,566	345,583	14,983	4.3%
746,052	**735,075**	**10,977**	**1.5%**	**Medi-Cal**	**1,485,823**	**1,471,846**	**13,977**	**0.9%**
14,090	**14,176**	**(86)**	**(0.6%)**	**OneCare Connect**	**28,347**	**28,392**	**(45)**	**(0.2%)**
1,545	**1,496**	**49**	**3.3%**	**OneCare**	**3,075**	**2,990**	**85**	**2.8%**
345	**348**	**(3)**	**(0.9%)**	**PACE**	**680**	**689**	**(9)**	**(1.3%)**
762,032	**751,095**	**10,937**	**1.5%**	**CalOptima Total**	**1,517,925**	**1,503,917**	**14,008**	**0.9%**

CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2020

Network Type	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	MMs
HMO													
Aged	3,723	3,740											7,463
BCCTP	1	1											2
Disabled	6,539	6,547											13,086
TANF Child	54,046	53,703											107,749
TANF Adult	27,944	27,740											55,684
LTC	2	1											3
MCE	68,973	69,077											138,050
WCM	2,026	2,087											4,113
	163,254	**162,896**											**326,150**
PHC													
Aged	1,548	1,540											3,088
BCCTP	-	-											-
Disabled	5,416	5,499											10,915
TANF Child	148,665	148,131											296,796
TANF Adult	11,149	11,322											22,471
LTC	-	-											-
MCE	37,510	37,479											74,989
WCM	7,209	7,276											14,485
	211,497	**211,247**											**422,744**
Shared Risk Group													
Aged	3,569	3,523											7,092
BCCTP	-	-											-
Disabled	7,275	7,294											14,569
TANF Child	63,291	62,381											125,672
TANF Adult	28,681	28,390											57,071
LTC	1	3											4
MCE	84,595	83,922											168,517
WCM	1,732	1,706											3,438
	189,144	**187,219**											**376,363**
Fee for Service (Dual)													
Aged	51,730	52,454											104,184
BCCTP	15	18											33
Disabled	20,752	20,053											40,805
TANF Child	-	19											19
TANF Adult	964	1,923											2,887
LTC	3,044	3,097											6,141
MCE	2,116	2,171											4,287
WCM	15	15											30
	78,636	**79,750**											**158,386**
Fee for Service (Non-Dual)													
Aged	4,682	4,211											8,893
BCCTP	550	542											1,092
Disabled	4,928	5,692											10,620
TANF Child	25,571	32,106											57,677
TANF Adult	19,658	19,951											39,609
LTC	328	326											654
MCE	40,680	41,152											81,832
WCM	843	960											1,803
	97,240	**104,940**											**202,180**
MEDI-CAL TOTAL													
Aged	65,252	65,468											130,720
BCCTP	566	561											1,127
Disabled	44,910	45,085											89,995
TANF Child	291,573	296,340											587,913
TANF Adult	88,396	89,326											177,722
LTC	3,375	3,427											6,802
MCE	233,874	233,801											467,675
WCM	11,825	12,044											23,869
	739,771	**746,052**											**1,485,823**
OneCare Connect	14,257	14,090											28,347
OneCare	1,530	1,545											3,075
PACE	335	345											680
TOTAL	**755,893**	**762,032**											**1,517,925**

ENROLLMENT:

Overall August enrollment was 762,032

- Favorable to budget 10,937 or 1.5%. August enrollment includes 9,300 members from prior year (PY) retro adjustments in TANF Child
- Increased 6,139 or 0.8% from prior month (July 2019)
- Decreased 13,809 or 1.8% from PY (August 2018)

Medi-Cal enrollment was 746,052

- Favorable to budget 10,977 or 1.5%
    - Temporary Assistance for Needy Families (TANF) favorable 11,832 due to retroactive adjustments of 4,989 for fiscal year (FY) 2019, 2,942 for FY 2018, and 1,442 for FY 2017. The remaining variance is from FY 2020
    - Seniors and Persons with Disabilities (SPD) favorable 1,348
    - Medi-Cal Expansion (MCE) unfavorable 1,330
    - Whole Child Model (WCM) unfavorable 896
    - Long-Term Care (LTC) favorable 23
- Increased 6,281 from prior month

OneCare Connect enrollment was 14,090

- Unfavorable to budget 86 or 0.6%
- Decreased 167 from prior month

OneCare enrollment was 1,545

- Favorable to budget 49 or 3.3%
- Increased 15 from prior month

PACE enrollment was 345

- Unfavorable to budget 3 or 0.9%
- Increased 10 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
746,052	**735,075**	**10,977**	**1.5%**	**Member Months**	**1,485,823**	**1,471,846**	**13,977**	**0.9%**
				Revenues				
271,438,587	269,393,894	2,044,694	0 8%	Capitation revenue	541,797,817	539,035,185	2,762,632	0 5%
-	-	-	0 0%	Other income	-	-	-	0 0%
271,438,587	**269,393,894**	**2,044,694**	**0.8%**	**Total Operating Revenue**	**541,797,817**	**539,035,185**	**2,762,632**	**0.5%**
				Medical Expenses				
96,609,682	95,339,517	(1,270,165)	(1 3%)	Provider capitation	191,429,550	190,889,774	(539,776)	(0 3%)
52,702,210	48,612,723	(4,089,487)	(8 4%)	Facilities	101,948,698	97,154,598	(4,794,100)	(4 9%)
29,158,409	23,278,734	(5,879,675)	(25 3%)	Professional Claims	55,117,503	46,503,836	(8,613,667)	(18 5%)
38,459,136	44,421,607	5,962,471	13 4%	Prescription drugs	90,393,428	88,820,615	(1,572,813)	(1 8%)
37,144,679	37,460,336	315,657	0 8%	MLTSS	74,500,049	74,872,352	372,304	0 5%
3,570,184	4,541,282	971,098	21 4%	Medical management	7,003,534	9,149,324	2,145,790	23 5%
1,023,199	3,209,018	2,185,819	68 1%	Reinsurance & other	2,248,031	6,411,051	4,163,021	64 9%
258,667,499	**256,863,217**	**(1,804,282)**	**(0.7%)**	**Total Medical Expenses**	**522,640,793**	**513,801,550**	**(8,839,243)**	**(1.7%)**
12,771,088	**12,530,677**	**240,412**	**1.9%**	**Gross Margin**	**19,157,024**	**25,233,635**	**(6,076,611)**	**(24.1%)**
				Administrative Expenses				
5,589,855	7,319,885	1,730,030	23 6%	Salaries, wages & employee benefits	12,509,092	14,751,112	2,242,020	15 2%
186,706	344,039	157,333	45 7%	Professional fees	278,653	706,745	428,092	60 6%
884,484	954,253	69,769	7 3%	Purchased services	1,718,644	1,908,506	189,862	9 9%
203,265	442,570	239,305	54 1%	Printing and postage	520,406	885,140	364,734	41 2%
398,581	455,750	57,169	12 5%	Depreciation and amortization	799,840	911,500	111,660	12 3%
2,172,074	1,636,015	(536,059)	(32 8%)	Other operating expenses	3,324,766	3,279,373	(45,393)	(1 4%)
(142,262)	(173,387)	(31,125)	(18 0%)	Indirect cost allocation, Occupancy Expense	(304,057)	(345,710)	(41,653)	(12 0%)
9,292,703	**10,979,125**	**1,686,422**	**15.4%**	**Total Administrative Expenses**	**18,847,345**	**22,096,666**	**3,249,321**	**14.7%**
				Operating Tax				
-	11,332,427	(11,332,427)	(100 0%)	Tax Revenue	-	22,690,549	(22,690,549)	(100 0%)
-	11,332,427	11,332,427	100 0%	Premium tax expense	-	22,690,549	22,690,549	100 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
9,683	-	9,683	0 0%	Grant Revenue	18,592	-	18,592	0 0%
-	-	-	0 0%	Grant expense - Service Partner	-	-	-	0 0%
9,835	-	(9,835)	0 0%	Grant expense - Administrative	18,744	-	(18,744)	0 0%
(151)	-	(151)	**0.0%**	**Total Grant Income**	(151)	-	(151)	**0.0%**
15	**-**	**15**	**0.0%**	**Other income**	**15**	**-**	**15**	**0.0%**
3,478,249	**1,551,552**	**1,926,698**	**124.2%**	**Change in Net Assets**	**309,543**	**3,136,969**	**(2,827,426)**	**(90.1%)**
95.3%	***95.3%***	***0.1%***	***0.1%***	***Medical Loss Ratio***	***96.5%***	***95.3%***	***(1.1%)***	***(1.2%)***
3.4%	***4.1%***	***0.7%***	***16.0%***	***Admin Loss Ratio***	***3.5%***	***4.1%***	***0.6%***	***15.1%***

MEDI-CAL INCOME STATEMENT - AUGUST MONTH:

REVENUES of $271.4 million are favorable to budget $2.0 million driven by:

- Favorable volume related variance of $4.0 million
- Unfavorable price related variance of $2.0 million due to:
  - ➢ $2.8 million of revenue from WCM
  - ➢ $0.5 million of Hepatitis C revenue
  - ➢ Offset by $1.2 million of PY revenue due to retroactive enrollment adjustments

MEDICAL EXPENSES of $258.7 million are unfavorable to budget $1.8 million driven by:

- ❖ Due to claim lag and limited information available, most of WCM medical expenses were estimated based on budget assumptions in August 2019

- **Professional Claims** expense is unfavorable to budget $5.9 million, due to:
  - ➢ $3.9 million of Behavioral Health Treatment (BHT) expenses
  - ➢ $1.5 million of crossover expenses
- **Facilities** expense is unfavorable to budget $4.1 million due to:
  - ➢ $2.3 million of in-patient expenses
  - ➢ $1.3 million of crossover expenses
  - ➢ $0.7 million of shared risk expenses
- **Provider Capitation** expense is unfavorable to budget $1.3 million
- **Prescription Drug** expense is favorable to budget $6.0 million due to YTD true-up

ADMINISTRATIVE EXPENSES of $9.3 million are favorable to budget $1.7 million driven by:

- Salaries & Benefit expenses are favorable to budget $1.7 million due to open positions
- Other Non-Salary expenses are slightly unfavorable to budget

CHANGE IN NET ASSETS is $3.5 million for the month, favorable to budget $1.9 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Two Months Ending August 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,090	**14,176**	**(86)**	**(0.6%)**	**Member Months**	**28,347**	**28,392**	**(45)**	**(0.2%)**
				Revenues				
2,520,529	2,804,297	(283,768)	(10.1%)	Medi-Cal Capitation revenue	4,809,051	5,620,873	(811,822)	(14.4%)
16,845,099	16,423,847	421,252	2.6%	Medicare Capitation revenue part C	33,657,962	32,488,711	1,169,251	3.6%
5,554,043	4,810,656	743,387	15.5%	Medicare Capitation revenue part D	11,204,736	9,587,934	1,616,802	16.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
24,919,671	**24,038,800**	**880,871**	**3.7%**	**Total Operating Revenue**	**49,671,748**	**47,697,518**	**1,974,230**	**4.1%**
				Medical Expenses				
11,191,249	11,053,268	(137,981)	(1.2%)	Provider capitation	22,754,599	21,913,482	(841,117)	(3.8%)
4,665,655	3,523,533	(1,142,122)	(32.4%)	Facilities	7,937,428	7,010,180	(927,248)	(13.2%)
648,221	686,072	37,851	5.5%	Ancillary	1,375,332	1,370,191	(5,141)	(0.4%)
1,332,719	1,581,298	248,579	15.7%	Long Term Care	2,836,199	3,168,693	332,494	10.5%
5,645,784	5,472,123	(173,661)	(3.2%)	Prescription drugs	11,362,010	10,945,475	(416,535)	(3.8%)
1,010,892	1,121,356	110,464	9.9%	Medical management	2,161,186	2,259,621	98,435	4.4%
102,346	216,249	113,903	52.7%	Other medical expenses	252,127	431,691	179,564	41.6%
24,596,867	**23,653,899**	**(942,968)**	**(4.0%)**	**Total Medical Expenses**	**48,678,881**	**47,099,333**	**(1,579,548)**	**(3.4%)**
322,804	**384,901**	**(62,097)**	**(16.1%)**	**Gross Margin**	**992,867**	**598,185**	**394,682**	**66.0%**
				Administrative Expenses				
666,166	840,218	174,052	20.7%	Salaries, wages & employee benefits	1,440,293	1,689,018	248,725	14.7%
(20,619)	77,796	98,415	126.5%	Professional fees	(21,469)	155,592	177,061	113.8%
210,733	242,989	32,256	13.3%	Purchased services	367,820	485,978	118,158	24.3%
17,452	95,860	78,408	81.8%	Printing and postage	67,537	191,720	124,183	64.8%
-	-	-	0.0%	Depreciation & amortization	-	-	-	0.0%
(59,380)	71,888	131,268	182.6%	Other operating expenses	(22,251)	143,776	166,027	115.5%
519,792	519,792	-	0.0%	Indirect cost allocation	1,039,584	1,039,584	-	0.0%
1,334,144	**1,848,543**	**514,399**	**27.8%**	**Total Administrative Expenses**	**2,871,515**	**3,705,668**	**834,153**	**22.5%**
(1,011,340)	**(1,463,642)**	**452,302**	**30.9%**	**Change in Net Assets**	**(1,878,648)**	**(3,107,483)**	**1,228,835**	**39.5%**
98.7%	***98.4%***	***(0.3%)***	***(0.3%)***	***Medical Loss Ratio***	***98.0%***	***98.7%***	***0.7%***	***0.8%***
5.4%	***7.7%***	***2.3%***	***30.4%***	***Admin Loss Ratio***	***5.8%***	***7.8%***	***2.0%***	***25.6%***

ONECARE CONNECT INCOME STATEMENT - AUGUST MONTH:

REVENUES of $24.9 million are favorable to budget $0.9 million driven by:

- Unfavorable volume related variance of $0.1 million due to mix and retro disenrollment
- Favorable price related variance of $1.0 million due to favorable Medicare capitation rates

MEDICAL EXPENSES of $24.6 million are unfavorable to budget $0.9 million driven by:

- Favorable volume related variance of $0.1 million
- Unfavorable price related variance of $1.1 million

ADMINISTRATIVE EXPENSES of $1.3 million are favorable to budget $0.5 million

C**HANGE IN NET ASSETS** is ($1.0) million, favorable to budget $0.5 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,545	**1,496**	**49**	**3.3%**	**Member Months**	**3,075**	**2,990**	**85**	**2.8%**
				Revenues				
1,245,059	1,141,643	103,416	9 1%	Medicare Part C revenue	2,485,467	2,207,418	278,049	12 6%
583,443	520,487	62,956	12 1%	Medicare Part D revenue	1,161,246	1,029,195	132,051	12 8%
1,828,503	**1,662,130**	**166,373**	**10.0%**	**Total Operating Revenue**	**3,646,712**	**3,236,613**	**410,099**	**12.7%**
				Medical Expenses				
462,094	452,073	(10,021)	(2 2%)	Provider capitation	945,018	874,831	(70,187)	(8 0%)
439,947	509,792	69,845	13 7%	Inpatient	759,021	1,018,903	259,882	25 5%
31,857	55,660	23,803	42 8%	Ancillary	103,758	111,246	7,488	6 7%
21,013	45,734	24,721	54 1%	Skilled nursing facilities	18,537	91,407	72,870	79 7%
546,699	505,895	(40,804)	(8 1%)	Prescription drugs	1,040,869	1,011,800	(29,069)	(2 9%)
27,513	48,963	21,450	43 8%	Medical management	84,442	98,504	14,062	14 3%
-	10,797	10,797	100 0%	Other medical expenses	-	21,580	21,580	100 0%
1,529,123	**1,628,914**	**99,791**	**6.1%**	**Total Medical Expenses**	**2,951,645**	**3,228,271**	**276,626**	**8.6%**
299,380	**33,216**	**266,164**	**801.3%**	**Gross Margin**	**695,067**	**8,342**	**686,725**	**8232.1%**
				Administrative Expenses				
71,542	53,239	(18,303)	(34 4%)	Salaries, wages & employee benefits	106,750	107,455	705	0 7%
30,000	21,480	(8,520)	(39 7%)	Professional fees	30,000	42,960	12,960	30 2%
18,775	17,063	(1,712)	(10 0%)	Purchased services	35,535	34,126	(1,409)	(4 1%)
4,014	16,667	12,653	75 9%	Printing and postage	(4,865)	33,334	38,199	114 6%
-	4,738	4,738	100 0%	Other operating expenses	-	9,476	9,476	100 0%
35,589	35,589	-	0 0%	Indirect cost allocation, occupancy expens	71,178	71,178	-	0 0%
159,920	**148,776**	**(11,144)**	**(7.5%)**	**Total Administrative Expenses**	**238,599**	**298,529**	**59,930**	**20.1%**
139,460	**(115,560)**	**255,020**	**220.7%**	**Change in Net Assets**	**456,469**	**(290,187)**	**746,656**	**257.3%**
83.6%	***98.0%***	***14.4%***	***14.7%***	***Medical Loss Ratio***	***80.9%***	***99.7%***	***18.8%***	***18.9%***
8.7%	***9.0%***	***0.2%***	***2.3%***	***Admin Loss Ratio***	***6.5%***	***9.2%***	***2.7%***	***29.1%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
345	**348**	**(3)**	**(0.9%)**	**Member Months**	**680**	**689**	**(9)**	**-1.3%**
				Revenues				
2,126,529	2,091,775	34,754	1 7%	Medi-Cal capitation revenue	4,195,841	4,142,133	53,708	1 3%
464,947	487,437	(22,490)	(4 6%)	Medicare Part C revenue	923,838	966,332	(42,494)	(4 4%)
133,487	128,476	5,011	3 9%	Medicare Part D revenue	246,396	254,232	(7,836)	(3 1%)
2,724,963	**2,707,688**	**17,275**	**0.6%**	**Total Operating Revenue**	**5,366,075**	**5,362,697**	**3,378**	**0.1%**
				Medical Expenses				
697,672	884,526	186,854	21 1%	Medical Management	1,347,621	1,777,692	430,071	24 2%
529,945	514,259	(15,686)	(3 1%)	Claims payments to hospitals	1,589,524	1,017,250	(572,274)	(56 3%)
669,213	564,695	(104,518)	(18 5%)	Professional claims	1,089,546	1,117,422	27,876	2 5%
151,788	222,090	70,302	31 7%	Patient transportation	230,625	437,874	207,249	47 3%
210,415	214,468	4,053	1 9%	Prescription drugs	424,888	424,245	(643)	(0 2%)
35,871	20,770	(15,101)	(72 7%)	MLTSS	61,525	39,887	(21,638)	(54 2%)
4,313	6,667	2,355	35 3%	Other Expenses	8,862	13,334	4,472	33 5%
2,299,217	**2,427,475**	**128,258**	**5.3%**	**Total Medical Expenses**	**4,752,591**	**4,827,704**	**75,113**	**1.6%**
425,746	**280,213**	**145,533**	**51.9%**	**Gross Margin**	**613,484**	**534,993**	**78,491**	**14.7%**
				Administrative Expenses				
124,619	147,593	22,974	15 6%	Salaries, wages & employee benefits	281,264	296,927	15,663	5 3%
249	153	(96)	(62 7%)	Professional fees	249	306	57	18 6%
5,309	18,971	13,662	72 0%	Purchased services	26,511	37,942	11,431	30 1%
9	10,533	10,524	99 9%	Printing and postage	728	21,066	20,338	96 5%
2,092	2,116	24	1 1%	Depreciation & amortization	4,184	4,232	48	1 1%
2,626	4,135	1,509	36 5%	Other operating expenses	5,038	8,271	3,233	39 1%
3,685	3,915	230	5 9%	Indirect cost allocation, Occupancy Expense	7,327	7,788	461	5 9%
138,589	**187,416**	**48,827**	**26.1%**	**Total Administrative Expenses**	**325,301**	**376,532**	**51,231**	**13.6%**
287,157	**92,797**	**194,360**	**209.4%**	**Change in Net Assets**	**288,183**	**158,461**	**129,722**	**81.9%**
84.4%	***89.7%***	***5.3%***	***5.9%***	***Medical Loss Ratio***	***88.6%***	***90.0%***	***1.5%***	***1.6%***
5.1%	***6.9%***	***1.8%***	***26.5%***	***Admin Loss Ratio***	***6.1%***	***7.0%***	***1.0%***	***13.7%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Two Months Ending August 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				
56,281	23,101	(33,180)	(143.6%)	Purchase services	98,615	46,202	(52,413)	(113.4%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	328,988	349,450	20,462	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	34,953	31,732	(3,221)	(10.2%)
124,263	140,162	15,899	11.3%	Repair and maintenance	220,418	280,324	59,906	21.4%
65,231	46,432	(18,799)	(40.5%)	Other Operating Expense	134,755	92,864	(41,891)	(45.1%)
(427,745)	(400,286)	27,459	6.9%	Indirect allocation, Occupancy	(817,728)	(800,572)	17,156	2.1%
1	**-**	**(1)**	**0.0%**	**Total Administrative Expenses**	**0**	**-**	**(0)**	**0.0%**
(1)	**-**	**(1)**	**0.0%**	**Change in Net Assets**	**(0)**	**-**	**(0)**	**0.0%**

OTHER INCOME STATEMENTS - AUGUST MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $139.5 thousand, favorable to budget $255.0 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $287.2 thousand, favorable to budget $194.4 thousand

CalOptima
Balance Sheet
August 31, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$243,527,228	Accounts Payable	$7,138,624
Investments	667,764,921	Medical Claims liability	739,416,951
Capitation receivable	312,080,181	Accrued Payroll Liabilities	12,631,264
Receivables - Other	38,585,030	Deferred Revenue	62,426,886
Prepaid expenses	6,641,243	Deferred Lease Obligations	31,794
		Capitation and Withholds	131,031,756
Total Current Assets	**1,268,598,602**	**Total Current Liabilities**	**952,677,275**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	8,814,963		
505 City Parkway West	50,489,717		
	96,391,045		
Less: accumulated depreciation	(47,718,929)		
Capital assets, net	48,672,116	Other (than pensions) post employment benefits liability	24,948,553
Other Assets		Net Pension Liabilities	23,386,495
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,001,012,324**
Cash and Cash Equivalents	2,473,277		
Long-term Investments	561,713,310	Deferred Inflows	
Total Board-designated Assets	564,186,586	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	622,685,499	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**1,939,956,218**	TNE	93,332,612
		Funds in Excess of TNE	849,294,897
Deferred Outflows		**TOTAL NET POSITION**	942,627,509
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,951,046,667**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**1,951,046,667**

CalOptima
Board Designated Reserve and TNE Analysis
as of August 31, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	154,696,265				
	Tier 1 - Logan Circle	153,368,808				
	Tier 1 - Wells Capital	153,900,688				
Board-designated Reserve		461,965,760	334,693,548	518,133,330	127,272,213	(56,167,570)
TNE Requirement	Tier 2 - Logan Circle	102,220,826	93,332,612	93,332,612	8,888,214	8,888,214
	Consolidated:	564,186,586	428,026,159	611,465,942	136,160,427	(47,279,356)
	Current reserve level	*1.85*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
as of August 31, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	9,054,820	7,084,639
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	565,167	1,133,012
Changes in assets and liabilities:		
Prepaid expenses and other	234,648	(853,502)
Catastrophic reserves		
Capitation receivable	(15,371,619)	1,276,556
Medical claims liability	10,641,169	(12,894,001)
Deferred revenue	22,508,923	11,392,123
Payable to providers	4,999,872	22,128,616
Accounts payable	(1,146,029)	(33,904,312)
Other accrued liabilities	(230,133)	15,268
Net cash provided by/(used in) operating activities	31,256,817	(4,621,601)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(77,822,631)	(94,058,624)
Change in Property and Equipment	(1,699,200)	(3,180,239)
Change in Board designated reserves	(4,014,795)	(4,041,179)
Change in Homeless Health reserve	1,801,087	1,801,087
Net cash provided by/(used in) investing activities	(81,735,539)	(99,478,955)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(50,478,721)	(104,100,556)
CASH AND CASH EQUIVALENTS, beginning of period	$294,005,950	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**243,527,228**	**243,527,228**

BALANCE SHEET - AUGUST MONTH:

ASSETS of $2.0 billion increased $45.8 million from July or 2.4%

- **Operating Cash** decreased $50.5 million primarily due to the investment of cash with offsetting increase in Investments
- **Investments** increased $77.8 million due to the investment of operating cash and capitation received in advance from Centers for Medicare & Medicaid Services (CMS)
- **Capitation Receivables** increased $13.0 million or 4.4% due to timing of the Department of Healthcare Services (DHCS) capitation payments

LIABILITIES increased $36.8 million from July or 3.8%

- **Deferred Revenue** increased $22.5 million due to timing of capitation payments from CMS
- **Medical Claims Liability** increased $10.6 million due to increase in estimates of claims Incurred But Not Reported (IBNR)
- **Capitation and Withholds** increased $5.0 million due to shared risk pool expenses

NET ASSETS total $942.6 million

Homeless Health Initiatives and Allocated Funds
as of August 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 Strat-up & Federally Qualified Health Plans (FQHC's)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOp Day & QI Program	1,231,087	
FQHC - Expansion	570,000	
Funds Allocation Total		**41,801,087**
Program Commitment Balance, available for new initiatives		**$ 58,198,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.
This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for August 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Huma Resources Corporate Application)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020

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
October 3, 2019

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- CY 2014 Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit:

  On February 26, 2019, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected to participate in the CY 2014 Contract-Level Risk Adjustment Data Validation (RADV) audit. CMS will be conducting a medical records review to validate the accuracy of the CY 2014 Medicare Part C risk adjustment data and payments. The collection of medical records and medical director/review approval began in April and will continue through September 2019. The deadline for submission of medical records for the selected enrollees has been extended from August 20 to September 20, 2019. As of August 28, 2019, CalOptima completed the medical records submission to CMS.

- Compliance Program Effectiveness (CPE) Audit (OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit on the effectiveness of its compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its compliance program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The audit is scheduled to take place from August through October 2019. CalOptima is currently preparing documents and tracer presentations for the onsite audit scheduled for the week of September 23, 2019.

2. OneCare Connect

- 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 following 2018 measurement year elements:

- 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. Validation activities will focus on enrollment and eligibility data processes, assessment and care plan completion processes, performance measure production, and primary source verification. On August 1, 2019, CalOptima received approval of source code documentation that was included with the initial PMV document submission completed in July 2019. CalOptima also responded to additional follow-up requests from CMS auditors on August 23, 2019. The validation webinar is scheduled for September 18, 2019.

- Annual Network Adequacy Review:

On August 6, 2019, CMS provided MMPs guidance on the annual network submission to support compliance with MMP Core Reporting Requirements, *Section VII Provider Networks*. MMPs must demonstrate, on an annual basis, an adequate contracted provider network sufficient to provide access to covered services in each demonstration. The submission is due to CMS no later than September 17, 2019. CalOptima has completed the submission and is pending results from CMS on the automated criteria check to determine whether the MMP provider network for CalOptima has met the network adequacy standards.

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 - 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019 and consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. 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. CalOptima submitted a timely Corrective Action Plan (CAP) to the DHCS, and it is currently under review.

- Rate Development Template (RDT) Audit:

On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which will focus on the accuracy and completeness of calendar year 2017 Medi-Cal RDT encounter

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

and financial data submitted to the DHCS as part of the rate development process for 2019-2020.

On August 7, 2019, Mercer auditors came onsite to review CalOptima's claims systems as well as conduct staff interviews. CalOptima anticipates a final draft report from Mercer in the coming weeks. CalOptima will have one (1) week to provide any feedback before Mercer communicates the report to the DHCS for final review and approval.

- Department of Managed Health Care (DMHC) Routine Examination:

  On August 8, 2019, the DMHC engaged CalOptima for the tri-annual routine examination. This examination will review CalOptima's fiscal and administrative affairs and will include an examination of CalOptima's financial reports. CalOptima's last routine examination was conducted in 2016.

- 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. CalOptima did not receive any notices of non-compliance from its regulators for the month of September 2019.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2019	100%	100%	100%	100%
May 2019	100%	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

June 2019	100%	100%	100%	100%

➢ For the June 2019 file review of Medi-Cal claims, CalOptima's Claims department received a score of 100% for a focused audit of sixty (60) claims selected for review and a score of 99% for timeliness based on the overall universe of 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
April 2019	100%	100%	100%	100%	100%
May 2019	100%	100%	93%	100%	50%
June 2019	100%	100%	95%	100%	100%

➢ For the June 2019 file review of Medi-Cal PDRs, CalOptima's Claims department received a score of 99% for a focused audit of forty (40) claims selected for review and a score of 99% for timeliness based on the overall universe of PDRs.

- Medi-Cal Grievance & Appeals Resolution Services (GARS): Standard Appeals

Month	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Written Response in Member's Preferred Language	Accuracy of Member Notice Content	Standard Appeal Resolved within ≤ 30 Calendar Days of Receipt	Appeal Classification
February 2019	100%	89%	89%	100%	100%
March 2019	100%	100%	78%	100%	100%

➢ For the February 2019 file review of Medi-Cal standard appeals, CalOptima's GARS department received a compliance score of 100% for timeliness based on the overall universe of standard and expedited prior authorizations.
  – Based on a focused review of nine (9) appeals, the lower compliance score of 89% for written response in member's preferred language for February 2019 was due to one (1) letter not mailed in a member's preferred language.
  – Based on a focused review of nine (9) appeals, the lower compliance score of 89% for accuracy of member notice content for February 2019 was due to one (1) inaccurate member notice.

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 March 2019 file review of Medi-Cal standard appeals, CalOptima's GARS department received a compliance score of 99% for timeliness based on the overall universe of standard and expedited prior authorizations.
  - Based on a focused review of nine (9) appeals, the lower compliance score of 78% for accuracy of member notice content for February 2019 was due to two (2) inaccurate member notices.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of appeals. 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 accurate and timely processing of appeals within regulatory requirements

- Medi-Cal Grievance & Appeals Resolution Services (GARS): Expedited Appeals

Month	Expedited Appeals Verbally Acknowledged ≤ 24 Hours of Receipt	Written Response in Members Preferred Language	Accuracy of Member Notice Content	Expedited Appeals Resolved within ≤ 72 Hours of Receipt	Appeal Classification
February 2019	100%	100%	100%	100%	
March 2019	100%	100%	100%	100%	

- For the February 2019 file review of Medi-Cal expedited appeals, CalOptima's GARS department received a score of 100% for a focused audit of one (1) appeal selected for review and a score of 92% for timeliness based on the overall universe of appeals.

- For the March 2019 file review of Medi-Cal expedited appeals, CalOptima's GARS department received a score of 100% for a focused audit of one (1) appeal selected for review and a score of 72% for timeliness based on the overall universe of appeals.

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 Utilization Management (UM): Prior Authorizations

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
October-December 2018	0%	100%	100%	50%	55%	100%	100%	9%	100%	100%	57%	100%	100%

  - For the October-December 2018 file review of Medi-Cal prior authorizations, CalOptima's Utilization Management department received a compliance score of 99% for timeliness based on the overall universe of standard and expedited prior authorizations.

  - Based on a focused review of fifty-four (54) prior authorizations, the lower compliance score of 34% for resolution and notification timeliness for October-December 2018 was due to multiple authorizations with untimely turnaround times.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of prior authorizations. The A&O department continues to work with the Utilization Management 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 accurate and timely processing of prior authorizations within regulatory requirements.

- Medi-Cal Customer Service: Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
January – March 2019	100%	100%	100%

  - For the January-March 2019 file review of Medi-Cal inquiries, CalOptima's Customer Service department received a score of 100% for a focused audit of nine (9) inquiry calls selected for 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

- 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
	100%	100%	100%			100%

➢ For the January-March 2019 file review of Medi-Cal exempt grievances, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) exempt grievances selected for review and a score of 100% for timeliness based on the overall universe of exempt grievances.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2019	100%	100%	100%	100%
May 2019	100%	100%	100%	100%
June 2019	100%	100%	100%	100%

➢ For the June 2019 file review of OneCare claims, CalOptima's Claims department received a score of 100% on a focused audit of twenty (20) claims selected for review and a score of 99.91% for timeliness based on the overall universe of electronic/paper acknowledgements, resolved claims, forwarding misdirected claims, and requested payments of organization determinations.

➢ Based on a focused review of three (3) claims, the lower compliance score of 67% for check clearing timeliness for June 2019 was due to one (1) untimely cashed check.

➢ 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,

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

system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
April 2019	Nothing to Report	Nothing to Report	Nothing to Report
May 2019	100%	100%	100%
June 2019	Nothing to Report	Nothing to Report	Nothing to Report

  - For the June 2019 file review of OneCare PDRs, CalOptima's Claims department received a score of 100% for timeliness based on the overall universe of PDRs.

- OneCare Grievance & Appeals Resolution Services (GARS): Standard Pre-Service Reconsiderations

Month	Pre Service Reconsideration Acknowledged within ≤ 5 Calendar Days of Receipt	Written Response in Member's Preferred Language	Accuracy of Member Notice Content	Pre Service Reconsideration Resolved within ≤ 30 Calendar Days of Receipt	Appeal Classification
February 2019	100%	100%	0%	100%	
March 2019	100%	100%	50%	100%	100%

  - For the February 2019 file review of OneCare standard pre-service reconsiderations, CalOptima's GARS department received a compliance score of 100% for timeliness based on the overall universe of standard and expedited pre-service reconsiderations.
    - Based on a focused review of one (1) pre-service reconsiderations, the lower compliance score of 0% for accuracy of member notice content for February 2019 was due to one (1) inaccurate member notice.

  - For the March 2019 file review of OneCare standard appeals, CalOptima's GARS department received a compliance score of 100% for timeliness based on the overall universe of standard and expedited pre-service reconsiderations.
    - Based on a focused review of two (2) pre-service reconsiderations, the lower compliance score of 50% for accuracy of member notice content for March 2019 was due to one (1) inaccurate member notice.

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 pre-service reconsiderations. 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 accurate and timely processing of pre-service reconsiderations within regulatory requirements

- OneCare Grievance & Appeals Resolution Services (GARS): Expedited Pre-Service Reconsiderations

Month	Expedited Pre Service Reconsideration Verbally Acknowledged ≤ 24 Hours of Receipt	Written Response in Member's Preferred Language	Accuracy of Member Notice Content	Pre Service Reconsideration Resolved within ≤ 30 Calendar Days of Receipt	Appeal Classification
February 2019	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
March 2019	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- No trends to report.

- OneCare Utilization Management: Pre-Service Organization Determinations

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
October-December 2018	Nothing to Report	Nothing to Report	Nothing to Report	100%	25%	Nothing to Report	Nothing to Report	Nothing to Report

- For the October-December 2018 file review of OneCare standard pre-service organization determinations, CalOptima's Utilization Management department received a compliance score of 100% for timeliness based on the overall universe of standard and expedited pre-service organization determinations.

- Based on a focused review of four (4) pre-service organization determination, the lower compliance score of 25% for letter score for October-December 2018 was due to multiple inaccurate member notices.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of pre-service organization determinations. The A&O department continues to work with 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

Utilization Management 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 accurate and timely processing of pre-service organization determination within regulatory requirements.

- OneCare Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
	100%	100%	100%

➢ For the January-March 2019 file review of OneCare Part C inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
	100%	100%	100%

➢ For the January-March 2019 file review of OneCare Part D inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
	100%	100%	100%

➢ For the January-March 2019 file review of OneCare oral grievances, CalOptima's Customer Service department received a score of 100% for a focused audit of nine (9)

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

oral grievances selected for review and a score of 100% for timeliness based on 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
April 2019	90%	100%	100%	90%
May 2019	100%	100%	100%	90%
June 2019	100%	100%	100%	90%

➢ For the June 2019 file review of OneCare Connect claims, CalOptima's Claims department received a score of 98% for a focused audit of twenty (20) claims selected for review and a score of 99% for timeliness based on the overall universe of professional claims.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy	Check Lag
April 2019	100%	100%	100%	N/A
May 2019	100%	100%	100%	N/A
June 2019	100%	100%	100%	N/A

➢ For the June 2019 file review of OneCare Connect PDRs, CalOptima's Claims department received a score of 100% for a focused audit of four (4) PDRs selected for review and a score of 100% for timeliness based on 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 Grievance & Appeals Resolution Services (GARS): Standard Appeals

Month	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Written Response in Members Preferred Language	Accuracy of Member Notice Content	Standard Appeal Resolved within ≤ 30 Calendar Days of Receipt	Appeal Classification
February 2019	100%	100%	0%	100%	100%
March 2019	100%	100%	70%	100%	100%

  - For the February 2019 file review of OneCare Connect standard appeals, CalOptima's GARS department received a compliance score of 100% for timeliness based on the overall universe of standard and expedited appeals.
    - Based on a focused review of nine (9) appeals, the lower compliance score of 0% for accuracy of member notice content for February 2019 was due to nine (9) inaccurate member notices.

  - For the March 2019 file review of OneCare Connect standard appeals, CalOptima's GARS department received a compliance score of 100% for timeliness based on the overall universe of standard and expedited appeals.
    - Based on a focused review of ten (10) appeals, the lower compliance score of 70% for accuracy of member notice content for March 2019 was due to three (3) inaccurate member notices.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of appeals. 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 accurate and timely processing of appeals within regulatory requirements

- OneCare Connect Grievance & Appeals Resolution Services (GARS): Expedited Appeals

	Expedited Appeals Verbally Acknowledged ≤ 24 Hours of Receipt	Written Response in Members Preferred Language	Accuracy of Member Notice Content		
February 2019	N/A	100%	50%	100%	100%
March 2019	N/A	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 February 2019 file review of OneCare Connect expedited appeals, CalOptima's GARS department received a score of 75% for timeliness based on the overall universe of standard and expedited appeals.
  - Based on a focused review of two (2) appeals, the lower compliance score of 50% for accuracy of member notice content for February 2019 was due to one (1) inaccurate member notice.

- For the March 2019 file review of OneCare Connect expedited appeals, CalOptima's GARS department received a score of 100% for a focused audit of one (1) appeal selected for review and a score of 100% for timeliness based on the overall universe of appeals.

- OneCare Connect Utilization Management: Pre-Service Organization Determinations

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified
October-December 2018	83%	100%	100%	92%	100%	100%	100%	100%	Nothing to Report	Nothing to Report	Nothing to Report

- For the October-December 2018 file review of OneCare Connect standard and urgent pre-service organization determinations, CalOptima's Utilization Management department received a compliance score of 99% for timeliness based on the overall universe of standard and expedited pre-service organization determinations.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of pre-service organization determinations. The A&O department continues to work with the Utilization Management 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 accurate and timely processing of pre-service organization determinations within regulatory requirements.

- OneCare Connect Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
January-March 2019	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 January-March 2019 file review of OneCare Connect Part C inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Connect Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
	100%	100%	100%

- For the January-March 2019 file review of OneCare Connect Part D inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Connect Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
	100%	100%	100%

- For the January-March 2019 file review of OneCare Connect oral grievances, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances.

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

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
April 2019	100%	100%	100%	100%
May 2019	100%	100%	100%	100%
June 2019	80%	100%	100%	100%

  - The lower compliance score of 80% for paid claims accuracy for June 2019 was due to two (2) inaccurate claims.

  - 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.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
	100%	100%	100%	N/A
	100%	100%	100%	N/A
	100%	100%	100%	50%

  - The lower compliance score of 50% for check clearing timeliness for June 2019 was due to one (1) uncleared check.

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 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.

- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
April 2019	0%	100%
May 2019	Nothing to Report	67%
June 2019	100%	100%

- For the June 2019 file review of PACE SDRs, CalOptima's PACE department received a score of 100% for a focused audit of five (5) SDRs selected for 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

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
April 2019	87%	85%	85%	82%	88%	84%	85%	89%	84%	83%	100%	78%	80%
May 2019	62%	87%	81%	76%	78%	91%	91%	64%	86%	87%	80%	87%	92%
June 2019	82%	91%	93%	88%	76%	89%	93%	82%	94%	92%	67%	100%	100%

- Based on a focused review of select files, thirteen (13) of the twenty-two (22) files were deficient for timeliness, and attributed to four (4) health networks. The reasons for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for member notification
  - Failure to meet timeframe for provider initial notification to the requesting provider
  - Failure to meet timeframe for provider written notification

- Based on a focused review of select files, fifteen (15) of the twenty-one (21) files were deficient for clinical decision making (CDM), and attributed to three (3) health networks. The reasons for the lower scores for CDM include the following:
  - Failure to obtain adequate clinical information
  - Failure to obtain appropriate professional to make decision
  - Failure to cite criteria for decision

- Based on the overall universe of Medi-Cal authorizations for May 2019, CalOptima's health networks received an aggregate compliance score of 91% for timely processing of routine authorization requests and an aggregate compliance score of 90% 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.

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 Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2019	99%	84%	98%	87%
May 2019	99%	88%	99%	88%
June 2019	97%	94%	100%	94%

- Based on a focused review of select files, the decrease in the compliance rate for paid claims timeliness from 99% in May 2019 to 97% in June 2019 was attributed to the untimely processing of multiple claims for one (1) health network. For the one (1) health network, four (4) of the eleven (11) files reviewed were deficient.

- Based on the overall universe of Medi-Cal claims for May 2019, CalOptima's health networks received an overall compliance score of 88% for timely processing of claims.

- 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.

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
April 2019	98%	100%	90%	97%	92%	100%	78%	95%
May 2019	83%	100%	93%	87%	93%	78%	67%	96%
June 2019	85%	100%	99%	93%	93%	80%	79%	95%

- Based on a focused review of select files, the lower scores for letter language were attributed to two (2) health networks. All three (3) files reviewed for both of these

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

health networks were deficient. The reasons for the lower scores for letter language include the following:
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for the month of May 2019, CalOptima's health networks received an overall compliance score of 85% for timely processing of standard Part C authorization requests and 83% 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.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2019	98%	92%	100%	88%
May 2019	100%	98%	98%	90%
June 2019	100%	95%	100%	95%

- Based on a focused review of select files, the decrease in the compliance score for paid claims accuracy from 98% in May 2019 to 95% in June 2019 was attributed to two (2) health networks with missing documents required for processing accurate payment on claims. For these two (2) health networks, three (3) of the eleven (11) files reviewed were deficient.

- 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 training, process development, system enhancements, ongoing inline monitoring, and

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

policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

- Based on the overall universe of OneCare claims for CalOptima's health networks for the month of May 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 83% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 89% 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
April 2019	83%	84%	84%	88%	87%	92%	85%	79%	94%	81%	78%
May 2019	71%	75%	82%	70%	87%	83%	83%	82%	82%	83%	70%
June 2019	80%	100%	90%	81%	90%	80%	80%	83%	63%	90%	84%

- Based on a focused review of select files, the lower scores for timeliness were attributed to three (3) health networks. Eight (8) of the eighteen (18) files received from the three (3) health networks were deficient. The reasons for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for member notification
  - Failure to meet timeframe for provider initial notification
  - Failure to meet timeframe for provider written notification

- Based on a focused review of select files, the lower score for clinical decision making (CDM) was attributed to three (3) health networks. Six (6) of the eight (8) files received from the three (3) health networks were deficient. The reasons for the lower score for CDM include the following:
  - Failure to obtain adequate clinical information
  - Failure to obtain appropriate professional to make decision
  - Failure to cite criteria for decision

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for the month of May 2019, CalOptima's health networks received an

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

overall compliance score of 91% for timely processing of routine authorization requests and 87% 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
April 2019	99%	94%	99%	89%
May 2019	100%	99%	99%	88%
June 2019	93%	93%	99%	91%

- Based on a focused review of select files, the decrease in the compliance score for paid claims timeliness from 100% in May 2019 to 93% in June 2019 was attributed to three (3) health networks. For the three (3) health networks, eight (8) of the thirty-one (31) files reviewed were deficient.

- Based on a focused review of select files, the decrease in the compliance score for paid claims accuracy from 99% in May 2019 to 93% in June 2019 was attributed to one (1) health network with missing documents required for processing accurate payment on claims. For the one (1) health network, six (6) of the ten (10) files reviewed were deficient.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for May 2019, CalOptima's health networks received the following overall compliance scores:
  - 89% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 89% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 91% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

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

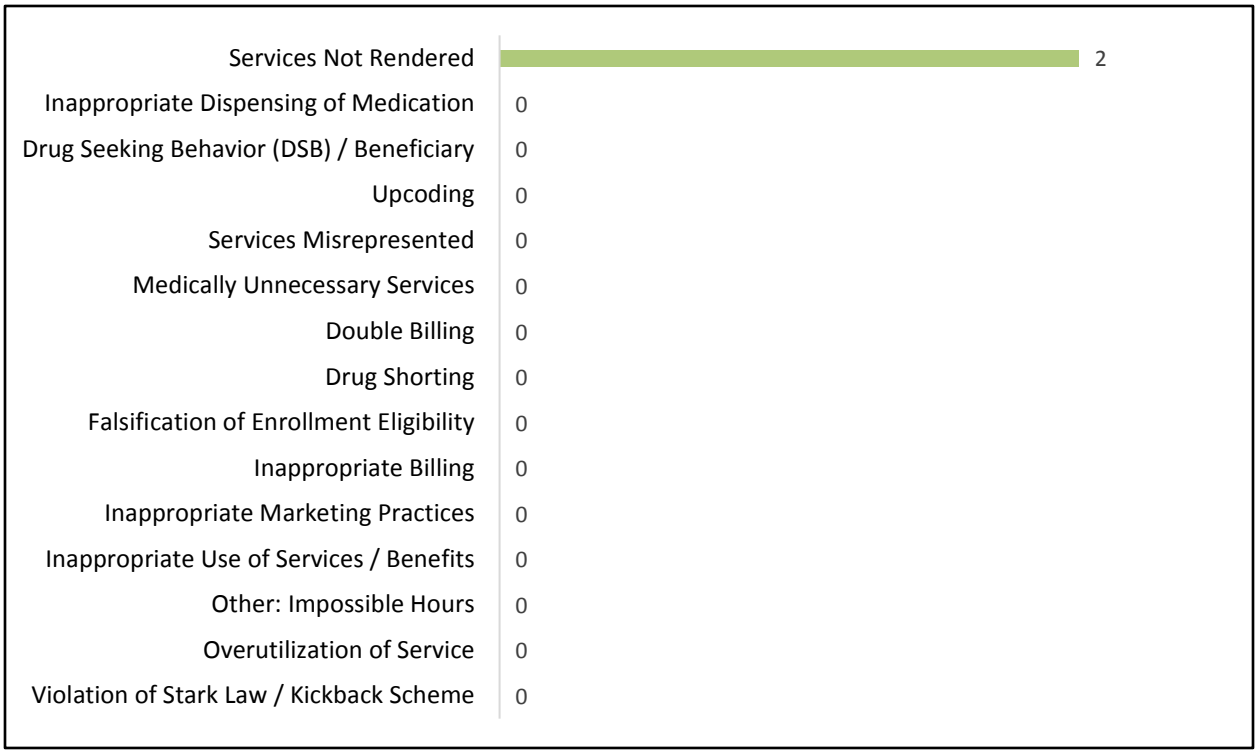
- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies 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.

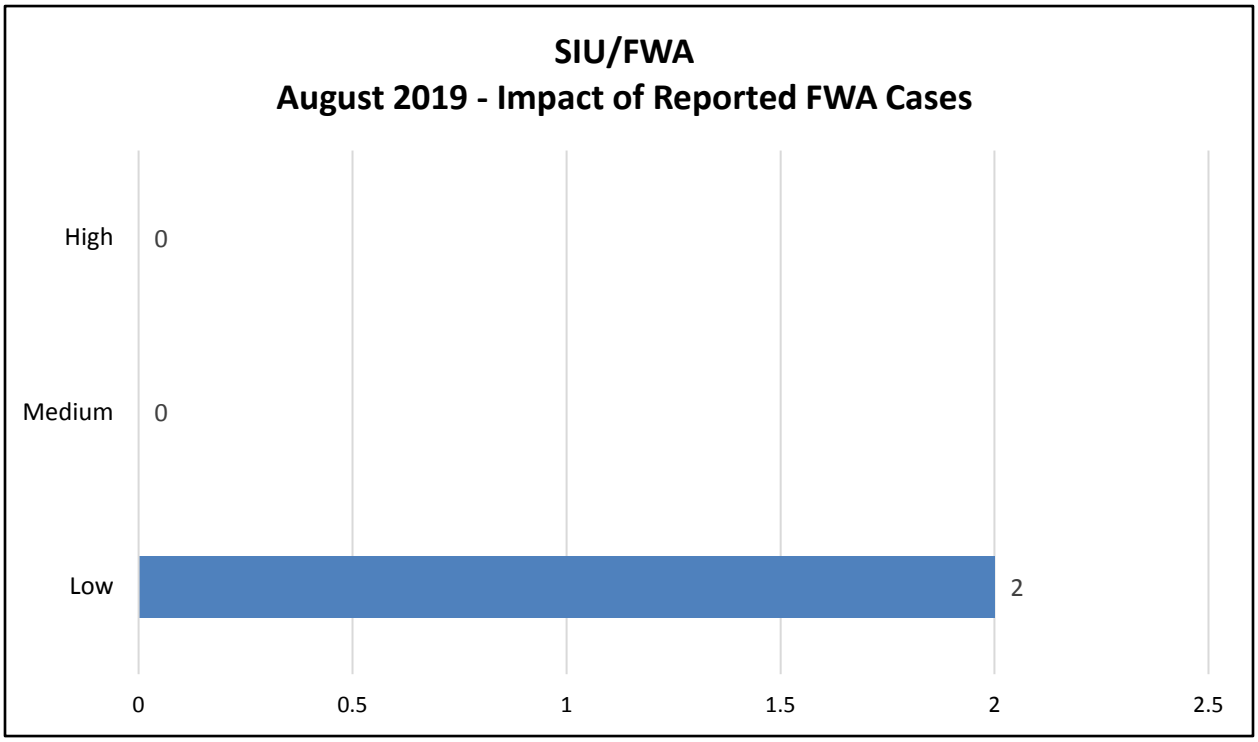
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in August 2019)

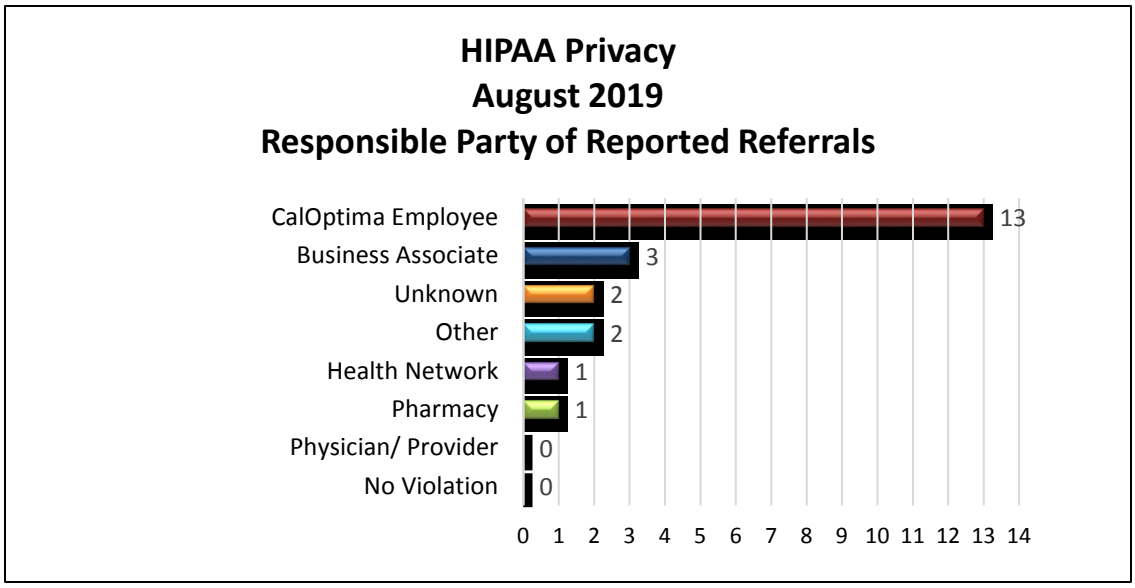


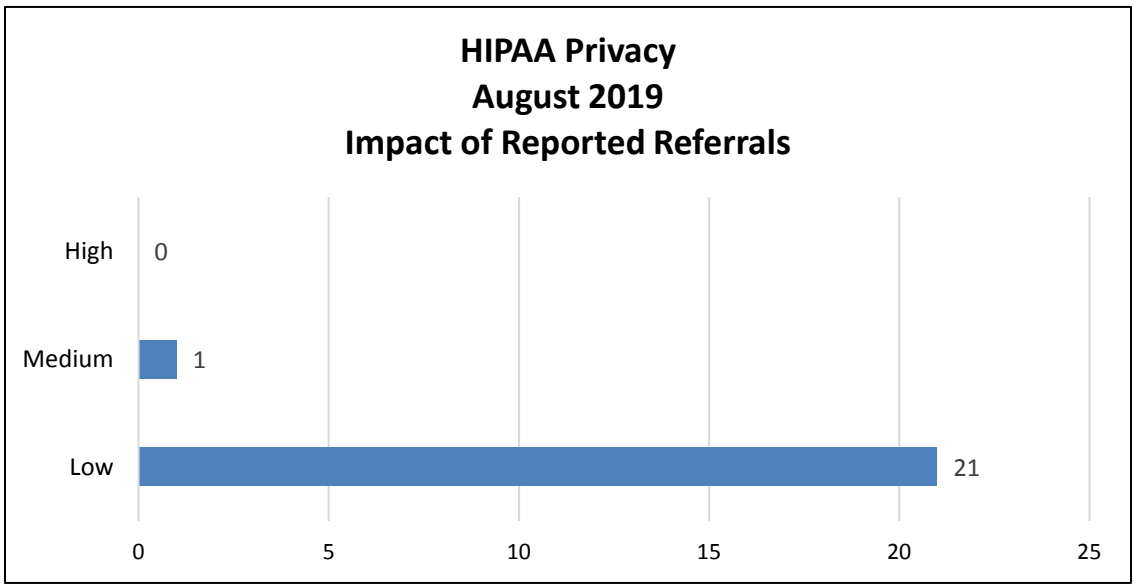


a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

E. Privacy Update (August 2019)





Total Number of Referrals Reported to DHCS (State)	22
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**22**

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

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

September 9, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: September Board of Directors Report

August was a quiet month for Congress, with both the House and Senate on recess. Now that lawmakers have returned to Washington, appropriators are racing to pass at least a few spending bills before the end of the fiscal year on September 30. Further action is also expected on health care cost containment legislation, though it remains to be seen if a bipartisan consensus can be found on prescription drug pricing. This report provides an update on activity through September 9, 2019.

FY 2020 Budget and Appropriations

September is likely to be dominated by appropriations activity before the start of the new fiscal year on October 1. The House has passed the majority of its Fiscal Year (FY) 2020 appropriations bills except for the Homeland Security and Legislative Branch measures, due to controversy over immigration and Member salary increases. Many of these bills will need to be rewritten, however, as they exceed the spending limits set under the bipartisan budget deal that congressional leaders struck on August 2. The Senate Appropriations Committee, meanwhile, has yet to mark up any of the 12 individual appropriations bills. The Committee plans to take up four spending bills on September 12: Defense, Labor-HHS-Education, Energy-Water, and State-Foreign operations.

While Senate Appropriations Chairman Richard Shelby (R-AL) has expressed optimism about advancing some of the FY 2020 spending bills before the end of the month, Congress is expected to pass at least a partial Continuing Resolution (CR) to avoid a government shutdown. House Majority Leader Steny Hoyer (D-MD) has already announced that the House will consider a stopgap measure next week that will fund the government at current levels through late November. While the White House is anxious to avoid a government shutdown, it is unclear whether the Administration and Senate GOP leaders will agree to the details of such a CR.

Back to Agenda

Health Care Cost Legislation

Senate committee leaders are holding to their initial plan to combine the Senate Finance Committee's Prescription Drug Pricing Reduction Act; the Senate Health, Education, Labor and Pensions (HELP) Committee's Lower Health Care Costs Act; and the Senate Judiciary Committee's slate of bills related to drug patents and exclusivities. Finance Committee leaders may need to shore up additional support for their package; fewer than half of the Republicans on the committee voted to advance the bill during markup. Finance Chairman Chuck Grassley (R-IA) recently stated that he is pre-negotiating with House Democrats on drug pricing legislation, although there are indications these conversations are limited and high-level.

In the House, the Energy and Commerce Committee, the Ways and Means Committee, and the Judiciary Committee have advanced a number of drug pricing bills. House Speaker Nancy Pelosi (D-CA) is also developing her own drug pricing plan, which could be unveiled in September. Staff indicate that the plan would require the U.S. Department of Health and Human Services to negotiate prices for at least 250 single-source drugs in Medicare Part B, Part D and Medicaid.

Meanwhile, the Lower Health Care Costs Act reported out of the Senate HELP Committee contains a number of surprise billing provisions, many of which remain controversial with Members. The bill adopts a benchmark payment rate approach under which insurance companies would pay out-of-network providers the median in-network rate based on their geographic area. Senators on both sides of the aisle have raised concerns about the benchmark payment approach, which is seen as favoring insurers, and HELP Committee Chairman Lamar Alexander (R-TN) has signaled that he is open to making changes to the payment methodology before the bill moves to the Senate floor. Even if the Lower Health Care Costs Act passes the Senate as is, it would need to be reconciled with House legislation, which includes arbitration as an optional appeals process.

The House Energy and Commerce Committee's own surprise billing legislation, the No Surprises Act, initially utilized a benchmark payment approach. In response to concerns from several Members, however, the Committee adopted an amendment to add an independent dispute resolution process as a backstop to the benchmark approach. The House Education and Labor Committee is expected to mark up the No Surprises Act after the August recess, and the House Ways and Means Committee may release its own legislative proposal on surprise billing, though details have not yet been released.

Back to Agenda

Public Charge Final Regulation and CMS Guidance

On August 12, the Department of Homeland Security released its "public charge" final rule, which would limit the ability of immigrants to become citizens or permanent residents or to extend their residency if they have received public benefits such as Medicaid or food stamps. The rule also asks immigration officers to take into account certain factors such as poverty or lack of a high school degree in determining whether a person is "more likely than not at any time in the future" to rely on one or more public benefits. Critics say the new rule, which is likely to face legal challenges, could result in many legal immigrants losing or declining coverage, including children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

On August 23, the Centers for Medicare and Medicaid Services (CMS) issued guidance on how states should determine sponsored immigrants' eligibility for Medicaid and CHIP. The guidance reminds states that they are required to count the income and resources of the sponsors of certain immigrants in determining eligibility for federal means-tested benefit programs.

Substance Abuse Privacy Proposed Rule

On August 22, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its proposed rule to revise the confidentiality restrictions for substance use disorder treatment records under 42 C.F.R. Part 2. The rule proposes to update the definition of what constitutes a Part 2 record and its applicability, in order to encourage care coordination among providers. The proposed rule would also allow providers to note substance use treatment disclosed willingly by patients within their medical records, covered under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under the proposed rule, non-Part 2 providers will also have access to central registries to determine if a patient is enrolled in an Opioid Treatment Program (OTP) and receiving medication as part of substance use disorder treatment. Comments on the proposed rule are due October 25, 2019.

SAMHSA insisted that the proposed rule retains the basic framework for confidentiality of substance use disorder patient records under Part 2. Provider groups have called for fully aligning the Part 2 regulations with HIPAA, while behavioral health advocates have cautioned against loosening confidentiality protections under the law. HHS Secretary Alex Azar also noted that legislation would be needed to align Part 2 with HIPAA.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

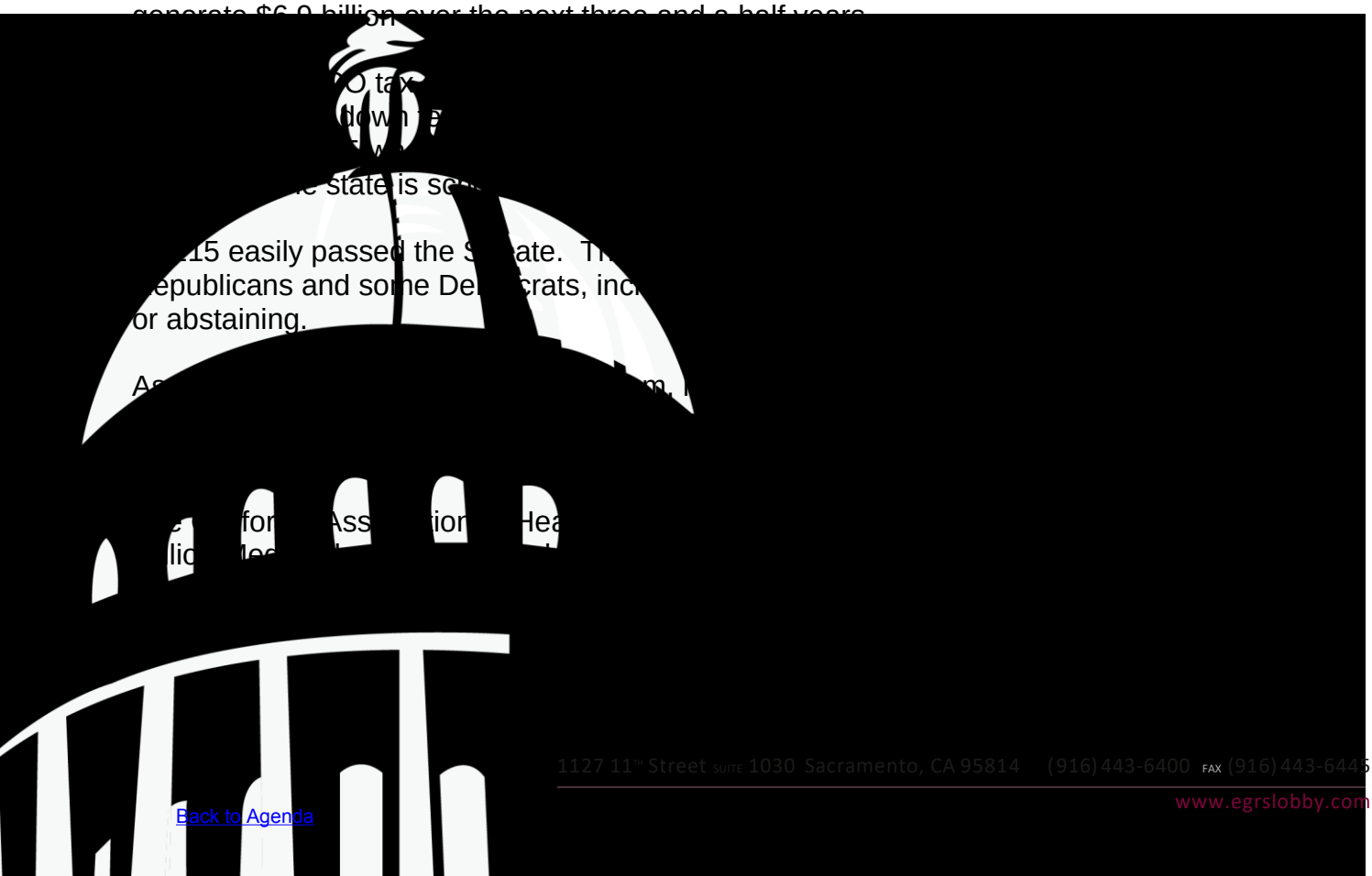
CalOptima
Legislative Report
By Don Gilbert and Trent Smith
September 19, 2019

The State Legislature adjourned for the year at approximately 3:00 a.m. on Saturday, September 14. The Senate was delayed almost three hours after a protester threw what was reported to be blood from the viewing gallery onto the Senate Chamber Floor, striking at least six Senators. The Senate later reconvened in a large committee room to finish the balance of their work.

The Governor has until October 13 to sign or veto bills that were sent to him by the Legislature. The Legislature will reconvene on January 6, 2020, to finish the second year of the two-year session. Bills introduced in 2019 that were not passed to the Governor, or held in the Appropriations Committees, may be pursued further in 2020. In addition, new bills may be introduced by legislators starting in January.

Several bills of interest to CalOptima passed the Legislature and are awaiting action by Governor Newsom.

AB 115 – Assembly Budget Committee
State lawmakers sent Gov. Gavin Newsom a budget trailer bill to tax state-contracted Managed Care Organizations (MCO), the revenue from which would be matched with federal dollars and returned to the state to offset Medi-Cal costs. The MCO tax is expected to generate $6.9 billion over the next three and a half years.



AB 744 – (Aguiar-Curry)
This measure requires health plans to reimburse providers for the diagnosis, consultation, or treatment of an enrollee delivered through telehealth services on the same basis and rates as in-person diagnosis, consultation, or treatment. CAHP and the California Chamber of Commerce opposed AB 744 on the bases that the bill created a new mandate that would increase the cost of healthcare. Despite the opposition, AB 744 passed the Assembly 79-0. The author, who represents a rural district in Northern California, successfully argued that telehealth enhances access to care, thereby keeping people healthy and preventing more costly health care services.

AB 1494 – (Aguiar-Curry)
Another bill by Aguiar-Curry would make the use of telehealth easier in the time of natural disasters. The bill would require that telehealth services, telephonic services, and other specified services be reimbursable when provided by health clinics or similar facilities immediately following a state of emergency. The bill requires the Department of Health Care Services to obtain federal approval and federal matching funds.

AB 218 – (Chu)
Assemblyman Chu's bill, commencing January 1, 2020, requires field testing of all Medi-Cal beneficiary informational materials that are translated into threshold languages. "Field testing" is defined as a review of translations for accuracy, cultural appropriateness, and readability. Managed care plans, like GCHP, must have their materials field tested under this program.

AB 218 would also require the department to consult with stakeholders to identify at least ten documents that are released to Medi-Cal beneficiaries so that a readability expert and stakeholders may review and revise those documents. The bill requires the readability expert and the stakeholders to provide the department with specific recommendations for revising the selected documents to improve the readability of the documents. AB 218 requires the department to rerelease the documents with revisions based on those recommendations and requires the translation and field testing of those documents. Implementation of AB 218 is required no later than January 1, 2021.

AB 166 – (Gabriel)
This bill requires DHCS to establish, no later than January 1, 2021, a violence intervention pilot program in nine specified counties. DHCS is required to consult with identified stakeholders, such as professionals in the community violence intervention field, for purposes of establishing the pilot programs. AB 166 requires DHCS to provide violence preventive services that are rendered by a qualified violence prevention professional to a Medi-Cal beneficiary who meets identified criteria, including that the beneficiary has received medical treatment for a violent injury.

Back to Agenda

AB 166 requires DHCS to seek any federal approvals necessary to implement these requirements, and would condition the department's implementation of these provisions to the extent that federal financial participation is available and not otherwise jeopardized.

Finally, AB 166 requires DHCS to issue a report to the Legislature on the implementation of the violence intervention pilot program, and the demonstrated impact of violence preventive services.

AB 848 – (Gray)
Assemblyman Gray's bill adds continuous glucose monitors to the schedule of benefits under the Medi-Cal program for the treatment of diabetes mellitus when medically necessary; subject to utilization controls. The bill also authorizes DHCS to require manufacturers of a continuous glucose monitors to enter into rebate agreements with the department.

AB 1088 – (Wood)
AB 1088 requires DHCS to seek a federal waiver to implement an income disregard, allowing an aged, blind, or disabled individual who becomes ineligible for Medi-Cal benefits because of the state's payment of the individual's Medicare Part B premiums, to remain eligible for the Medi-Cal program if their income and resources otherwise meet all eligibility requirements. The bill authorizes DHCS to implement this policy by provider bulletins or similar instructions until regulations are adopted. DHCS is required to provide the Legislature with a status report by July 1, 2021, and on a semiannual basis, until regulations have been adopted.

AB 1642 – (Wood)
Assemblyman Wood authored AB 1642 in response to a report criticizing the timely access to care provided in many parts of rural California. AB 1642 mandates new reporting requirements on Medi-Cal managed care plans outlining to DHCS how the plans arranges for the delivery of services, such as transportation services, to enrollees. The bill requires the department to evaluate, as part of its review and approval of an alternative access standard, if the resulting time and distance is reasonable to expect a beneficiary to travel to receive care. AB 1642 further requires a Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard to provide their enrollees with transportation services if the enrollee must travel to a medical appointment further than established access standards allow.

Finally, in the last week of the Legislative Session, DHCS Director, Jennifer Kent, announced she was resigning at the end of September. Kent was appointed director by Governor Brown. She also worked in the Schwarzenegger Administration. Kent's replacement has not yet been announced.

Back to Agenda

2019–20 Legislative Tracking Matrix

BUDGET BILLS

Bill Number	Bill Summary	Bill Status	Position/Notes*
H.R. 3877	**Bipartisan Budget Act of 2019:** Will enact a two-year framework for the federal budget (through fiscal year 2021). This bill gives a broad blueprint for federal spending and prevents the implementation of automatic spending cuts – also known as sequestration – that are triggered, generally, when Congress misses budget deadlines. Of note, the passing of the Bipartisan Budget Act of 2019 removed proposed spending cuts to Medicaid.	**08/02/2019** Signed into law	CalOptima: Watch
AB 74	**FY 2019-20 California State Budget:** Will enact a $214.8 billion spending plan for FY 2019-20, with General Fund (GF) spending at $147.8 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Updates on the Pharmacy Services carve-out ■ Revisions to the expansion of Medi-Cal ■ Proposition 56 supplemental payment funding ■ Funding to respond to the homelessness crisis	**06/30/2019** Signed into law	CalOptima: Watch
AB 101	**Housing Development and Financing Budget:** Will enact housing trailer bills in the California 2019-2020 budget. Housing Development and Financing budget trailer bills include policy changes related to the housing and homeless services budget, including: ■ $650 million in grant funding for homeless services ■ Bypassing certain California Environmental Quality Act (CEQA) regulations to expedite the establishment of homeless shelters	**07/31/2019** Signed into law	CalOptima: Watch
SB 104	**Health Budget:** Will enact health care trailer bills in the California 2019-2020 budget. ■ Expansion of full-scope Medi-Cal ages 19-25 regardless of immigration status ■ Eligibility expansion for low-income seniors (122% FPL to 138% FPL) ■ Extension of maternal-mental health Medi-Cal coverage ■ Implementation of a PACE rate adjustment	**07/09/2019** Signed into law	CalOptima: Watch
SB 78	**Health Budget:** Will enact health care trailer bills in the California 2019-2020 budget. ■ Prop 56 Value Based Payment (VBP) Behavioral Health integration program ■ Optional benefit restoration (optician and optical services, audiology, speech therapy, podiatry, and incontinence creams) ■ Health Homes Program (HHP) funding extension until 7/1/2024 ■ State-based Individual Mandate ■ Managed Care Organization (MCO) Tax renewal intent language	**06/27/2019** Signed into law	CalOptima: Watch

Bill Number	Bill Summary	Bill Status	Position/Notes*
AB 115	**Managed Care Organization (MCO) Tax Renewal:** Proposes a renewal of, until 12/31/2022, and new structure for the MCO tax, which would be effective retroactive to 7/1/2019.	**09/17/2019** Enrolled with the Governor **09/12/2019** Passed Senate floor **09/12/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 577 Eggman	**Maternal Mental Health Care Services:** Would extend eligibility for an individual to receive maternal mental health care services through the Medi-Cal Access Program for women below 138% federal poverty level from 60 days post-pregnancy to 12 months post-pregnancy or the diagnosis of a maternal mental health condition. Medi-Cal postpartum care services are covered for any individual who was pregnant and experienced child birth, delivery or miscarriage.	**09/06/2019** Enrolled with the Governor **09/03/2019** Passed Senate floor **05/24/2019** Passed Assembly floor **02/14/2019** Introduced	CalOptima: Watch
AB 1175 Wood	**Medi-Cal Mental Health Services Data Sharing:** Would require the monthly exchange of member data between a County Specialty Mental Health Plan (MHP) and a Medi-Cal Managed Care Plan (MCP) for any member that has received or is receiving specialty mental health services. The use of a data exchange system would be mutually agreed upon between the MHP and MCP. Data collected would be used to improve care coordination for those with mild, moderate or severe mental health needs. Any disputes regarding covered mental health services between the MHP and MCP would be required to be resolved by the Department of Health Care Services within 30 calendar days.	**09/12/2019** Enrolled with the Governor **09/04/2019** Passed Senate floor **05/28/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch
SB 10 Beall	**Mental Health Support Services Certificate:** Would create the Certified Support Specialist (CSS) certificate program, which would allow parents, peers, and family to become a CSS. A CSS would be able to provide non-medical mental health and substance abuse support services. Additionally, would require the Department of Health Care Services (DHCS) to include CSS as a provider type, covered by Medi-Cal. The certificate program would be funded through Mental Health Services Act funds and, if federally approved, the peer-support program would be funded through Medi-Cal reimbursement.	**09/11/2019** Enrolled with the Governor **09/05/2019** Passed Assembly floor **05/21/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 163 Portantino	**Autism Spectrum Disorder (ASD) Treatment:** Would revise and expand the definitions of those providing care and support to individuals with Autism Spectrum Disorder (ASD) and redefine the minimum qualifications of autism service professionals. Additionally, ASD treatment such as the Developmental Individual-differences, and Relationship-based model (DIR), or "DIRFloortime," not currently covered by Medi-Cal, may be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider. The authorization of ASD treatment services would not be denied or limited if a parent or caregiver is unable to participate.	**09/13/2019** Enrolled with the Governor **09/09/2019** Passed Assembly floor **05/22/2019** Passed Senate floor **01/24/2019** Introduced	CalOptima: Watch CAHP: Oppose AHIP: Oppose

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 678 Flora	**Podiatric Services as a Medi-Cal Covered Benefit:** Would modify authorizations of services so that a podiatrist would no longer be required to submit prior authorization for services during the patient's visit if a physician and surgeon providing the same services would not be required to submit prior authorization. Additionally, removes the limit on how many visits the patient can make to a podiatrist. Permits a podiatrist to bill Medi-Cal the same rate that a physician or surgeon would bill for the same services.	**09/03/2019** Enrolled with the Governor **08/15/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **02/15/2019** Introduced	CalOptima: Watch
AB 781 Maienschein	**Pediatric Day Health Care (PDHC) Services:** Expands PDHC service hours to any day of the week and at any time of the day, so long the number of respite hours allocated are available. Would allow no more than 23 hours per calendar day of covered services. Currently, a parent or guardian may seek PDHC services up to 30 calendar days each year and for no more than 24 hours at a time. PDHC services are required to be provided by a facility licensed through the Department of Public Health and include both physical and social services.	**07/09/2019** Signed into law **06/27/2019** Passed Senate floor **06/17/2019** Passed Assembly floor **02/19/2019** Introduced	CalOptima: Watch
AB 848 Gray	**Continuous Medi-Cal Coverage for Glucose Monitors:** Would include continuous glucose monitors as a Medi-Cal covered benefit. Cost of the glucose monitoring devices is unknown at this time. The Department of Health Care Services estimates this will cost $100.8 million total funds ($31.9 million General Fund (GF), $68.9 million Federal Fund (FF)) the first year and $92.7 million total funds ($29.4 million GF, $63.3 million FF) the second year.	**09/13/2019** Enrolled with the Governor **09/04/2019** Passed Senate floor **05/22/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1004 McCarty	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Developmental Screening Services:** Would include developmental screenings services as part of the EPSDT program for children 0-3 years of age. Would recommend developmental screenings take place for children at the age of 9 months, 18 months, and 30 months. All screenings are to be in compliance with developmental screening guidelines set in place by the American Academy of Pediatrics. Additionally, would allow DHCS to adjust capitation rates for providers, with the use of value-based purchasing, as an incentive to improve EPSDT outcomes.	**09/13/2019** Enrolled with the Governor **09/05/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1839 Ruiz	**Medicaid Services Investment and Accountability Act of 2019:** Extends spousal impoverishment protections when a spouse is receiving skilled nursing care, provides states the ability to provide coordinated care for children with special needs through the use of health home services, and would require drug manufacturers to disclose drug product information and pay a fine for the misclassification of prescribed medications.	**04/18/2019** Signed into law **04/02/2019** Passed the Senate **03/25/2019** Passed the House **03/21/2019** Introduced	CalOptima: Watch
AB 1088 Wood	**Medi-Cal Eligibility without a Share-of-Cost:** Effective July 1, 2021 through the use of a State Plan Amendment or Waiver, would eliminate the "Share of Cost (SOC)" and maintain eligibility for Medi-Cal, for individuals who are aged, blind, or disabled, once the Department of Health Care Services (DHCS) begins to pay for the individual's Medicare Part B premium. Currently, individuals in this eligibility category with income levels above 100 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as SOC. Under SOC, beneficiaries must take full responsibility for health care expenses up to a predetermined amount for the month in which they receive services or risk losing Medi-Cal eligibility. This bill aims to ensure that individuals have access to Medi-Cal without incurring extra financial burdens.	**09/13/2019** Enrolled with the Governor **09/05/2019** Passed Senate floor **05/29/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older.	**09/13/2019** Held in Assembly **08/30/2019** Passed Assembly Committee on Appropriations **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch
AB 143 Quirk-Silva	**Homeless Shelter Crisis:** Would extend existing law, AB 932 (2017), until January 1, 2023, allowing designated cities or counties to establish a shelter crisis that exempts the construction of a homeless shelter from the California Environmental Quality Act (CEQA). Would add to the list of designated municipalities the County of Alameda, the County of Orange, and the City of San Jose. Would require transition plans for permanent housing for participants within the operational plans of each shelter. Additionally, this exemption would only apply to the construction of a homeless shelter owned by either a state agency, city, county, or government-owned land.	**09/10/2019** Enrolled with the Governor **09/05/2019** Passed Senate floor **05/09/2019** Passed Assembly floor **12/13/2018** Introduced	CalOptima: Watch County of Orange: Support
AB 1199 Petrie-Norris	**Use of Fairview Developmental Center:** Would require public hearing and public comments regarding the use of the Fairview Developmental Center in Costa Mesa, CA.	**09/09/2019** Enrolled with the Governor **09/05/2019** Passed Senate floor **05/16/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 450 Umberg	**Motel Conversion for Supportive and Transitional Housing:** Would exempt developers from following California Environmental Quality Act (CEQA) steps in order to expedite the development of motel rooms into supportive and transitional housing units.	**09/12/2019** Enrolled with the Governor **09/09/2019** Passed Assembly floor **05/06/2019** Passed the Senate **02/21/2019** Introduced	CalOptima: Watch County of Orange: Support

MEDI-CAL MANAGED CARE PLAN OVERSIGHT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1642 Wood	**Medi-Cal Managed Care Plans:** Would require Medi-Cal managed care plans (MCPs) to provide assistance with transportation services for long-distance medical appointments and scheduling for out-of-network providers that may be necessary due to network adequacy deficiencies. Would also broaden and clarify the authority of the Department of Health Care Services (DHCS) to levy sanctions on both MCPs and Mental Health Plans.	**09/12/2019** Enrolled with the Governor **09/04/2019** Passed Senate floor **05/29/2019** Passed Assembly floor **02/22/2019** Introduced	CalOptima: Watch
SB 503 Pan	**Subcontracts:** Would require Medi-Cal managed care plans (MCPs) to conduct annual audits, with at least 10 percent being conducted as surprise audits, of subcontractors who perform delegated functions involving medical review and decision making. Would require the Department of Health Care Services (DHCS) to establish an audit tool to be used by the MCP, beginning January 1, 2021. Audits of subcontractors would begin no sooner than January 1, 2022 and would require audit results to be reported to DHCS, including the identification of the subcontractor being audited. Additionally, if more than one MCP subcontract with the same subcontracted provider, those MCPs may choose to conduct a joint audit.	**09/12/2019** Enrolled with the Governor **09/09/2019** Passed Assembly floor **05/22/2019** Passed Senate **02/21/2019** Introduced	CalOptima: Watch

MEMBER MATERIALS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 318 Chu	**Materials for Medi-Cal Members:** Would require Medi-Cal managed care plans' (MCPs) specific written health education and information materials to be reviewed through "field testing" to ensure all materials meet readability and suitability standards. Materials required for field testing include: "Enrollment and disenrollment forms and information, new member welcome packets, member handbooks, appointment notices and reminders, forms and information regarding grievance or complaint procedures and information regarding external review of plan decisions, and notices of action." Field testing may be conducted internally by the MCP or by an external entity, but must be done by a native speaker of the language being reviewed. The findings of the field testing will then be reported to the Department of Health Care Services (DHCS). Additionally, would require DHCS to establish a workgroup of advocates and MCPs to measure the readability of member-facing materials used by MCPs, such as the *Rights and Responsibilities Form and the Medi-Cal Request for Information Form.*	**09/10/2019** Enrolled with the Governor **09/05/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **01/30/2019** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
ACR 131 Petrie-Norris	**Programs of All-Inclusive Care for the Elderly (PACE) Month:** Assembly Concurrent Resolution that recognizes September 2019 as PACE Month in California.	**09/09/2019** Resolution adopted in the Senate **08/30/2019** Resolution adopted in the Assembly **08/19/2019** Introduced	CalOptima: Watch CalPACE: Support; Sponsor
AB 1128 Petrie-Norris	**Programs of All-Inclusive Care (PACE) Licensing:** Would exempt a primary a care clinic, adult day health care center, or home health agency from the Department of Public Health (DPH) licensing requirements. Would apply to agencies solely serving PACE participants, effective upon agreement of the Department of Health Care Services (DHCS), but no later than January 1, 2021. This would streamline the licensing process by having the clinic licensing, adult day services licensing, or home health licensing under the responsibility of DHCS. Additionally, would authorize a primary care clinic, adult day health care center, or home health agency to provide services to a Medi-Cal beneficiary during the PACE enrollment eligibility period, for no more than 60 days, when that center solely serves PACE participants.	**09/16/2019** Enrolled with the Governor **09/10/2019** Passed Senate floor **05/28/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch CalPACE: Support; Sponsor

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement:** Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Moved to inactive file; Two-year bill at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Support; Cosponsor

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: September 23, 2019

2019 Federal Legislative Dates

January 3	116th Congress convenes 1st session
April 15–26	Spring recess
July 29–September 6	Summer recess
September 30–October 11	Fall recess

2019 State Legislative Dates

January 7	Legislature reconvenes
February 22	Last day for legislation to be introduced
April 26	Last day for policy committees to hear and report bills to fiscal committees
May 3	Last day for policy committees to hear and report non-fiscal bills to the floor
May 17	Last day for fiscal committees to report fiscal bills to the floor
May 28–31	Floor session only
May 31	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 12–August 9	Summer recess
August 30	Last day for fiscal committees to report bills to the floor
September 3–13	Floor session only
September 13	Last day for bills to be passed. Final recess begins upon adjournment
October 13	Last day for Governor to sign or veto bills passed by the Legislature
December 2	Convening of the 2020–21 session

Sources: 2019 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
~~October 4, 2019~~ October 3, 2019 | *Rev. 10/3/19*

CalOptima Community Outreach Summary — September 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 Saturday, August 3, 2019, Community Relations sponsored and hosted a resource table at the Back to School Bash organized by the Santa Ana Unified School District. The event brought in thousands of students and their families living in Santa Ana, a city with the highest concentration of CalOptima membership.

In addition to providing information about Medi-Cal benefits and supportive services, Community Relations distributed more than 1,000 school supplies such as glue sticks, erasers, pencils and calendars at the event. Over 40 community partners shared information about programs and services available to serve this high need and under-served community. The organizers provided more than a 1,000 backpacks and lunches at no cost to families residing in this school district. Thousands of kids left the event feeling classroom ready!

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Back to Agenda

Summary of Public Activities

During September 2019, CalOptima participated in 47 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
9/03/19	• Collaborative to Assist Motel Families Meeting
9/05/19	• Homeless Provider Forum • Refugee Forum of Orange County
9/06/19	• Covered Orange County General Meeting • HOPES Collaborative Homeless Liaisons Network Meeting
9/09/19	• Fullerton Collaborative Meeting • Orange County Veterans and Military Families Collaborative Children and Family Workgroup Meeting
9/10/19	• Orange County Strategic Plan for Aging Social Engagement Committee Meeting • Orange County Cancer Coalition Meeting • San Clemente Youth Wellness and Prevention Coalition Meeting
9/11/19	• Orange County Strategic Plan for Aging Healthcare Subcommittee Meeting • Buena Park Collaborative Meeting • Orange County Communications Workgroup • Anaheim Human Services Network Meeting • Together4Teens Conference Planning Meeting
9/12/19	• Kid Healthy Community Advisory Committee Meeting • Orange County Women's Health Project Advisory Meeting • Garden Grove Collaborative Meeting • State Council on Developmental Disabilities Advisory Committee Meeting
9/13/19	• Orange County Diabetes Collaborative • Senior Citizens Advisory Council Meeting
9/18/19	• Orange County Promotoras • Minnie Street Family Resource Center Professionals Roundtable • La Habra Community Collaborative Meeting • Covered California Steering Committee Meeting • Human Service Providers Quarterly Networking Luncheon
9/19/19	• Orange County Children's Partnership Committee Meeting • Provider Outreach Event hosted by Orange County Health Care Agency
9/23/19	• Stanton Collaborative Meeting

Back to Agenda

9/24/19	• Orange County Senior Roundtable Meeting • Susan G. Komen Orange County Unidos Coalition Meeting
9/26/19	• Orange County Care Coordination for Kids

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
9/07/19	2	• Annual Senior Saturday Community Festival hosted by Huntington Beach Council on Aging (Sponsorship Fee: $850 included a quarter page ad in the newsletter, agency's logo display on banner at the event, on event map, link to agency's website on council website for six months and one table for outreach at the event)
	2	• Mid-Autumn Children's Festival hosted by Vietnamese American Youth Organizations (Sponsorship Fee: $1,000 included acknowledgement on stage at the event, certificate of appreciation, agency's name and logo on event t-shirts, banner placement at event and one table for outreach)
9/11/19	2	• We Care Parent Event hosted by Santa Ana Unified School District
9/12/19	2	• Annual Health Fair hosted by City of Tustin
9/13/19	1	• Open House and Resource hosted by City of Stanton
9/14/19	1	• Health Fair at Washington Elementary hosted by Santa Unified School District
	2	• Health Expo hosted by Orange County Iranian American Chamber of Commerce (Sponsorship Fee: $2,600 included a blog post on chamber's website, recognition at event and on all social media promotions, agency's logo on all printed materials, in email blasts, agency logo and weblink on host website event page, four ads on newsletter throughout the year, credit value toward membership and one table for outreach at the event)
	4	• 2019 Mid-Autumn Moon Festival hosted by Vietnamese Cultural Center (Sponsorship Fee: $10,000 includes one resource table, speaking opportunity and lanterns to pass out at the event)
9/19/19	1	• Senior Scam Stopper hosted by Office of Assemblywoman Cottie Petrie-Norris
9/20/19	1	• Senior Health Expo 2019 hosted by City of Laguna Niguel (Sponsorship Fee: $700 included one table for outreach and announcement of sponsorship during the event, company name listed on postcard, in the newsletter/activity guide, on e-monitors throughout the center and displayed at the event)

Back to Agenda

9/22/19	2	• Cultivating Hope in the Community hosted by Be Well Orange County
9/28/19	2	• National Alliance on Mental Illness (NAMI) Walks Orange County hosted by NAMI Orange County (Registration Fee: $1,000 included company logo/name on walk route sign, logo on the Angel Stadium jumbotron on walk day, exhibitor table, recognition as an exhibition with logo on the back of our walk t-shirt.)
	2	• Family Health Expo hosted by Clinic in the Park
	2	• Health Fair hosted by Family Health Matters Community Health Center
	2	• XXVI Annual Family and Community Conference hosted by Santa Ana Unified School District

CalOptima organized or convened the following eight community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
9/17/19	• Community Alliances Forum — Topic: Orange County's Healthier Together: Update on the Orange County Health Improvement Plan
9/24/19	• CalOptima Continuing Medical Education (CME) Workshop — Topic: Opioids and Analgesics Strategies Workshop: What Every Physician Should Know in Today's Regulatory Climate

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
9/05/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)
9/11/19	• County Community Service Center Health Seminar — Topic: Learn About Medicare Benefits, Social Security Disability Benefits (SSDI) and Supplemental Security Income (SSI) (Vietnamese)
9/12/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)
9/19/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)
9/25/19	• County Community Service Center Health Seminar — Topic: Learn About Medicare Benefits, Social Security Disability Benefits (SSDI) and Supplemental Security Income (SSI) (Vietnamese)
9/26/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)

Back to Agenda

CalOptima provided two endorsement during this reporting period (e.g., letters of support, program/public activity events with support or use of name/logo) based on the considerations and processes established under Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo.

1. Letter of Support for the City of Garden Grove on behalf of the Magnolia Park Family Resource Center's application for County of Orange Social Services for the Families and Communities Together (FaCT) program.

2. Letter of Support for Latino Health Access's application for the Downtown Family Resource Center funding through the Families and Communities Together (FaCT) program.

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.

October

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Tuesday, 10/1 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Downtown Anaheim Community Center 250 E. Center St. Anaheim

Tuesday, 10/1 10am-2pm	+City of Santa Ana Senior Center Annual International Older Adults Fair	Health/Resource Fair Open to the Public	1 Staff	Birch Park 424 W. 3rd St. Santa Ana
Tuesday, 10/1 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	CalOptima
Wednesday, 10/2 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's Orange County 2515 McCabe Way Irvine
Wednesday, 10/2 10am-2pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 10/2 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's Orange County 2515 McCabe Way Irvine
Thursday 10/3 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 10/3 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Friday, 10/4 10am-12pm	+City of Orange Senior Center Senior Wellness Fair	Health/Resource Fair Open to the Public	Registration fee $75 1 Staff	City of Orange Senior Center 170 S. Olive St. Orange
Friday, 10/4 10-11am	++Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 10/5 10am-1pm	+Office of Assemblyman Brough and Senator Bates	Health/Resource Fair Open to the Public	2 Staff	Laguna Niguel City Hall

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

	5th Annual Veterans Resource Fair			30111 Crown Valley Pkwy. Laguna Niguel
Monday, 10/7 1-4pm	++OCHCA Mental Health Services Act Steering Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 10/8 9-10:30am	++OC Strategic Plan for Aging Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 10/8 10-11:30am	++OC Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Cancer Society 1940 E. Deere Ave. Santa Ana
Tuesday, 10/8 3:30-5:30pm	++San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Tuesday, 10/8 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	CalOptima
Wednesday, 10/9 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 10/9 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 10/9 3:30-4:30pm	++OC Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 10/10 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, 10/10 12:30-1:30pm	++Kid Health Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC 1901 E. Fourth St. Santa Ana
Thursday, 10/10 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, 10/10 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Friday, 10/11 9am-12:30pm	+City of Brea Senior Center Health Fair and Flu Clinic	Health/Resource Fair Open to the Public	Registration fee $60 2 Staff	City of Brea Senior Center 500 S. Sievers Ave. Brea
Friday, 10/11 9:30-11:30am	++Senior Citizens Advisory Council Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Friday, 10/11 9:30-11:30am	*OneCare Connect Retention and Sales Event	Community Presentation Open to the Public	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Saturday, 10/12 8:30am-1pm	+Wellness and Prevention Coalition Together4Teens Conference	Conference Health/Resource Fair Open to the Public	Sponsorship $1,000 3 Staff	Capistrano Valley High School 26301 Via Escola Mission Viejo
Saturday, 10/12 9am-4pm	+Somang Society 2019 Somang Society Conference	Conference	Sponsorship $1,500 3 Staff	Grace Ministries Church 1645 W. Valencia Dr. Tustin
Saturday, 10/12 9am-1pm	+Nhan Hoa Comprehensive Clinic Health and Wellness Fair	Health/Resource Fair Open to the Public	2 Staff	Nhan Hoa Comprehensive Clinic 7761 Garden Grove Blvd. Garden Grove

Monday, 10/14 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, 10/14 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 10/15 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, 10/15 10-11:30am	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	TBD
Tuesday, 10/15 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	CalOptima
Wednesday, 10/16 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Wednesday, 10/16 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Wednesday, 10/16 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, 10/16 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies

Thursday, 10/17 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, 10/17 1-2:30pm	++Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center in Central Park 18041 Goldenwest St. Huntington Beach
Thursday, 10/17 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	Ponderosa Family Resource Center 320 E. Orangewood Ave. Anaheim
Saturday, 10/19 9-11am	+OASIS Senior Center Senior Health and Resource Fair	Health/Resource Fair Open to the Public	1 Staff	OASIS Senior Center 801 Narcissus Ave. Corona Del Mar
Tuesday, 10/22 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 10/22 5:30-7pm	*Health Education Workshops Shape Your Life	Open to the Public Registration required.	N/A	CalOptima
Wednesday, 10/23 9-11:30am	+City of Cypress Senior Center Medicare Info Fair	Health/Resource Fair Open to the Public	Registration fee $50 1 Staff	Cypress Senior Center 9031 Grindley St. Cypress
Wednesday, 10/23 2-4pm	+Garden Grove Unified School District Annual Community Resource and Health Fair	Health/Resource Fair Open to the Public	1 Staff	Clinton Corner Family Campus 13581 Clinton St. Garden Grove
Thursday, 10/24 1-3pm	++Orange County Care Coordination for Kids Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana

Friday, 10/25 7:30am-4pm	+UCI MINDs Annual Socal Alzheimer's Disease Conference	Conference Health/Resource Fair Open to the Public	Registration $250 1 Staff	Irvine Marriott Hotel 18000 Von Karman Ave. Irvine
Sunday, 10/27 9am-2pm	+Vietnamese Physician Association of Southern California Foundation OC Free Health Fair	Health/Resource Fair Open to the Public	Sponsorship $10,000 3 Staff	Mile Square Park 16801 Euclid St. Fountain Valley
Monday, 10/28 9-11am	++Community Health Research Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana