NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, FEBRUARY 6, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	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. Health Homes Program
   b. Behavioral Health Administration Transition
   c. Restored Medi-Cal Benefits
   d. Medi-Cal Healthier California for All
   e. Proposed FY 2020–21 California Budget
   f. Behavioral Health Integration Incentive Program
   g. Medicaid Fiscal Accountability Rule Comment Letter
   h. Public Charge Rule Implementation
   i. California Children's Services Advisory Group Activities
   j. Annual Medi-Cal Audit
   k. OneCare Connect Member Retention/Outreach Event
   l. Clerk of the Board

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. Approve Minutes of the December 5, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the February 20, 2019 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the May 16, 2019 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the May 22, 2019 Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the September 19, 2019 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the October 17, 2019 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee
   c. Receive and File Minutes of the February 26, 2019 Regular Meeting of the Whole-Child Model Family Advisory Committee, the November 14, 2019 Regular Meeting of the Provider Advisory Committee

3. Consider Approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology

4. Consider Approval of Unbudgeted Expenditures to Support Community Education Efforts to Increase Medi-Cal Provider Awareness of Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening

REPORTS

5. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

6. Consider Authorizing an Amendment to Contract to the Vision Service Plan HMO Services Contracts

7. Consider Ratifying a Revised Amendment with the California Department of Health Care Services

8. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment(s) to the Primary Agreement with the California Department of Health Care Services

9. Consider Authorizing Extension of Federal Legislative Advocacy Services Contract with Akin Gump Straus Hauer & Feld LLP

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

11. Receive and File Delivery System Evaluation and Recommendations

12. Consider Selecting Vendor and Authorizing Contract for Real Estate Consulting Services

13. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

14. Consider Actions Related to Memorandums of Understanding for Department of Health Care Services Behavioral Health Integration Incentive Program

15. Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

16. Receive Report from Grant Thornton on Compensation and Benefits Benchmarking and Analysis; Consider Actions Related to Recommendations from Grant Thornton

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

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

ADVISORY COMMITTEE UPDATES

19. Provider Advisory Committee Update

20. Whole-Child Model Advisory Committee Update

INFORMATION ITEMS

21. IGT 9 and 10 Update

22. Governor's State Budget Update

23. Medi-Cal Healthier California for All

24. Health Homes Program Update

25. Update on Hospital Data Sharing

26. Program of All-Inclusive Care for the Elderly Update

27. November and December 2019 Financial Summaries

28. Compliance Report

29. Federal and State Legislative Advocates Reports

30. CalOptima Community Outreach and Program Summary

CLOSED SESSION

CS 1 Pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS 2 Pursuant to Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Dr. Nikan Khatibi; Richard Sanchez; Scott Schoeffel)
Unrepresented Employee: (Chief Executive Officer)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

MEMORANDUM

DATE:	January 28, 2020
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report — February 6, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

January 2020 Brings Two Program Launches, Restoration of Medi-Cal Benefits

As the new decade rang in, two CalOptima programs designed to enhance services and care coordination for members began and a variety of Medi-Cal benefits were restored.

- *Health Homes Program (HHP)*: Phase 1 of CalOptima's HHP went live January 1 for members with eligible chronic conditions and substance use disorders. Raising awareness about the voluntary program is an ongoing priority, and CalOptima and our health networks are reaching out to eligible members with information about the program and enrollment details. HHP benefits range from comprehensive care management and care transitions support to housing navigation services and accompaniment to doctor visits. Data show that approximately 7,000 members may be eligible to participate in the first phase. A second phase is planned for July 2020.
- *Behavioral Health*: Administration of behavioral health benefits for OneCare and OneCare Connect (OCC) members has transitioned from Magellan Healthcare to CalOptima. Members in need of services for mild to moderate mental health conditions will now work with CalOptima directly. The January 1 change went smoothly, as CalOptima took over utilization management of members with active services and began responding to incoming calls. The transition allows for a more coordinated approach to physical and mental health.
- *Restored Medi-Cal Benefits*: California has reinstated several Medi-Cal benefits that were cut in 2009 due to the recession. Effective January 1, adult members are now covered for eyeglasses, podiatry, audiology, speech therapy, and incontinence creams and washes. The FY 2019–20 state budget includes more than $17 million for the benefits.

California Advancing and Innovating Medi-Cal (CalAIM) Changed to Medi-Cal Healthier California for All; Stakeholder Engagement Continues

Effective January 8, Gov. Gavin Newsom and the Department of Health Care Services (DHCS) renamed CalAIM to Medi-Cal Healthier California for All. The change was made to highlight the well-known Medi-Cal name and better align the initiative with the governor's platform to build a "California for All," according to a press release. The effort to gather stakeholder feedback about the many proposals is ongoing. As I have shared in prior reports, CalOptima is focused on those initiatives that have the most potential to immediately impact our agency, especially enhanced care management and in lieu of services. In fact, managed care plans must provide a transition plan by July 2020 that addresses how Whole-Person Care and HHP will move to enhanced care management and in lieu of services, effective January 2021. CalOptima is looking forward to a February 10 meeting with DHCS to learn more about the proposed

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transition. Given the significance of the changes under consideration, I will continue to share regular updates about Medi-Cal Healthier California for All with your Board.

State Budget Proposal Offers a Glimpse at FY 2020–21 Priorities
On January 10, Gov. Newsom released his proposed budget for FY 2020–21. Overall, the budget anticipates that the California economy will continue to grow (albeit at a slower rate than previous years) and proposes a total state budget of $222.2 billion, with a surplus of more than $5 billion. Some of the surplus will support the governor's policy priorities, including expanding access to Medi-Cal for undocumented seniors age 65 and older, and addressing the state's homelessness crisis. To that end, the budget proposes $750 million to establish the California Access to Housing and Services Fund, which would be dedicated to moving individuals and families into stable housing. The governor is also pursuing an ambitious agenda to transform the Medi-Cal delivery system through the newly renamed Medi-Cal Healthier California for All package of proposals, which received a $695 million allocation. Another major piece of the governor's health plan is reducing prescription drug costs. This past year, his emphasis was on bulk purchasing of prescription drugs by carving out pharmacy from Medi-Cal managed care. This year, he proposes that the state negotiate partnerships with generic drug manufacturers to establish California's own generic drug label. The May Revision is the next step in California's budget process, and staff are monitoring its development.

Organizations Respond to Behavioral Health Integration (BHI) Incentive Opportunity
Aiming to improve health outcomes, DHCS created six BHI incentive programs using Proposition 56 funds and tasked Medi-Cal managed care plans with administering the application process and applying DHCS-developed selection criteria. CalOptima received 30 BHI incentive program applications from 15 organizations seeking nearly $10 million.

BHI Incentive Program	Number of Applications	Dollars Requested
Basic behavioral health integration	13	$6,974,676
Maternal access to mental health and substance use disorder screening and treatment	1	$200,000
Medication management for beneficiaries with co-occurring chronic medical and behavioral diagnoses	4	$710,000
Diabetes screening and treatment for people with serious mental illness	5	$740,160
Improving follow-up after hospitalization for mental illness	4	$755,000
Improving follow-up after emergency department visit for behavioral health diagnosis	3	$530,000
TOTALS	30	$9,909,836

CalOptima is required to review and score applicants, subject to DHCS criteria and approval, as well as distribute funding and monitor the programs. CalOptima formed an evaluation committee of internal and external reviewers, and the group met in late January for training on the state's scoring criteria and timeline. Reviews are due to DHCS by February 18, and CalOptima will issue participation decisions by March 18. Programs are then expected to go live on April 1 and continue until December 31, 2022.

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CalOptima Submits Medicaid Fiscal Accountability Rule (MFAR) Comment Letter
In my December 2019 CEO Report, I shared the growing concern about MFAR's impact on Medi-Cal financing. At the recommendation of our advocates, CalOptima submitted formal comments to complement the efforts of DHCS and our state and federal trade associations. MFAR's proposed constraints on generating additional funding through public hospital financing, the Managed Care Organization tax, and supplemental payments, such as Intergovernmental Transfers, could leave a large hole in California's budget that was previously filled by federal matching dollars.

Supreme Court Permits Public Charge Rule, Potentially Affecting Medicaid Enrollment
On January 27, in a 5–4 decision, the Supreme Court ruled to allow the Trump Administration to implement the Public Charge Final Rule with an expanded means test for immigrants seeking naturalization. The rule expands how the federal government interprets and determines "public charge" to include immigrants who access cash public benefits, such as welfare, but also non-cash public benefits, including Medicaid (Medi-Cal in California). The rule makes it more difficult for immigrants to obtain permanent residency if they have used or are likely to use public benefits. Observers believe the rule will discourage immigrants from seeking health care coverage or cause them to drop their existing coverage, lest they compromise their naturalization status. The Supreme Court lifted a stay that had blocked implementation until a lawsuit against the rule was settled. The lawsuit is still pending.

California Children's Services (CCS) Advisory Group to Gather Post-Transition Data
The January 22 quarterly meeting of the CCS Advisory Group focused on upcoming efforts to capture family feedback about the Whole-Child Model (WCM) and establish health plan performance measures.

- *Telephone Survey:* UC San Francisco has been engaged to conduct a telephone survey of parents of CCS children in WCM and non-WCM counties. The goal is to assess participant satisfaction, experiences with care, and perceived changes in access, quality and care coordination since the WCM transition. UCSF is in the process of finalizing the survey, which will be administered from April to June. The target sample size is 3,000 respondents. Preliminary findings are not expected until December 2020.
- *Dashboard Template:* The state released a sample WCM Performance Dashboard for stakeholder review and comment. It is designed to collect data about health plans' WCM programs. Some of the suggested measures include enrollment figures, emergency room visits, inpatient admissions, prescription use, mental health services, NICU authorizations, and grievances and appeals. The timeframe for publishing the dashboard was not announced. The group was supportive of the dashboard and asked that it include data from not only the five WCM plans but also from the counties that have not transitioned to WCM.

Annual State Audit Underway, Reviewing Medi-Cal and OCC
On January 27, DHCS began its annual medical audit of Medi-Cal and OCC (Medicaid-based services only). Auditors are expected to be on site until February 7, studying CalOptima's compliance with contractual and regulatory requirements 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, for the review period of February 1, 2019, to January 31, 2020.

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OCC Event Draws Current and Prospective Members
On Saturday morning, January 25, CalOptima welcomed more than 60 prospective and current members to our third OCC Member Retention/Outreach Event at the Garden Grove Community Center. The event included a presentation about the 2020 OCC program and benefits, which was followed by a Q&A session with internal subject matter experts from our Customer Service and Pharmacy departments as well as external experts from Community Legal Aid SoCal, Vision Service Plan and Denti-Cal. In addition, members had an opportunity to visit 16 resource tables, which featured contracted health networks, vendors, CalOptima departments and community-based organizations.

CalOptima Names Sharon Dwiers Clerk of the Board
After serving in an interim capacity, Sharon Dwiers has been named Clerk of the Board. Ms. Dwiers assists the Board and Board committee chairs in conducting public meetings and serves as the custodian of official agency records for public and government use. She has been with CalOptima for more than 23 years.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

December 5, 2019

A Regular Meeting of the CalOptima Board of Directors was held on December 5, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2.00 p.m. Director DiLuigi led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Ria Berger; Supervisor Andrew Do; Supervisor Michelle Steel

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

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Chief Executive Officer (CEO) Michael Schrader highlighted several items from his CEO Report. Mr. Schrader reported that CalOptima has earned the State Quality Award for the fifth year in a row from the Department of Health Care Services for outstanding performance for a large-scale Medi-Cal plan. In addition, he noted that CalOptima was honored at the Coalition of Orange County Community Health Centers' 45th anniversary event, receiving the Community Partner Award.

Mr. Schrader reported that on November 12, 2019, the Centers for Medicare & Medicaid Services (CMS) released its draft Medicaid Fiscal Accountability Rule, which was proposed in response to federal Medicaid spending growth and concerns about financial transparency. In a fact sheet accompanying the proposed rule, CMS stated that the intent is to strengthen fiscal integrity of the Medicaid program and ensure that state supplemental payments and financing arrangements are transparent and value driven. Mr. Schrader noted that the proposed regulation could have implications for CalOptima regarding Intergovernmental Transfers (IGTs). Under the proposed regulation, going forward, IGT dollars must be derived from state or local tax revenues and the providers must receive one hundred percent of the IGT payments.

Mr. Schrader also provided an update on the California Advancing and Innovating Medi-Cal (CalAIM) initiative, noting that the Department of Health Care Services (DHCS) has held the first three workgroup sessions: the Population Health Management and Annual Health Plan Open Enrollment workgroup met on November 5; the Behavioral Health (BH) workgroup met on November 8; and the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) workgroup met on November 20, 2019. Another 19 workgroup sessions are planned through February 2020. Mr. Schrader reported that DHCS recently

announced an all-day meeting scheduled for February 10, 2020 between the state and plan leaders to discuss ECM and ILOS.

Mr. Schrader also highlighted three items on today's agenda that were continued from the last Board meeting: Agenda Item 13, to consider approval of the revised guiding principles; Agenda Item 15, to consider approval of CalOptima's 2020-22 Strategic Plan; and Agenda Item 21, the preliminary report from the Board's consultants regarding the delivery system evaluation.

Chair Yost thanked the CEO for highlighting these items from his report, noting that the State Quality and the Community Partner Awards are very meaningful because they highlight quality, which is a key cornerstone to the work that CalOptima does to ensure that members receive the healthcare services they need. Chair Yost also noted that the IGT funding that CalOptima has received to date has made a difference and made possible many new initiatives for our members and community. Chair Yost thanked the Board members who have served on the IGT and Homeless Health Ad Hocs for their volunteer service and for their significant investment of time. He commented that with the landscape changing on IGTs, and IGT dollars now being accounted for as part of capitation payments, he did not see a need to continue to appoint Board Ad Hocs to make special recommendations on IGT funding. Chair Yost also commented that, with much progress made by the Homeless Health Ad Hoc based on its initial charter to examine the issues related to homeless health, he plans to evaluate what work remains and make recommendations to the full Board on how this work can best be completed.

PUBLIC COMMENTS

1. Dr. Michael Weiss, CHOC Children's Hospital – Oral re: Agenda Item 13, Consider Approval of Homeless Health Initiatives Guiding Principles

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the November 7, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the August 22, 2019 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee and the September 12, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

4. Consider Approval of CalOptima's Health Homes Program Policies

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

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REPORTS

5. 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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendment A09 to the Program of All-Inclusive Care for the Elderly Agreement between the California Department of Health Care Services and CalOptima regarding extension of the contract termination date to June 30, 2020. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

6. Consider Authorizing and Directing Execution of Amendment(s) to the Primary Agreement with the California Department of Health Care Services

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule). (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

7. Consider Authorizing Further Actions Related to the California Department of Health Care Services Medi-Cal Provider Enrollment Requirements

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

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to issue Letters of Agreement with non-Medi-Cal enrolled specialist/Behavioral Health providers identified by the Chief Medical Officer through December 31, 2020, as required for access to services or continuity of care purposes. (Motion carried 5-0-0; Director Berger, Supervisor Do, Director Schoeffel, and Supervisor Steel absent)***

8. Consider Approval of OneCare and OneCare Connect Polices related to Direct Member Reimbursement for Covered Services

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors approved the following new Policies and Procedures related to OneCare and OneCare Connect: 1) MA.4016: Direct Member Reimbursement for Covered Services and 2) CMC.4012: Direct Member Reimbursement for Covered***

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Services. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)

9. Consider Approval of CalOptima Utilization Management Policy and Procedure Related to Palliative Care Services

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors approved revisions to CalOptima Policy GG.1550: Palliative Care Services. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

10. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized updates to the existing Policies and Procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows: 1.) GG.1105: Coverage for Organ Tissue Transplant [Medi-Cal]; 2.) MA.6044: Coverage of Solid Organ and Stem Cell Transplants [OneCare, OneCare Connect]; 3.) GG.1327: Coordination for Dual-Eligible members, Not Enrolled in OneCare Connect, with LTSS [Medi-Cal]; and 4.) GG.1423: Medication Quality Assurance Program [Medi-Cal]. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

11. Consider Approval of Modifications to CalOptima Long Term Services and Supports Policies and Procedures related to Annual Policy Review

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved modifications to existing CalOptima Policies and Procedures for Long Term Services and Supports to be in compliance with Regulatory requirements as follows: 1.) GG.1810: Bed Hold, Long Term Care; and 2.) GG.1822 Process for Transitioning CalOptima Members Between Levels of Care. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

12. Consider Adoption of Resolution Approving Revised CalOptima 2020 Compliance Plan and Authorizing the Chief Executive Office to Approve Revised Office of Compliance Policies and Procedures

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1.) Adopted Resolution No. 19-1205-01, Approving Revised CalOptima 2020 Compliance Plan; and 2.) Authorized the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)***

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13. Consider Approval of Homeless Health Initiatives Guiding Principles

Mr. Schrader, TC Roady, Director, Regulatory Affairs and Compliance, and Candice Gomez, Executive Director, Program Implementation, provided an overview of the proposed Homeless Health Initiatives Guiding Principles.

Mr. Schrader noted that at its November 7, 2019 meeting, the Board directed staff to revise the guiding principles document to take into consideration DHCS's new CalAIM initiative. Mr. Schrader mentioned that today's presentation includes the full menu of the ILOS options.

Mr. Roady provided high-level background on the proposed CalAIM initiative as it exists today, noting that CalAIM is more of a framework, and contains many proposals that will likely evolve over time. He reported that there are more than 20 core initiatives that span a five-year period from 2021 to 2025. CalAIM also expands Medi-Cal managed care plans' responsibilities. The proposal represents the start of a process that will include stakeholder engagement, and multiple federal and state approvals. Mr. Roady noted that DHCS has created five CalAIM Workgroups: Population Health/Annual Enrollment; Enhanced Care Management; Behavioral Health; NCQA Accreditation; and Full Integration Plans and the state will receive input from the workgroups.

Ms. Gomez reported that CalOptima participates in certain state programs today that may be absorbed into the CalAIM program, such as Whole-Person Care (WPC) program and the Health Homes Program (HHP). Ms. Gomez noted that many of the CalAIM proposals are of particular interest to CalOptima, including the ECM and ILOS proposals, which staff believes have the potential to better meet the healthcare needs of Orange County's homeless population. Specific to ILOS, staff anticipates that the state will require Medi-Cal plans to submit a proposal demonstrating how using ILOS rather than standard covered Medi-Cal benefits will improve member health and result in cost savings.

After considerable discussion, the Board took the following action.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations. (Motion carried 6-0-0*; *Director Berger, Supervisor Do and Supervisor Steel absent)***

14. Consider Authorizing Reallocation of Intergovernmental Transfer (IGT) Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with the County of Orange for Implementation

Director Sanchez did not participate in this item due to his position as Director of the Orange County Health Care Agency and left the room during the discussion and vote. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Ms. Gomez introduced the item and reported that this action is to request the reallocation of $2.5 million from the $10 million previously allocated from IGT 6 and 7 funds for recuperative care and the medical respite program to housing supportive services for CalOptima Medi-Cal members.

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Vice Chair Khatibi asked staff how providers could make member referrals for these services. Vice Chair Khatibi also inquired whether the reallocation of $2.5 million could come from the homeless health allocation of $100 million instead of pulling it from already allocated IGT 6 and 7 funding. Ms. Gomez responded that the homeless health allocation of $100 million is from Medi-Cal and new IGT funds, which can only be used for Medi-Cal covered benefits for CalOptima Medi-Cal beneficiaries. Ms. Gomez noted that housing supportive services will be available as an enhanced benefit to CalOptima Medi-Cal beneficiaries who participate in the HHP, but not until after the HHP program goes live on January 1, 2020.

Director Nguyen asked how much of the $11 million allocation that the CalOptima Board has made has been spent for recuperative care services. While CalOptima has received invoices from the Orange County Health Care Agency (HCA) for less $1 million, HCA representative Melissa Tober stated that once invoicing is up-to-date, HCA plans to spend approximately $5 million. Ms. Tober noted that HCA staff anticipates billing CalOptima for at least another $2 to $3 million in 2020.

Director DiLuigi commended HCA and the Board of Supervisors for their work and collaboration to provide funding to address the social determinates of health care, including recuperative care, and homeless health care, and noted how well these county programs align with the state's CalAIM initiatives.

Director Penrose also commended the county and staff. He also reminded staff on the need for transparency and inclusiveness, and the for integration of services where feasible. Director Penrose suggested using the biweekly provider meetings to engage and inform the provider community and other stakeholders as CalAIM evolves so that CalOptima can identify appropriate metrics to start measuring now so that we will have data to support some of the potential programs such as ILOS.

Chair Yost also reminded staff on the need for transparency and inclusiveness with CalOptima's hospital and health network partners.

Director Penrose asked staff about any early thoughts on how we will go about measuring outcomes. While more details can be provided in the future as the CalAIM program is finalized, Mr. Schrader responded that measures under consideration include hospital admissions, hospital days, ER visits and overall member health care costs.

Director Nguyen also reminded staff to reach out to our Member Advisory Committee (MAC) and include MAC members in the discussions.

After considerable discussion, the Board took the following action:

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors 1.) Authorized reallocation of $2.5 million from the $10 million previously allocated IGT 6 and 7 funds of the total of $11 million allocated for recuperative care and medical respite program to housing supportive services for CalOptima Medi-Cal members; 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to a.) Amend CalOptima's current***

agreement with the County of Orange as necessary to allow for reallocation of funds previously allocated to recuperative care for CalOptima members under the County's Whole Person Care (WPC) Pilot Program; and b.) Enter into a new agreement or amend CalOptima's current agreement with the County of Orange to include housing supportive services for qualifying CalOptima members. (Motion carried 5-0-0; Director Berger, Supervisor Do, Director Sanchez (non-voting), Director Schoeffel, and Supervisor Steel absent)

15. Consider Approval of CalOptima's 2020-2022 Strategic Plan

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1.) Adopted CalOptima's 2020-2022 Strategic Plan; and 2.) Directed the Chief Executive Officer (CEO) to implement the strategic plan and provide regular progress reports to the Board of Directors over the course of its implementation. (Motion carried 5-0-0; Director Berger, Supervisor Do, Director Schoeffel, and Supervisor Steel absent)***

16. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

This item was continued to a future meeting due to lack of a quorum.

17. Consider Ratification of Amendments to the AltaMed Health Services Corporation Medi-Cal Health Network Contract, and Expenditures for Whole-Child Model Program Implementation

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1.) Ratified amendments to the AltaMed Health Services Corporation Medi-Cal health network contract, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and 2.) Ratified the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation. (Motion carried 5-0-0; Director Berger, Supervisor Do, Director Schoeffel, and Supervisor Steel absent)***

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1) authorized expenditures for CalOptima's participation in the following community events: a) up to $10,000 and staff participation at the Vietnamese Community of Southern California (VNCSC) 2019 Year of the Rat Tet Festival in Fountain Valley on January 25-26, 2020; b) up to $10,000 and staff participation at the Union of Vietnamese Student Associations Southern***

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California (UVSA) 39th Annual Tet Festival Year of the Rat in Costa Mesa on January 25-26, 2020; and c) up to $5,000 for CalOptima's participation in the Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day on March 15-17, 2020 in Sacramento; 2) made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 6-0-0; Director Berger, Supervisor Do, and Supervisor Steel absent)

ADVISORY COMMITTEE UPDATES

19. Provider Advisory Committee Update

John Nishimoto, O.D., PAC Chair, provided a brief update noting that the PAC's report is in the Board packet. Dr. Nishimoto thanked PAC member Jena Jensen for inviting Dr. Megerian from CHOC Children's to give a presentation on the new Thompson Autism Center.

20. OneCare Connect Member Advisory Update

Patty Mouton, OCC MAC Chair, provided a brief update on recent activities. Ms. Mouton reported that the OCC MAC has formed an ad hoc committee that will review OCC MAC seat descriptions and make recommendations to the recruitment workgroup made up of MAC, OCC MAC, and PAC members to ensure that all members are being represented on each committee.

INFORMATION ITEMS

21. Delivery System Evaluation

Tim Reilly, Pacific Health Policy Group (PHPG), briefly provided background and scope of work used to evaluate CalOptima's health care delivery system, which included comparisons with other local health plan delivery systems and national health plan delivery systems. Mr. Reilly provided high-level preliminary findings for the delivery system evaluation noting that he will also present the preliminary findings at the upcoming Provider Advisory Committee (PAC) meeting. He plans to present the final report and recommendations at the February Board meeting.

Agenda Items 22, 23 and 25 were accepted as presented.
22. October 2019 Financials
23. Compliance Report
25. CalOptima Community Outreach and Program Summary

24. Federal and State Legislative Advocates Reports

Josh Teitelbaum, Senior Counsel, and Eli Tomar, Counsel, at Akin Gump Strauss Hauer & Feld LLP, provided an overview of the 2020 campaigns for the presidential race and races to represent Orange County, as well as provided an update on key federal policies that are being considered by Congress.

Chair Yost announced his was reordering the agenda to hear Board Member Comments and Board Committee Reports ahead of closed session.

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Board members extended their wishes for a safe and happy holiday season.

CLOSED SESSION
The Board of Directors adjourned to closed session at 4:28 p.m. pursuant to: 1) Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer) and 2) Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D. and Dr. Nikan Khatibi) Unrepresented Employee: (Chief Executive Officer).

The Board reconvened to open session at 5:15 p.m. and it was reported out that the Board had reviewed the CEO's FY 2018-19 incentive goals and awarded the CEO 82% of his goals achieved, and that he would receive incentive compensation consistent with his contract; and that the Board would continue to consider the CEO's proposed incentive goals for FY 2019-20 at the next Board meeting.

ADJOURNMENT
Hearing no further business, the meeting was adjourned at 5:23 p.m.

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

Approved: February 6, 2020

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 20, 2019

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on February 20, 2019, at CalOptima, 505 City Parkway West, Orange, California.

Chair Yost reordered the agenda to hear Agenda Item 11, Depression Screening Initiative Update, until a quorum was reached.

INFORMATION ITEMS

11. Depression Screening Initiative Update
Edwin. Poon, M.D., Director, Behavioral Health Services, presented a brief update on the activities of the depression screening initiative approved by the Board of Directors in December 2016, using Intergovernmental Transfer (IGT) 1 funding to increase the rate of depression screenings conducted during annual wellness visits for members aged 12 to 18 years old. Approximately 7,000 members received a depression screening as of December 31, 2018. It was noted that this incentive initiative is scheduled to end in May 2019.

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:16 p.m. Director Khatibi led the Pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi (at 3:16 p.m.), Alexander Nguyen, M.D.

Members Absent: Ria Berger

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

12. Intergovernmental Transfer (IGT) Funding Update
Cheryl Meronk, Director, Strategic Development, presented an overview of IGT 1 through 7 funding, and the impact of the Medicaid Final Rule effective July 2017. The Final Rule prohibits retrospective payments to Medicaid managed care plans and must be tied to Medi-Cal covered services provided under CalOptima's contract with the Department of Managed Health Care Services (DHCS). Potential

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strategic areas for IGT 8 funding were reviewed with the Committee. It is anticipated that IGT 8 funds will be received in May 2019, and recommendations will be presented to the Board of Directors for consideration.

13. Telehealth Strategy

David Ramirez, M.D., Chief Medical Officer, provided a review of CalOptima's telehealth strategy that is being developed in collaboration with health network and provider partners to ensure CalOptima members access quality care that is convenient, maintains CalOptima's National Committee for Quality Assurance (NCQA) ranking, and meets the new NCQA Population Health Standards. The telehealth strategy will be presented at the February 2019 Health Network Forum, and a comprehensive Health Network Telehealth Survey will be conducted in late February. The proposed Telehealth Program will be presented to the Board for consideration at a future meeting.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the January 17, 2019 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

2. Receive and File the CalOptima 2018 Quality Improvement Program Evaluation

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the CalOptima 2018 Quality Improvement Program Evaluation as presented. (Motion carried 3-0-0; Director Berger absent)***

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

Betsy Ha, Executive Director, Quality Analytics, presented the action to recommend Board of Directors' approval of the CalOptima 2019 QI Program and 2019 QI Work Plan. The recommended revisions were presented to the Committee for discussion. As proposed, the recommended revisions ensure that the QI Program reflects health network and strategic organizational changes, and that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2019 QI Program and 2019 QI Work Plan as presented. (Motion carried 3-0-0; Director Berger absent)***

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4. Receive and File the CalOptima 2018 Utilization Management Program Evaluation

Action: ***On motion of Director Khatibi, seconded and carried, the Committee received and filed the CalOptima 2018 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Director Berger absent)***

5. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Utilization Management Program

Kathie Mutter, Manager, Utilization Management, presented the action to recommend Board of Directors' approval of the 2019 CalOptima Utilization Management Program. Ms. Mutter provided an overview of the program description revisions for 2019. The proposed changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, DHCS, and NCQA accreditation standards.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval of the 2019 CalOptima Utilization Management Program as presented. (Motion carried 3-0-0; Director Berger absent)***

6. Receive and File the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance Performance Improvement Plan Annual Evaluation

Action: ***On motion of Director Khatibi, seconded and carried, the Committee received and filed the 2018 CalOptima PACE Quality Assurance Performance Improvement Plan Annual Evaluation as presented. (Motion carried 3-0-0; Director Berger absent)***

7. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Miles Masatsugu, M.D., Medical Director, PACE, presented the action to recommend Board of Directors' approval of the 2019 CalOptima PACE Quality Assurance Performance Improvement Plan (QAPI). The 2019 QAPI encompasses all clinical care, clinical services, and organizational services provided to PACE participants and focuses on optimal health outcomes. Work plan elements for 2019 include comprehensive diabetes care, use of opioids at high dosage, reducing the rate of day center falls, participant satisfaction with meals, and Care for Older Adults: Advance Care Planning.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the 2019 CalOptima PACE Quality Assurance Performance Improvement Plan as presented. (Motion carried 3-0-0; Director Berger absent)***

8. Consider Recommending that the Board of Directors' Extend and Authorize Allocations/Reallocations of Spending Rate Year 2010-11 Intergovernmental Transfer (IGT 1) Funds

Pshyra Jones, Director, Health Education and Disease Management, presented the action to recommend that the Board of Directors: 1) Authorize extension of the timeline for previously-approved spending of Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds to expand the child and adolescent component of the Shape Your Life (SYL) weight management program for

CalOptima Medi-Cal members until the funds have been exhausted; and 2) Authorize the funds allocated for member interventions ($150,000) to support program awareness and outreach efforts, continued costs for program expansion, and the Department of Health Care Services (DHCS)-approved member and provider incentive program. Ms. Jones provided an overview of the program awareness and outreach efforts during 2018, the DHCS-approved incentive program for members and providers participating in this program, as well as the administrative expenses related to program expansion.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended that the Board of Directors: 1) Authorize extension of the timeline for previously-approved spending of Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds to expand the child and adolescent component of the Shape Your Life (SYL) weight management program for CalOptima Medi-Cal members until the funds have been exhausted; and 2) Authorize the funds allocated for member interventions ($150,000) to support program awareness and outreach efforts, continued costs for program expansion, and the Department of Health Care Services-approved member and provider incentive program. (Motion carried 3-0-0; Director Berger absent)***

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

Sesha Mudunuri, Executive Director, Operations, presented the action to recommend Board of Directors authorize modifications of the following CalOptima Policies and Procedures for the Grievance and Appeals process to be in compliance with regulatory requirements and Medicaid Final Rule: HH.1102: CalOptima Member Complaint; HH.1103: CalOptima Health Network Member Complaint; HH.1108: State Hearing Process; GG.1510: Appeal Process for Decisions Regarding Care and Services; and GG.1814: Appeal Process for Long Term Care Facility.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors authorize modifications of the following CalOptima Policies and Procedures for the Grievance and Appeals process to be in compliance with regulatory requirements and Medicaid Final Rule: HH.1102: CalOptima Member Complaint; HH.1103: CalOptima Health Network Member Complaint; HH.1108: State Hearing Process; GG.1510: Appeal Process for Decisions Regarding Care and Services; and GG.1814: Appeal Process for Long Term Care Facility. (Motion carried 3-0-0; Director Berger Absent)***

10. Consider Recommending Board of Directors' Approval of Policy GG.1657, the Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting Policy

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval of Policy GG.1657, the Medical Board of California and the NPDB Reporting Policy. (Motion carried 3-0-0; Director Berger Absent)***

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14. Quarterly Reports to the Board of Directors' Quality Assurance Committee
The following Quarterly Reports were accepted as presented:

a. Quality Improvement Committee Update
b. Member Trend Report Update

COMMITTEE MEMBER COMMENTS

Chair Yost commented on the more than 200 reported homeless deaths in Orange County during 2018 and directed staff to investigate the percentage of these homeless deaths that were CalOptima members, the demographics, causes of death, and prior access to medical care. Chair Yost also requested that staff identify opportunities for improvement for consideration at the May 15, 2019 Board of Directors' Quality Assurance Committee meeting.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:31 p.m.

/s/ Sharon Dwiers for
Suzanne Turf
Clerk of the Board

Approved: October 17, 2019

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 16, 2019

CALL TO ORDER

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

Members Present: Lee Penrose, Chair; Ria Berger, Scott Schoeffel

Members Absent: All Members present

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

PUBLIC COMMENT

Mallory Vega, Alzheimer's OC/Orange County Adult Day Services Coalition – Oral re: Agenda Item 3. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2019-20 Operating Budget

Gio Corzo, SeniorServ/Orange County Adult Day Services Coalition -- Oral re: Agenda Item 3. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2019-20 Operating Budget

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Nancy Huang, Interim Chief Financial Officer, presented an overview of the Treasurer's Report for the period January 1, 2019 through March 31, 2019. Based on a review by the Board of Directors' Investment Advisory Committee, she reported that all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

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CONSENT CALENDAR

2. Approve the Minutes of the February 21, 2019 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the January 28, 2019 Special Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2019-20 Operating Budget

Ms. Huang presented the actions to recommend that the Board of Directors approve the CalOptima Fiscal Year (FY) 2019-20 Operating Budget and authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. As proposed, the FY 2019-20 Operating Budget assumes an average monthly enrollment of approximately 743,500 members, revenue at approximately $3.5 billion, medical costs of approximately $3.3 billion, operating income loss of approximately $(45 million), and a total change in net assets of $(30 million.) A detailed review of the proposed FY 2019-20 Operating Budget by line of business was presented to the Committee for discussion.

Ms. Huang also stated that CalOptima expected to receive draft rates for FY2019-20 from the Department of Health Care Services (DHCS) on May 17, 2019, noting that rate reductions were expected. After considerable discussion on the matter, the Finance and Audit Committee agreed to convene Special FAC meeting if the rates were materially different than the assumptions included in the budget presented a today's FAC meeting.

Action: ***On motion of Chair Penrose, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Fiscal Year (FY) 2019-20 Operating Budget and authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 3-0-0)***

4. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2019-20 Capital Budget

Ms. Huang presented the action to recommend that the Board of Directors approve the CalOptima FY 2019-20 Capital Budget and authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2019-20 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. The recommended FY 2019-20 Capital Budget of $11 million in the following asset types within three asset categories: Information systems, including hardware, software, and professional fees related to implementation, approximately $9.6 million; 505 Building improvements, approximately $1.4 million; and PACE Center, $54,000.

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Ms. Huang also noted for the record that the Capital Budget includes security enhancements for the Member Services lobby as well as the much-needed replacement of the cooling tower for the 505 building.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Fiscal Year (FY) 2019-20 Capital Budget and authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2019-20 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. (Motion carried 3-0-0)***

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

Ms. Huang presented the recommended action that the Board of Directors reappoint Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee (IAC) noting that Mr. Johnson has served as a member of the IAC since June 6, 2013 and consistently provided leadership and services to CalOptima's investment strategies.

Action: ***On motion of Chair Penrose, seconded and carried, the Committee recommended that the Board of Directors' reappoint Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term beginning June 7, 2019. (Motion carried 3-0-0)***

6. Consider Recommending Board of Directors Ratification of Standardized Annual Proposition 56 Provider Payment Process; and Recommending Ratification of Amendments to Medi-Cal Health Network Contracts

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

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended the Board of Directors' ratification of standardized annual Proposition 56 provider payment process; and ratify Medi-Cal health network contract amendments to address continued payments to individual providers of Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services began in State Fiscal Year 2018-19 and all future extensions thereafter as long as the State of California continues the enhanced Proposition 56 payments to CalOptima. (Motion carried 2-0-0; Director Schoeffel absent)***

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

Len Rosignoli, Chief Information Officer introduced the recommended action, noting that the dollar amount of the budgeted but unused funds had been updated to $56,600 instead of $55,000 as originally presented.

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

Action: ***On motion of Chair Penrose, seconded and carried, the Committee recommended that the Board of Directors' approve the amended motion to approve reallocation of FY2018-19 budgeted but unused funds of up to $56,600 from Altruista Health Care Management System to MCG Health Care Guidelines to fund the additional cost for MCG Health Care Guidelines for Behavioral Health Services and authorize extension of the MCG Health contract through June 30, 2024. (Motion carried 2-0-0; Director Schoeffel absent)***

INFORMATION ITEMS

8. 2019 Audit Planning

DeVon Wiens of Moss-Adams LLP introduced Stacy Stelzriede, Engagement Partner new to the Moss Adams team, noting that he will be retiring this year. Ms. Stelzriede presented a review of the scope of services for the annual audit for the year ending June 30, 2019 and provided a brief overview of recent changes in accounting standards. For the FY2018-19 audit, interim fieldwork is scheduled to begin on May 20, 2019, and final fieldwork will begin on July 22, 2019. The draft audited financial statements will be presented to the Finance and Audit Committee for review at the September 2019 meeting.

Aparna Venkateswaran, Engagement Senior Manager, briefly reviewed the various reports that are produced during this audit as well as new standards that will affect CalOptima beginning in fiscal year 2020.

9. March 2019 Financial Summary

Ms. Huang provided an overview of the enrollment, balance sheet, Board-designated reserves and tangible net equity (TNE) as of March 31, 2019.

The following Information Items were accepted as presented:
10. Health Homes Program Update
11. CalOptima Information Systems Security Update
12. Cost Containment Improvements/Initiatives
13. Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System

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14. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

COMMITTEE MEMBER COMMENTS

Chair Penrose welcomed Director Berger to the Finance and Audit Committee and thank staff for all of their hard work

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 4:10 p.m.

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

Approved: 9/19/19

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 22, 2019

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:02 p.m. Chair Penrose led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Scott Schoeffel

Members Absent: Ria Berger

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

PUBLIC COMMENT
There were no requests for public comment.

REPORTS
1. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2019-20 Operating Budget

Director Penrose introduced the item and noted that at the May 16, 2019, Finance and Audit Committee (FAC) Meeting, the Committee members voted unanimously to recommend approval of the budget contingent on any new information received from the State being consistent with the staff presentation at the May 16, 2019 FAC meeting.

Ms. Huang presented the revised proposed budget for the CalOptima Fiscal Year (FY) 2019-20 Operating Budget and focused on the differences between the proposed budget presented on May 16, 2019 and updates included in the May 22, 2019 budget package. As proposed, the FY 2019-20 Operating Budget assumes an average monthly enrollment of approximately 743,500 members, revenue at approximately $3.5 billion, medical costs of approximately $3.3 billion, operating income of approximately $11 million, instead of the loss budget proposed on May 16, 2019, of $(45 million) and a total change in net assets of approximately $26 million positive, which had been previously proposed as a budgeted loss of approximately $(30 million). A detailed review of the proposed FY 2019-20 Operating Budget by line of business was presented to the Committee for discussion.

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Ms. Huang highlighted the differences in revenue proposed on May 16, 2019, for the FY2019-20 Operating Budget and the updated proposed budget presented today. For Medi-Cal Classic, staff had previously assumed no change in revenue but today with the new draft rates from the Department of Health Care Services (DHCS), staff is proposing a budget reflecting a 5% revenue increase. For Medi-Cal Expansion, staff had previously proposed a budget reflecting a (10) % decrease in Medi-Cal Expansion revenue; however, based on input from DHCS, staff is now anticipating a more moderate (6.7) % revenue drop. For Medi-Cal Whole-Child Model revenue, the May 16th budget assumed no revenue change; however, today staff is proposing a 2.0 % budgeted revenue increase. Ms. Huang reviewed the revised capitation rates and impact to various lines of business and aid codes, noting the draft rates were better than expected in most areas. After considerable review and discussion on the matter, the Finance and Audit Committee took the following action.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Fiscal Year (FY) 2019-20 Operating Budget and authorization of the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 2-0-0)***

Ms. Huang updated the FAC on follow-up items from the May 16, 2019 meeting. From the FY2019-20 Capital Budget, there were questions regarding the main cooling tower, which is the largest item in the capital budget. Ms. Huang introduced Carla Osimo, Property Manager at RiverRock Real Estate Group, CalOptima's building management company, to provide additional details regarding the need for replacement and the associated cost. Ms. Osimo stated that this building was built in 1978 when there were far fewer heat-generating electronic devices in the building. The current cooling tower is the original, and is no longer able to efficiently cool the building. This is causing the chiller to run at full capacity and CalOptima is required to run the air conditioning seven days a week to keep the building cool. The expected lifespan of cooling towers is about 20 to 30 years. With the new proposed cooling tower, we will have newer technology, with greater energy and water efficiency.

Ms. Huang updated the FAC on revised staffing vacancy factors moved from 3% to 5% based on actual trend. The Finance team also reached out to business owners on projects listed on Attachment B that are $250,000 or over to ensure the project implementation will begin in FY2019-20.

Also, Ms. Huang noted that, as Chair Penrose had mentioned, staff is continuing to monitor the financial performance of OneCare Connect and Whole-Child Model and will start bringing regular updates to the FAC.

COMMITTEE MEMBER COMMENTS

The Committee thanked staff for its hard work on the budget and thanked the providers for their support.

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

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

Approved: 9/19/19

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 19, 2019

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

Members Present: Lee Penrose, Chair; Ria Berger; Scott Schoeffel

Members Absent: All Members Present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Sharon Dwiers, Interim Clerk of the Board

PUBLIC COMMENT
There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Nancy Huang, Interim Chief Financial Officer, presented an overview of the Treasurer's Report for the period April 1, 2019 through June 30, 2019. Based on a review by the Board of Directors' Investment Advisory Committee, it was reported that all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

2. Approve the Minutes of the May 16, 2019 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Approve the Minutes of the May 22, 2019 Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File the Minutes of the CalOptima Board of Directors' Investment Advisory Committee

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

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REPORTS

3. Consider Recommending that the Board of Directors Accept and Receive and File Fiscal Year 2019 CalOptima Audited Financial Statements

Ms. Huang presented the action to recommend that the Board of Directors accept and receive and file the Fiscal Year 2019 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Stacy Stelzriede of Moss-Adams, LLP, CalOptima's independent financial auditor, presented the draft audit of the consolidated financial statement for the fiscal year ending June 30, 2019. A detailed review of the areas of audit emphasis were presented to the Committee for discussion, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. It was reported that Moss-Adams will be issuing an unmodified opinion on the financial statements indicating that the FY 2019 financial statements fairly state the financial condition of CalOptima in all material respects.

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

Action: ***On motion of Director Berger, seconded and carried, the Committee approved the draft Fiscal Year (FY) 2019 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP, and recommended that the Board of Directors accept and receive and file the final version of the FY 2019 consolidated audited financial statements. (Motion carried 3-0-0)***

4. Consider Recommending the Board of Directors' Adopt Resolution No. 19-1003-01 Amending Resolution No. 12-0301-01 to Amend CalOptima Policy GA.3202: CalOptima Signature Authority

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended that the Board of Directors adopt Resolution 19-1003-01 amending Resolution No. 12-0301-01 to amend CalOptima Policy GA.3202: CalOptima Signature Authority (Motion carried 3-0-0)***

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

Action: ***On motion of Chair Penrose, seconded and carried, the Committee recommended that the Board of Directors 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. (Motion carried 3-0-0)***

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6. Consider Recommending Board of Directors' Authorization to Issue a Request for Proposal(s) for CalOptima Real Estate Related Services

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize the issuance of a Request for Proposal(s) for CalOptima real estate related consultant services. (Motion carried 3-0-0)***

7. Consider Recommending Board of Directors' Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating and Capital Budgets for Various Information Services Items

Len Rosignoli, Chief Information Officer, presented an overview of various Information Services (IS) requests for additional funding during the current fiscal year. After considerable discussion, the Committee agreed to recommend that Board of Directors authorize the unbudgeted requests except item 2) a) An increase of up to $160,000 for Other Operating Expenses-Software Maintenance for royalty fees for use of the American Medical Association coded from Optum. The Committee asked staff to conduct additional study on the large proposed increase in royalty fees and return to the full Board of Directors with further recommendations.

Action: ***On motion of Chair Penrose, seconded and carried, the Committee recommended that the Board of Directors 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 with the Medi-Cal program administrative expenses category in an amount not to exceed ~~$553,000~~ $393,000 from existing reserves for the following: ~~a) An increase of up to $160,000 for Other Operating Expenses-Software Maintenance for royalty fees for use of the American Medical Association codes from Optum;~~ b)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; c) An increase of up to $300,000 for Professional Fees for Medical Affairs/Information Services consulting; and d) An increase of $18,000 for Other Operating Expenses-Software Maintenance to support an upgrade to CalOptima's help desk tool, uGovernIT. (Motion carried 3-0-0)***

8. Consider Recommending that the Board of Directors' Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year (CY) 2020

Brigette Gibb, Executive Director, Human Resources, presented an overview of the proposed employee and retiree group health insurance and wellness benefits for CY 2020.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors:***

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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.***

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.***

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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. (Motion carried 3-0-0)

INFORMATION ITEMS

9. July 2019 Financial Summary

Ms. Huang provided an overview of CalOptima's financial performance through July 31, 2019. She noted that CalOptima is booking approximately a $2.1 million loss for the month of July, which is largely due to high pharmaceutical costs associated with a new CCS Whole-Child Model member who has a condition for which there is a new life changing drug available for young children. While only a single injection is required to cure the condition, the cost of the injection is between $2 to $3 million. Staff is working with the state on reimbursement.

Chair Penrose reordered the agenda to move Agenda Item 11 to be heard after Agenda Item 9.

11. Quarterly Operating and Capital Budget Update

Ms. Huang provided an update of Board action approval details and summary, as well as CEO-approved budget allocation changes as of June 30, 2019, noting that this will be a standing item on the Finance and Audit Committee (FAC) agenda going forward.

Chair Penrose thanked staff for their work in putting this report together and noted that the report will be helpful in the Committee's review and recommendations to the full Board.

The following Information Items were accepted as presented:
10. CalOptima Information Systems Security Update
12. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

The Committee thanked staff for their hard work.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 3:19 p.m.

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

Approved: 11/15/2019

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

October 17, 2019

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:00 p.m. Chair Yost led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi

Members Absent: Alexander Nguyen M.D.

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel, Betsy Ha, Executive Director, Quality and Population Health Management; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Sharon Dwiers, Interim Clerk of the Board

PUBLIC COMMENTS
Dr. Michael Weiss, CHOC Children's – Oral re: Agenda Item 6, Proposed Health Network Quality Rating Methodology and Pay for Value 2020 Program Update

CONSENT CALENDAR

1. Approve the Minutes of the February 20, 2019 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

None

INFORMATION ITEMS

2. Updated Homeless Health Clinical Analysis
Marie Jeannis, Enterprise Analytics Manager, provided an update on the clinical analysis of health for members experiencing homelessness. Ms. Jeannis noted that the clinical analysis for these members is derived from demographic and claims data. She also noted that when comparing the homeless population to the not-homeless population there are large disparities including the

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following: homeless members are two times as likely to have a behavioral health diagnosis without treatment, two to six times higher rate of top behavioral health diagnoses, four times as likely to have a serious mental illness condition, 11 times more likely to have an overdose and substance abuse diagnosis, five to six times more likely to visit the ER, seven times more likely to have an inpatient stay, and two times as expensive per member per month.

The Committee directed staff to see whether the same members are frequently using the ER. If so, those members may benefit from more outreach to help better manage their care.

3. Introduction to Trauma Informed Care and Building Resilience

Betsy Ha, Executive Director, Population Health Management, presented an overview of trauma informed care. Ms. Ha explained that trauma and violence are widespread, harmful and costly public health concerns. She noted that trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity or sexual orientation. Many people who have experienced trauma may have no negative effects in their lives, but many others experience substance use and mental health issues, and this affects not only the individual, but also their families. Trauma can also lead to homelessness.

Ms. Ha reported that Adverse Childhood Experiences (ACE) screening is recommended for the Health Homes pilot and the AB360 workgroup recommends universal ACE screening. Because of the significant impact that trauma can have on people throughout their lives, and the possible associated health risks, use of the ACE screening tool, is recommended.

Ms. Ha suggested developing a quality incentive around this issue and that CalOptima implement ACE screening (for adults) and the Pediatric ACEs and Related Life Screening (PEARLS) screening (for children) and train CalOptima providers on using this tool. Ms. Ha also suggested that CalOptima purchase a book called *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity, by Dr. Nadine Burke Harris,* for primary care physicians serving CalOptima members.

4. HEDIS 2019 (MY 2018 results)

Ms. Ha presented a review of the HEDIS 2019 results for the Medi-Cal, OneCare and OneCare Connect lines of business using the Tableau tool, which enables comparisons of individual measures year to year and with other health plans. It was reported that the CalOptima Medi-Cal program met all DHCS minimum performance levels. For the OneCare program, 19% of the measures met the goal, 44% of measures were better than last year, and opportunities for improvement are in the areas of post discharge medical reconciliation and readmission measures. OneCare Connect measures were reported as follows: 37% of measures met the goal, 60% of measures were better than last year, and opportunities for improvement are in the areas of breast cancer screening, care for older adults, and readmissions measures. Next steps include raising the bar from the 25% percentile to the 50% percentile, focus on new Department of Health Care Services (DHCS) quality measures and implement strategies on low performing areas.

5. New Department of Health Care Services Managed Care Accountability Act Set (MCAS)

Ms. Ha highlighted the new requirements that were introduced by the Newsom administration, initial MCAS measures and the new minimum performance level (MPL) announced in April 2019, with the final MPL effective May 2019. Previously, for 19 of the measures, plans had to meet the 25th percentile to meet the MPL; plans will need to meet the 50th percentile for those 19 measures going forward. Financial sanctions will be applied to plans who do not achieve the MPL. Staff will be working with providers to meet these new requirements.

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6. Proposed Health Network Quality Rating Methodology and Pay for Value 2020 Program Update

Ms. Ha provided an overview of the new proposed health network quality rating methodology. Staff is proposing an administrative simplification by using a consistent measurement system across all programs. The proposed new scoring is based on health network Medicaid HEDIS/Member experience results, NCQA Quality Compass Medicaid national percentiles are used as benchmarks. Scoring points would be as follows: 5>=90th percentile; 4>=66th but <90th percentile; 3>=33rd but <66th percentile; 2>=10th but <33rd percentile; 1< 10th percentile.

Ms. Ha also provided an overview of the proposed pay for value (P4V) 2020 program noting that CalOptima staff is proposing a tier-based payment. Health Networks will be required to receive a score of 2.5 or higher to be eligible to receive P4V incentive payments, and Health Networks will only receive performance-based incentive dollars. Ms. Ha noted that in the past CalOptima awarded incentive dollars for improvement in measures. However, in MY 2020 proposal, Health Networks will only receive incentive dollars for performance not for improvement. Ms. Ha also noted that in prior years, Health Networks were awarded incentive dollars retrospectively but in the proposed P4V MY 2020, Health Networks would start the year earning an additional $3.00 per member per month (PMPM) prospectively to incentive providers to implement strategies to improve performance. If Health Networks score poorly on the measures, CalOptima will take dollars back.

Expressing concern about potentially taking dollars back from providers, Chair Yost noted that staff should further refine the recommendations and provide additional detail before taking the recommendations to the Board. The Committee also raised concerns about the prepayment and possibly needing to recoup those dollars if the health network did not meet all of the performance measures, noting that staff should reach out to the health networks and ensure they understand the proposed methodology.

7. PACE Member Advisory Committee Update

This item was accepted as presented.

8. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Committee Report
b. Member Trend Report

Agenda Items 8.a. and 8.b. were accepted as presented; however, with respect to Item 8.b. Chair Yost noted the results for CCN reflected in the report. Ana Aranda, Director, Grievance and Appeals Resolution Services, explained that following a recent state audit, certain member calls that were more of an inquiry or an issue that resolved at the time of a call, are reflected in the trend report as grievances. Previously, these types of calls were not categorized as grievances. Consequently, the results are not directly comparable with prior trend reports.

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COMMITTEE MEMBER COMMENTS

ADJOURNMENT

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

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

Approved: December 13, 2019

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MINUTES

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

February 26, 2019

A Regular Meeting of the CalOptima Board of Directors' Whole Child Model Family Advisory Committee (WCM FAC) was held on February 26, 2019, at CalOptima, 505 City Parkway West, Orange, California.

Chair Byron reordered the agenda to hear CEO and Management Reports until a quorum was reached.

MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided an update on the Health Homes Program (HHP) and noted CalOptima is working with the Department of Health Care Services (DHCS) to see if there is flexibility in moving program implementation to January 1, 2020, to allow CalOptima staff to focus on the Whole-Child Model (WCM) Program. Ms. Khamseh also provided an update on the WCM contracting initiative and noted that CalOptima will be providing DHCS with copies of signed provider contracts DHCS required WCM Specialists before March 1, 2019. She also noted that WCM member noticing is still required, and that the CCS eligible members with CalOptima will receive both a 90-day and a 60-day letter and an outreach call prior to July 1, 2019.

Ms. Khamseh also discussed the opportunity to integration of the dental program, Denti-Cal into Medi-Cal benefits.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, provided an update on CalOptima's plan to reduce barriers for the WCM families and members to receive care. Dr. Ramirez invited the committee to provide feedback they felt were areas of concern which led to a robust discussion among the committee members.

Whole-Child Model Update

Candice Gomez, Executive Director, Program Implementation, updated the Committee on the preparations undertaken in various departments to ensure readiness for the transition on July 1, 2019.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, provided an update on the WCM contracting initiative to contract with CCS providers by July 1, 2019. She noted that ten networks were using Children's Hospital of Orange County (CHOC) to create their WCM network. She also discussed the behavioral health program and reminded the Committee that the Orange County Health Care Agency (OCHCA) still handles the most severe mental health issues with CalOptima responsible for the mild to moderate mental health issues.

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CALL TO ORDER

Chair Byron called the meeting to order at 10:10 a.m.

ESTABLISH QUORUM

Members Present: Maura Byron, Chair; Pam Patterson, Vice Chair; Sandra Cortez-Schultz; Grace Leroy-Loge; Kristen Rogers; Malissa Watson; Diane Key (at 10:00 a.m.)

Members Absent: Melissa Hardaway

Others Present: Ladan Khamseh, Chief Operating Officer; David Ramirez M.D., Chief Medical Officer; Sesha Mudunuri, Executive Director, Operations; Candice Gomez. Executive Director, Program Implementation; Tracy Hitzeman, Executive Director, Clinical Operations; T.T. Nguyen Dr., Medical Director; Medical Management; Michelle Laughlin, Executive Director, Network Operations; Betsy Ha, Executive Director, Quality & Population Health Management; Belinda Abeyta, Director, Customer Service; Cheryl Simmons, Staff to the Advisory Committees. Customer Service; Samantha Fontenot, Program Specialist, Customer Service; Marlene Acevedo, Manager, Customer Service

MINUTES

Approve the Minutes of the January 17, 2019 Special Meeting of the CalOptima Board of Directors' Whole Child Model Family Advisory Committee

Action: ***On motion of Member Leroy-Loge, seconded and carried, the WCM FAC Committee approved the minutes of the January 19, 2019 meeting. (Motion carried 7-0-0, Member Hardaway absent)***

PUBLIC COMMENT

Michael Weiss M.D., Children's Hospital of Orange County - Oral re: Agenda Item VI. B. Care Management.

REPORTS

Consider Recommendation of Whole Child Model Family Advisory Committee Authorized Family Member Candidate

At the January 17, 2019 Special Meeting, Chair Byron formed a Nominations Ad Hoc Committee (Ad Hoc) comprised of herself, Vice Chair Pamela Patterson and Member Leroy-Loge to review an applicant for the Authorized Family Representative seat that expires on June 30, 2020.
On behalf of the Nominations Ad Hoc, Vice Chair Patterson summarized the qualifications of Cathleen Collins for the open Authorized Family Member seat and asked for a recommendation to forward her nomination to the CalOptima Board for approval.

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Action: ***On motion of Member Leroy-Loge, seconded and carried, the Committee approved the ad hoc recommendation to nominate Cathleen Collins as an Authorized Family Member Representative. Recommendation will be forwarded to the CalOptima Board of Directors for consideration at the April 4, 2019 meeting. (Motion carried 7-0-0; Member Hardaway absent).***

INFORMATION ITEMS

Whole-Child Model Pharmacy Update

David Ramirez M.D, Chief Medical Officer, provided comprehensive information regarding CalOptima's Pharmacy Management responsibilities and the WCM pharmacy goals.

Dental Initiative Update

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

WCM FAC Member Updates

Chair Byron announced that the recruitment process for the following seats whose terms will expire on June 30, 2019 will begin on March 1, 2019: three Authorized Family Member Representatives, and two Community Based Organization or Consumer Advocate Representatives. The Chair and Vice Chair positions are also open for nominations. Applications will be posted March 1, 2019 on CalOptima's website; applications must be returned by April 1, 2019. It was noted that members currently appointed to these seats must reapply. Chair Byron formed an ad hoc committee consisting of herself, and Members Rogers and Leroy-Loge to review applications prior to the next WCM FAC meeting. The ad hoc will present recommendations at the April WCM FAC meeting.

ADJOURNMENT

Hearing no further business, Chair Byron adjourned the meeting at 11:20 a.m.

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

Approved: December 10, 2019

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MINUTES

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

November 14, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, November 14, 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 8:03 a.m. Anjan Batra, M.D. led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Craig Myers; Jacob Sweidan, M.D.; Tina Bloomer, WHNP; Dr. Loc Tran; Pat Patton, MSN

Members Absent: John Kelly, M.D.

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Emily Fonda, M.D., Deputy Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Betsy Ha, Executive Director, Quality and Population Health Management, Tracy Hitzeman, Executive Director, Clinical Operations; Shamiq Hussain, Sr. Policy Advisor, Government/Legislative Affairs; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant

MINUTES

Approve the Minutes of the September 12, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the September 12, 2019 meeting. (Motion carried 11-0-0; Member Kelly absent)***

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PUBLIC COMMENTS

There were no requests for public comment.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer (CEO), provided brief updates on the Department of Health Care Services' (DHCS') California Advancing and Innovating Medi-Cal (CalAIM) program and the proposed state waiver for FY 2021-25. Mr. Schrader announced the promotion of Nancy Huang to Chief Financial Officer.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided an update on the Qualified Medicare Beneficiary (QMB) Program. Ms. Khamseh noted that the beneficiary outreach letters have been sent out to CalOptima members encouraging them to apply for the Medicare Part A Plan. Ms. Khamseh also notified the members of the open Member Advisory Committee Consumer seat.

Chair Nishimoto reordered the agenda to hear item VI.A CHOC Children's Autism Center before continuing with the Chief Medical Officer Report.

CHOC Children's Autism Center

Jonathan T. Megerian, M.D., a Board-Certified Pediatric Neurologist at CHOC Children's provided a comprehensive presentation on CHOC's new Thompson Autism Center. Dr. Megerian described the benefits and services that will be offered at the grand opening scheduled for January 2020. Dr. Megerian also provided an overview of the assessment clinic, the challenging behavior unit, and the co-occurring clinic which will be available to children and their families.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, notified the PAC that Emily Fonda, M.D., had been promoted to Deputy Chief Medical Officer. He also reported that CalOptima received a commendable rating from the National Committee for Quality Assurance (NCQA).

INFORMATION ITEMS

Proposition 56 Tobacco Tax Update

Candice Gomez, Executive Director, Program Implementation, discussed the Proposition 56 (Tobacco Tax) initiatives. Ms. Gomez noted that CalOptima's providers may see an increase in funding whether it's fee-for service or capitation. Ms. Gomez also noted that additional funding is available and mentioned that additional initiatives have been released by DHCS. DHCS has indicated that they will start reimbursing for developmental screenings, as well as advanced childhood experience screening (ACE) effective January 1, 2020.

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Health Network Quality Rating Methodology Presentation
Betsy Ha, Executive Director, Quality and Population Health Management, provided a presentation on Health Network Rating Methodology guiding principles and proposed changes. Ms. Ha noted that CalOptima is proposing a health network rating methodology and measurement for FY 2020. She also mentioned that DHCS is requiring that managed care plans such as CalOptima must perform at least or well above the fifty percent of the Medicaid plans across the country.

Federal and State Budget Update
Shamiq Hussain, Sr. Policy Advisor, Government/Legislative Affairs, provided a brief update on the State budget. Mr. Hussain noted that the DHCS policy discussion is centered around the CalAIM proposals, which will further develop once DHCS has received stakeholder feedback along with the Centers for Medicare & Medicaid Services (CMS) feedback.

PAC Member Updates
Chair Nishimoto provided an update on the Joint Advisory Committees' Recruitment Ad Hoc meetings and noted that the ad hoc has been developing a recruitment process for each committee seat and will provide a report at the next PAC meeting on December 12, 2019.

Committee Member Comments
Member Jensen thanked the PAC on behalf of Dr. Megerian for providing the opportunity to present on the CHOC Thompson Autism Center.

Member Sweidan provided feedback to CalOptima staff on the Whole-Child Model transition process, noting that the transition has been transparent and seamless.

ADJOURNMENT
There being no further business, Chair Nishimoto adjourned the meeting at 9:31 a.m.

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

Approved: December 12, 2019

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology

Contact

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

Recommended Action

Approve the Calendar Year (MY) 2020 Health Network Medi-Cal Pay for Value Performance Program incorporating the Quality Rating Methodology, for the Measurement Period effective January 1, 2020 through December 31, 2020.

Background

CalOptima has implemented a comprehensive Health Network Pay for Value (P4V) Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The existing P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board of Directors. Annually, CalOptima staff conducts a review of the current measures and their performance over time. Based on a 2018 retrospective longitudinal quality improvement performance review, although CalOptima consistently met the Minimum Performance Level, overall quality performance trends have been flat over the past five years.

This trend is very consistent with California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009 to 2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, more than half (59 percent) remained unchanged or declined. Based on feedback from CalOptima Health Networks including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data, the proposed new methodology aims for greater transparency, consistency and administrative simplification. Finally, the proposed methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, Centers for Medicare and Medicaid Services (CMS) Star Rating Status, newly required DHCS managed care accountability set (MCAS) and/or overall NCQA Health Plan Rating.

Discussion

For the Medi-Cal program, staff recommends adopting and incorporating a new "Quality Rating Methodology" consistent with NCQA validated methodology in the Health Network Medi-Cal P4V Program. Having a standard Quality Rating Methodology will provide CalOptima with one reliable methodology to establish an overall quality rating score for each Health Network. The quality rating score may be used for future P4V payment methodology, incorporated into the new Auto Assignment policy, or other future programs to improve quality health care for CalOptima members. Considering that this is a significant change, CalOptima proposed that 2020 be the baseline year.

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Measures

- All Managed Care Accountability Set (MCAS) measures that are required for Minimum Performance Level (MPL) by the Department of Health Care Services (DHCS) are used, including 12 prevention measures and seven treatment measures.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are used for member experience.
- Measures with small denominators (HEDIS < 30; CAHPS < 100) are not used in the score calculation.

Data and Frequency

- Each Health Network quality rating score will be calculated annually.
- The Health Network quality rating score will be derived from the most recently available audited, plan level Healthcare Effectiveness Data and Information Set (HEDIS) results. The HEDIS results for Health Networks are based on the administrative methodology. For measures that have a hybrid method option, the additional percentage from medical records collection (difference of CalOptima's hybrid and admin result) will be added to each Health Network's results.
- Health Network level Adult/Child CAHPS (member survey) results will be used for member experience scoring. The highest overall score results from either the Health Network's Adult or Child CAHPS survey results will be used.

Benchmarks

- NCQA Quality Compass National Medicaid percentiles

Score Calculation

- The CY2020 Health Network Medi-Cal P4V Program has a Measurement Period of January 1, 2020 through, and including, December 31, 2020.

- Overall Rating
  - The overall rating is the weighted average of a health network's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars (see below for rounding rules).
  - The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 (5 is highest) scale in half points.
- Measure point calculation
  - A measure result in the top decile (>= 90th percentile) receives 5 points.
  - A measure result in the top 3rd but not in the top 10th (>= 66th but < 90th percentile) receives 4 points.
  - A measure result in the middle 3rd (>= 33rd but < 66th percentile) receives 3 points.
  - A measure result in the bottom 3rd but not in the bottom 10th (>= 10th but < 33rd percentile) receives 2 points.
  - A measure result in the bottom 10th (< 10th percentile) receives 1 point.

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- Health Network's score = Σ (measure rating * measure weight) / Σ weights + Accreditation Bonus Points
- Health Network's Rating = round the score to the nearest half point
- Final scoring will result in an overall Health Network Quality Rating for each Health Network. Based on the final overall score, Health Networks will be assigned a score from 1–5, with 5.0 representing the best possible performance.
- NCQA Rounding Rules: The overall rating is calculated and truncated to three decimal places and round according to the rules below:

NCQA Rounding Rules	
Overall Rating	**Rating**
0.000–0.249	0.0
0.250–0.749	0.5
0.750–1.249	1.0
1.250–1.749	1.5
1.750–2.249	2.0
2.250–2.749	2.5
2.750–3.249	3.0
3.250–3.749	3.5
3.750–4.249	4.0
4.250–4.749	4.5
>= 4.750	5.0

Fiscal Impact

The recommended action to approve the 2020 Health Network Medi-Cal P4V Program to incorporate the new Health Network Quality Rating Methodology starting CY 2020 has no fiscal impact to CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. The current budget included Health Network Medi-Cal P4V program funding in an amount not to exceed $2.00 per member per month (PMPM) through June 30, 2020. Management will include expenses related to the Health Network Medi-Cal P4V program for the period beginning July 1, 2020, and after in future operating budgets.

Rationale for Recommendation

CalOptima needs to pivot from stagnant performance trend to demonstrate breakthrough improvement in all measures in order to maintain its standing as one of the high performing Medi-Cal Managed Care Plans. Having a consistent Health Network Quality Rating Methodology using NCQA methodology will provide CalOptima with one consistent quality measurement system to establish an overall quality rating score for each Health Network and it may be used in the future for other programs or policies.

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

Attachment
Medi-Cal Health Network Rating Methodology Presentation

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

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A Public Agency

CalOptima

Better. Together.

Proposed Health Network Quality Rating Methodology for CY2020 Update

Special Quality Advisory Committee Meeting
December 13, 2019

David Ramirez, M.D.
Chief Medical Officer

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A Public Agency

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Proposed Health Network Quality Rating Methodology

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Guiding Principles for Proposed Changes

- Align with Department of Health Care Services (DHCS). changes in Managed Care Accountability Sets (MCAS).
- Shift from “ranking” winner and loser thinking to a tiered rating system.
- Raise the tide of quality performance across all health networks (HN) to promote win-win thinking.
- Align with industry National Committee for Quality Assurance (NCQA) methodology.
- External expert consultant validation.
- Administrative simplification by using a consistent measurement system across programs.
- Leverage behavioral economics.

MCAS

- Due to the governor's recent focus on increased accountability for managed care plan performance on select measures, CalOptima is proposing a HN rating methodology and measurement set for Calendar Year (CY) 2020 (January 1, 2020 – December 31, 2020)
- Effective immediately, DHCS will require Managed Care Plans to perform at least as well as 50 percent of Medicaid plans in the US.
  - We must achieve the 50th National Medicaid Benchmark for each measure to avoid sanctions.
  - To achieve the new minimum performance levels, we propose adopting a new HN rating methodology and MCAS measures to the Pay for Value (P4V) program to incentivize HNs for the additional quality metrics required by DHCS

HN Rating Methodology

- NCQA Health Plan Rating method adopted for HN Rating:
  - Each HN is assessed a quality score between 1 and 5.
  - Score is based on HN performance on the list of DHCS Minimum Performance Level (MPL) Medicaid measures on 1–5 (5 is highest) scale.
  - Healthcare Effectiveness Data and Information Set (HEDIS) measures will be weighted 1.0.
  - Member Experience measures: Consumer Assessment of Healthcare Providers and Systems (CAHPS) will be weighted 1.5.
  - Hybrid measures: the additional percentage from medical records collection (difference of CalOptima's hybrid and admin result) will be added to each HN result.
  - Measures having small denominator (HEDIS < 30; CAHPS <100) will be assigned "NA," and the measure will not used in the calculation.

Proposed New Scoring

- Score calculation is based on HN Medicaid HEDIS/Member Experience results
- NCQA Quality Compass Medicaid national percentiles are used as benchmarks
- Score points
  - 5 > = 90th percentile
  - 4 > = 66th but <90th percentile
  - 3 > = 33rd but <66th percentile
  - 2 > = 10th but <33rd percentile
  - 1 < 10th percentile

Proposed Measures for MY 2020

- Children's Health
  - * **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Body Mass Index (WCC BMI)**
  - * Childhood Immunization Status — Combo 10 (CIS 10)
  - * Well Child Visits in the first 15 months of life (W15)
  - * Well Child Visits in the Third, Fourth, Fifth and Sixth years of life (W34)
  - * **Immunizations for Adolescents (IMA 2)**
  - * Adolescents Well-Care Visits (AWC)
- Behavioral Health
  - **Antidepressant Medication Management (AMM Acute phase)**
  - **Antidepressant Medication Management (AMM Continuation phase)**

** Measure rate may include findings from medical record review.*

Measures highlighted in bold are proposed new measures for P4V MY2020.

Proposed Measures for MY 2020 (cont.)

- Women's Health
  - *Cervical Cancer Screening (CCS)
  - **Chlamydia Screening in Women Ages 21–24 (CHL)**
  - Breast Cancer Screening (BCS)
  - ***Prenatal and Postpartum Care (PPC-Pre)**
  - ***Prenatal and Postpartum Care (PPC-Post)**
- Acute and Chronic Disease Management
  - ***Adult Body Mass Index Assessment (Adult BMI)**
  - ***Comprehensive Diabetes Care HbA1c Testing (CDC HT)**
  - ***Comprehensive Diabetes Care HbA1c Poor Control (CDC H9)**
  - **Asthma Medication Ratio Ages 19–64 (AMR)**
- Readmissions
  - **Plan All-Cause Readmissions (PCR)**

** Measure rate may include findings from medical record review.*

Measures highlighted in bold are proposed new measures for P4V MY2020.

Member Satisfaction Measures

- Member Experience Performance remains an important metric (and required by DHCS)
- CAHPS measures
  - Rating of Health Care
  - Rating of Health Network
  - Rating of PCP
  - Rating of Specialist
  - Getting Needed Care
  - Getting Care Quickly
  - Care Coordination
  - Customer Service

Health Network Quality Rating Tiers Overall Rating

Based on 2018 Performance and Proposed Measures

HEDIS + CAHPS + Accreditation Bonus Rating	
Health Network Name (alphabetical order for tied tiers)	Stars
Kaiser Permanente	★ ★ ★ ★ ½
AltaMed Health Services	★ ★ ★ ★
AMVI Care Health Network Arta Western Health Network CalOptima Overall CHOC Health Alliance Monarch Family HealthCare Talbert Medical Group United Care Medical Group	★ ★ ★ ½
CCN Family Choice Health Network Noble Mid-Orange County Prospect Medical Group	★ ★ ★
Heritage – Regal Medical Group	★ ★ ½

Health Network Quality Rating

Based on 2018 Performance and Proposed Measures

Health Network Name	HEDIS	Member Experience	Overall Rating
AltaMed Health Services	★★★★	★★½	★★★★
AMVI Care Health Network	★★★★	★	★★★½
Arta Western Health Network	★★★½	★½	★★★½
CalOptima Overall	★★★★	★½	★★★½
CCN	★★★	★★	★★★
CHOC Health Alliance	★★★	★★	★★★½
Family Choice Health Network	★★★½	★	★★★
Heritage – Regal Medical Group	★★★	★½	★★½
Kaiser Permanente	★★★★½	★★★★	★★★★½
Monarch Family HealthCare	★★★½	★½	★★★½
Noble Mid-Orange County	★★½	★½	★★★
Prospect Medical Group	★★★½	★	★★★
Talbert Medical Group	★★★½	★★½	★★★½
United Care Medical Group	★★★½	★½	★★★½

Next Steps

- Present the final recommendations for Board approval in February 2020.

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Approval of Unbudgeted Expenditures to Support Community Education Efforts to Increase Medi-Cal Provider Awareness of Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening

Contact

David Ramirez, MD, Chief Medical Officer, 714-246-8400
Betsy Chang Ha, R.N., Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Action

Authorize unbudgeted expenditures of up to $80,000 from existing reserves for outreach and education efforts to increase Medi-Cal provider awareness of evidence-based ACE screening and Trauma-Informed Care.

Background

At the October 17, 2019, Special Quality Assurance Committee (QAC) meeting, the QAC members directed CalOptima staff to develop a Trauma-Informed Care plan of action. As a high-performing Medi-Cal managed care plan, CalOptima is positioned to increase provider awareness and position Orange County as an early adopter in support of the Office of the California Surgeon General's (CA-OSG) statewide effort to reduce ACE and toxic stress by half in one generation, starting with Medi-Cal members.

Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epic-genetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation.

The proposed first step to building awareness and supporting the early adopters is consistent with the Governor's focus on increased accountability for managed care plan performance on select pediatric measures and the DHCS introduced additional requirements to screen and mitigate risk impacting children's health and well-being. The 25th Annual Report on the Condition of Children in Orange County also pointed out that many OC children are impacted by Social Determinants of Health (SDoH). For example, one in six children lives in poverty and nearly 30,000 students experience housing insecurity. Mental health hospitalization rates grew from 87 percent over the past 10 years and 6 percent in the past year alone. The report demonstrates strong correlation between ACE, youth suicidal behaviors and emergency department visits for self-harm. Disparities continue to persist in OC among races, ethnicities, geographies, communities and school districts. Considering that most of these children experiencing child poverty, housing insecurity, homelessness and/or foster care, they are likely members of CalOptima. As the single payer for Medi-Cal, CalOptima has the unique opportunity to support community training and increase provider awareness about Trauma-Informed Care and ACE screening.

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Separate from the provider outreach and education efforts addressed with this staff recommendation, and subject to obtaining the necessary federal approvals, the California Department hf Health Care Services (DHCS) is requiring managed care plans (MCPs) including CalOptima, through the Proposition 56 payment mechanism, either directly or through their delegated entities and subcontractors, to comply with a minimum fee schedule of $29.00 for each qualifying ACE screening service by a Network Provider with dates of services on or after January 1, 2020.

Discussion

Considering that DHCS is still finalizing the All Plan Letter, (APL) 19-XXX: Proposition 56 Directed Payments for ACE Screening Services for MCPs. Staff recommends that CalOptima focus on building awareness and buy-in and develop a more comprehensive plan of action once DHCS releases the final APL. To this end, staff proposes to:

- Promote and support dissemination of DHCS Trauma-Informed Care and ACE screening and education materials via mailings, texting, webinars, workshops, and conferences, etc. to primary care providers serving the CalOptima Medi-Cal population;

- Support early adopters, provider training dissemination events, workshops and tool kits to CalOptima contracted providers in collaboration with DHCS, Health Networks and other community partners; and

- Sponsor training events on Trauma Informed Care and ACE screening for providers serving CalOptima Medi-Cal members.

- Establish baseline process measures in year-one:
    1. Number of providers completed ACE training in year one
    2. Number of PEARL/ACE screening completed for members

While staff is not proposing to include any incentive payments associated with this initial proposed ACE outreach and education initiative, quality incentive payments may be included in future quality programs presented to the QAC and CalOptima Board. Staff's intent is to consider data collected related to ACE training provided as well as the number of screenings conducted under the DHCS Proposition 56 funded initiative as a broader ACE-based quality initiative(s) are formulated.

Fiscal Impact

The recommended action to authorize expenditures for provider education for the period of January 1, 2020, through June 30, 2020 is an unbudgeted item. A proposed allocation of up to $80,000 from existing reserves will fund this action. Management plans to include program funding to support ACEs Aware in future operating budgets.

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

Attachments:
1. ACE Aware Presentation
2. Proposed Budget

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

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Trauma-Informed Care
ACEs Aware

Special Quality Assurance Committee Meeting
December 13, 2019

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

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Agenda

- Call To Action
- California Office of Surgeon General (CA-OSG) and Department of Health Care Services (DHCS) Adverse Childhood Experiences (ACE) Update
- Population Health Impact
- Building Awareness
- Questions

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October Special QAC Call to Actions

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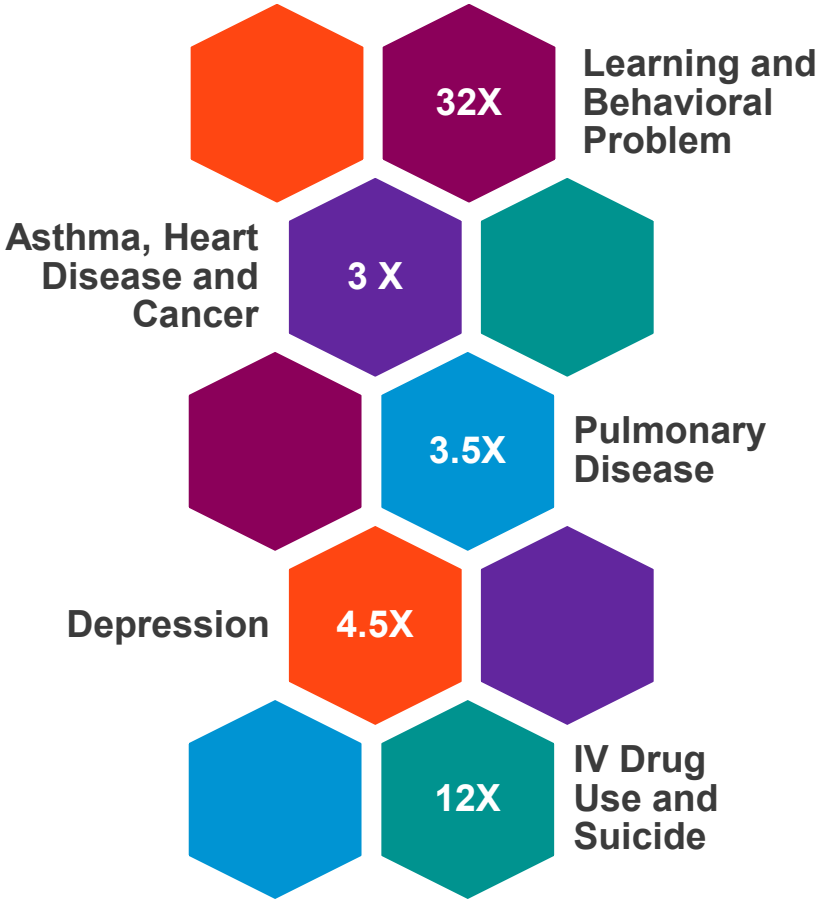
Population Health Impact

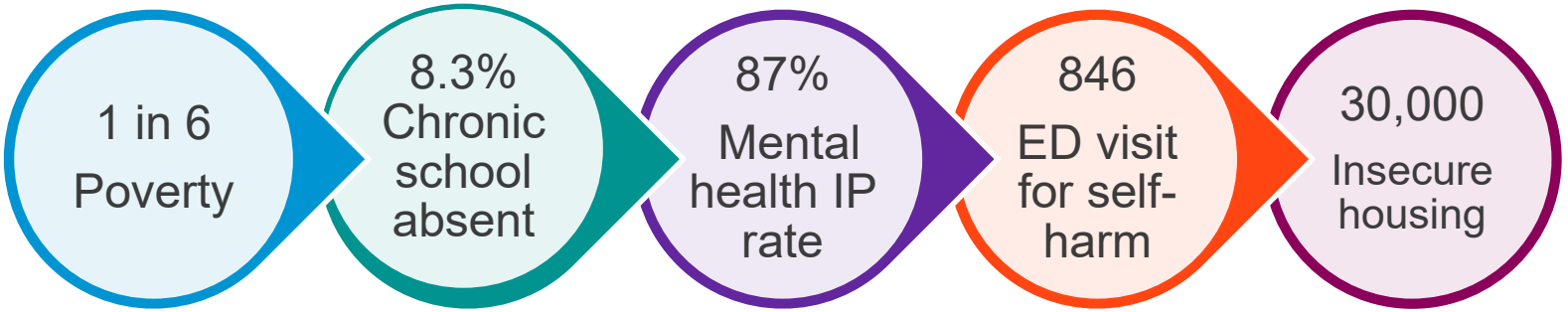
- Children Who Experience 4 or More ACEs:



Source: CDC–Kaiser Permanente ACEs Study, 1995-97

7 out of 10 Leading Causes of Death in the U.S. correlate with exposure to ≥ 4 ACEs

Condition of Children in OC



Source: 25th Annual Report on the Condition of Children in Orange County (OC)

Condition of CalOptima Children

- CalOptima has approximately 279,000 children between the ages of 0–18 years.
  - One percent (1,800) of these children are homeless
  - Over 90 percent of the children were identified through the homeless source of “address”
  - Nine percent of the homeless high confidence population
- Emergency Department Rates
  - Overall trends are slightly higher, but rates for ED visits related to diagnosis of suicidal ideation, self-harm or attempted suicide were low
- Social Determinants (Based on ICD-10 Codes)

Housing and Economics	Psychosocial	Social Environment	Support and Family	Upbringing
363	449	106	996	1,114

Population Segments at Risk for ACE

Age	Membership	ACE Tool	Estimated membership with >4+ ACE
0–5	82,406	PEARLS	30,000
6–18	216,029	PEARLS	80,000
19–40	192,494	ACE	71,000
41–64	158,892	ACE	58,000
65+	90,801	ACE	34,000

Legend:

1. Based on 2019 Medi-Cal Membership
2. >4 ACES prevalence based on the findings from the Philadelphia Urban ACE Survey; 37 percent experienced 4 or more ACE, Robert Wood Johnson Foundation. September 2013.
3. PEARLS — Pediatric ACES and Related Life Events Screener, ACE tool for children

CA-OSG and DHCS Update

- On October 17, 2019, the Department of Health Care Services (DHCS) released Draft All-Plan Letter (APL) 19-XXX: Proposition 56 Directed Payments for Adverse Childhood Experience (ACE) Screening Services for managed care plans (MCP)
- Beginning on January 1, 2020, MCP, either directly or through their delegated entities or subcontractors, to pay $29 per ACE screen completed by a Medi-Cal provider.
- Screening by provider is optional through July 2020 per CA-OSG.

CA-OSG and DHCS Update (cont.)

- CA-OSG to provide and/or authorize trauma-informed care training, in-person trainings, online learnings and regional convenings
- Positive ACE screens will need to be referred to a behavioral health specialist, manage by counseling, resiliency strategies, and/or referrals to mental health professionals.
- CA-OSG and DHCS jointly kicked off ACEs Aware Initiative on December 4, 2019.

ACEs Aware: Opportunities to Collaborate on Provider Engagement

- Provider training (kicked off on December 4, 2019)
  - Phase 1: CA-OSG and DHCS worked with Clinical Advisory Subcommittee (CAS) and developed a 2-hour online CME training via ACEsAware.org
    - ACE screening tools
    - Billing codes
  - Phase 2: CA-OSG and DHCS are interested in partnering with organizations to provide additional certified training opportunities.
    - Targeted to specific provider specialties
    - Offer different modalities (such as in-person)

ACES Aware (cont.)

- Provider Outreach and Communication
  - Look for partner and leverage existing communication channels on outreach and developing resources with guidance on incorporating ACE screening into clinical work.
  - Identify ACES Aware Champions.
- Phase 3: Learning and Quality Improvement (QI) Collaborative
  - Implement a data driven, iterative evaluation and QI process
  - Provide technical assistance to implement evidence-based best practices
  - Disseminate best practices to health systems across the state via ACEsAware.org

Build Awareness and Buy-In

- Promote and support dissemination of DHCS Trauma-Informed Care and ACE screening member and provider education materials via mailing, texting, website, workshop, conferences, etc.
- Support early adopter provider training dissemination events, workshops and tool kits, in collaboration with DHCS, community partners and health networks
- Sponsor community training event in partnership with academic institutions, professional associations and other key stakeholders
- Establish baseline process measures:
  - Number of providers completed ACE training
  - Number of PEARL/ACE screenings completed

Requested Unbudgeted Fund

- Estimated Provider Awareness Promotion budget = $80,000 for 6 months for the following expenditures:
  - Support outreach, community training, and CME events related to Trauma- Informed Care and ACE screening in addition to CA-OSG and DHCS-offered webinar
  - Distribute provider education materials

Questions

CalOptima's Mission

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

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ACEs Aware 1 Year Budget Summary

		CY2020 - Year 1				
		Jan-Mar 2020 *	**Apr-Jun 2020 ***	**Jul-Sep 2020**	**Oct-Dec 2020**	
Medical Expenses						
	Provider Education Material (Book/PCP)	15,000	15,000			$18 + mailing per book for 1,600 PCPs
	Provider Education Events Sponsrship	20,000	30,000	30,000	15,000	$10,000 CME sponsorship, per event
	Total Medical Expenses	35,000	45,000	30,000	15,000	
Administrative Expenses						
	Total Admin Expenses	-	-	-	-	
	Grand Total:	35,000	45,000	30,000	15,000	**$ 125,000**

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Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

Contact

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

Recommended Actions

1. Ratify amendments to the Medi-Cal health network contracts, except AltaMed Health Services Corporation, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and,
2. Ratify the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation.

Background

The California Children's Services Program (CCS) is a statewide program, providing medical care, case management, physical/occupational therapy, and financial assistance for children up to age 21 meeting financial and health condition eligibility criteria. Following the approval of Senate Bill 586 in September 2016, the Department of Healthcare Services (DHCS) was given the authority to incorporate a number of CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS), referred to as the Whole Child Model (WCM). CalOptima began the process of transitioning its Medi-Cal Health Networks in June 2018, with implementation going live as of July 1, 2019. The importance of a successful WCM transition cannot be overstated, as it directly impacts the wellbeing of CalOptima's most at-risk pediatric members.

IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 6 and 7 funds were received in May 2018 from the Department of Health Care Services (DHCS) totaled $31.1 million. After initial disbursements of $10 million for the Homeless Health Initiative, the Board authorized the remaining balance of $21.1 million to be used for community grants, internal initiatives and program administration. On August 1, 2019, the Board authorized $1.75 million for the Whole Child Model Assistance for Implementation and Development (WCM AID), which was approved as an internal initiative. The funds were designated to aid health networks in developing and implementing a successful delivery system for the WCM program.

Discussion

Health networks were required to cover a portion of the WCM program's startup expenses incurred before the launch on July 1, 2019. Following the Board's August 1, 2019 approval of the IGT 6 and 7 allocation for WCM startup costs, health networks were notified that they would receive a one-time, fixed payment of $50,000, plus applicable variable costs up to the amount allowed per network based on the number of WCM assigned members. CalOptima provided criteria for reimbursement, including

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receipt of attestations demonstrating that the costs were incurred prior to the WCM program go-live date of July 1, 2019, and that expenditures fall within the specified categories of:

- Staffing, recruitment and training.
- Systems and infrastructure.
- Other expenses such as educational materials, notices, etc.

Staff seeks authority to ratify contract amendments and expenditures for the Medi-Cal health networks, except AltaMed Health Services Corporation, to aid with start-up costs and implementation of the WCM program.

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. 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

The recommended action ensures CalOptima's Medi-Cal health network contracts are updated to reflect receipt of IGT 6 and 7 funds for reimbursement of startup costs associated with the WCM program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 3, 2017; Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot
3. Previous Board Action dated August 1, 2019; Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

/s/ Michael Schrader — *01/28/2020*
Authorized Signature — **Date**

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Attachment to February 6, 2020 Board of Directors Meeting – Agenda Item 5

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

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

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

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

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

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

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

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Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP responses and evaluated them based on the following criteria:

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

Discussion

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

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Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

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

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IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

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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 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

- Received 117 RFIs to identify strategies for each priority area
- IGT 6 and 7 funds of $31.1 million were received in May 2018
  - $10 million approved for recuperative care services in August 2018
  - $21.1 million allocated for community grants, internal initiatives and program administration in September 2018
    - $17.7 million in community grants
    - $2.5 million in internal initiatives
    - $900,000 in program administration (over 3 years)
- Released RFPs, evaluated responses and conducted site visits from September 2018–January 2019

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. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	26	4
2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)	10	2
3. Increase Access to Medication-Assisted Treatment ($6 million)	10	1
4. Expand Mobile Food Distribution Services ($500,000)	1	0
5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	5	1
6. Expand Access to Food Distribution Services for Older Adults ($500,000)	2	0
Total	**54**	**8**

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Children's Bureau of Southern California	$3,500,000	$3,390,000
2	OCAPICA (Orange County Asian & Pacific Islander Community Alliance Inc.)	$685,000	$685,000
3	Boys & Girls Club of Garden Grove	$325,200	$325,000
4	Jamboree Housing	$692,000	$450,000
	Total	**$5,202,200**	**$4,850,000**

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	CHOC Children's	$4,785,076	$4,250,000
2	Friends of Family Health Center	$600,000	$600,000
	Total	**$5,385,076**	**$4,850,000**

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3. Increase Access to Medication-Assisted Treatment ($6 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Coalition of Orange County Community Health Centers	$5,998,000	$6,000,000
	Total	**$5,998,000**	**$6,000,000**

5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

No Funding for RFPs 4 and 6

- No funding is recommended for two RFPs
  - 4. Expand Mobile Food Distribution Services ($500,000)
  - 6. Expand Access to Food Distribution Services for Older Adults ($500,000)
- Submitted proposals presented challenges
  - Did not demonstrate delivery of service to CalOptima members
  - Did not demonstrate sustainability after funds exhausted
- Funding was allocated to the Homeless Health Initiative's Clinical Field Team pilot on February 22, 2019

Internal Projects ($2.4 million)

Rank	Project	Original Request	Recommended Funding Amount
1	Whole-Child Model Assistance for Implementation and Development	$1,750,000	$1,750,000
2	Master Electronic Health Record (EHR) System	$700,000	$650,000
	Total	**$2,450,000**	**$2,400,000**

Recommended Board Actions

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; 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

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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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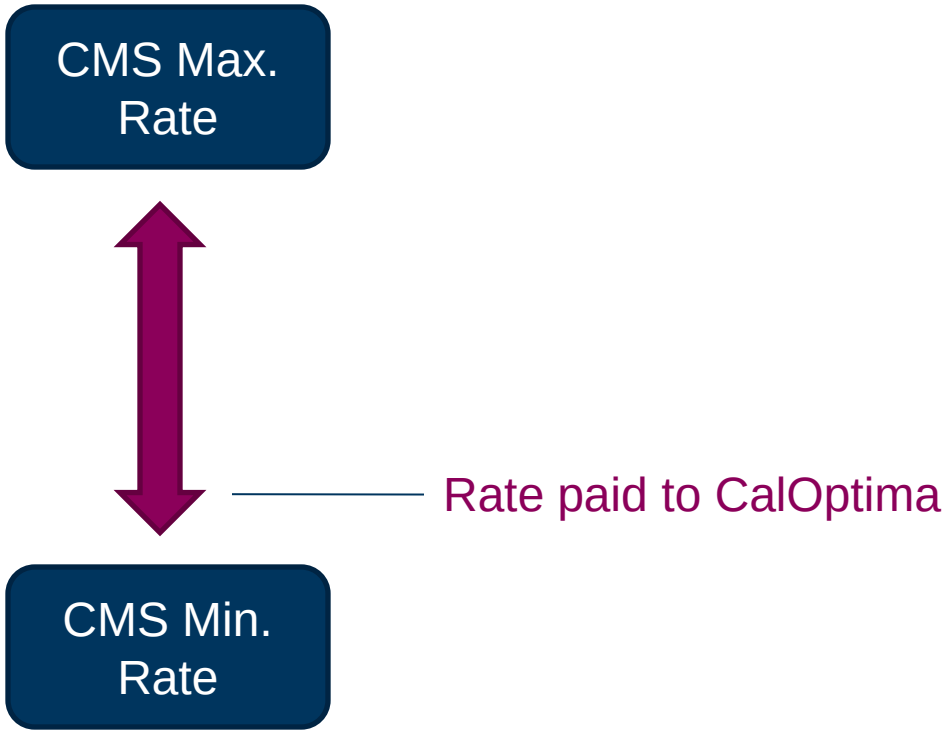
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

As of 5/31/2017

IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

As of 5/31/2017

IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

As of 5/31/2017

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IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

As of 5/31/2017

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CalOptima A Public Agency Better. Together.

IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

CalOptima's Mission

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

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

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

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

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

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

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

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

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

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants to Address Children's Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment

Contact

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

Recommended Actions

1. Approve the expenditure plan for allocation of IGT 6 and 7 funds in the amount of $21.1 million for the Department of Health Care Services (DHCS)-approved and Board-approved priority areas; and
2. Authorize the release of Requests for Proposal (RFPs) for community grants and internal project applications, with staff returning at a future Board meeting with evaluation of proposals and recommendations for award(s) being granted.

Background

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

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

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

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

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Staff performed an examination of all the responses and evaluated them based on the following criteria:

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

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

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Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

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Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

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

8/29/2018 — **Date**

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IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

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IGT 6 & 7 - Background

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

IGT 6 & 7 Funding

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Children's Mental Health – 2 RFPs

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Community Needs Identified by MHNA: Food Access – 3 RFPs

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

RFP 6

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Next Steps*

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

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Agenda

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

Current System of Care

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

**For Medi-Cal Members*

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Additional Considerations

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

Recommended Actions

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

Recommended Actions (Cont.)

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

CalOptima's Mission

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

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RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

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Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

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Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

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Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

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Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

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IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

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Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

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

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 Vision Service Plan (VSP) HMO Services Contract to reflect:

1) Reinstated Adult Routine Vision benefits for the Medi-Cal Line of Business Effective January 1, 2020, and
2) An Increase to VSP's Administrative Capitation rate in accordance with reinstated benefits.

Background and Discussion
VSP has been CalOptima's vision services provider since January 1, 2007. VSP is a vision HMO, to which CalOptima delegates credentialing, claims payment and management of benefits including reporting and audit functions, for its Medi-Cal and Medicare members. The current VSP contract's financial terms include a Per Member Per Month capitation for the administration of these services.

On December 11, 2019, the Department of Health Care Services (DHCS) notified all Managed Care Plans (MCPs), including CalOptima, that certain adult routine vision benefits, previously eliminated, would be reinstated effective January 1, 2020. The reinstated services, including routine eye exam and eyeglasses once every 24 months each, are restored as Medi-Cal benefits for eligible, full-scope Medi-Cal members 21 years of age or older. The reinstated benefits are expected to yield an increase in claims submissions as of the effective date, warranting an increase in the administrative services capitation rate provided to VSP by CalOptima.

In August 2019, VSP received an increase to the administrative capitation rate, due to the annual vision exam required for diabetic members. However, since the reinstatement of the adult routine vision services will result in an increased number of claims projected as of January 1, 2020, staff recommends amending the VSP HMO services contract to ensure the administrative capitation rate is commensurate with this increase in claims.

Fiscal Impact
The net fiscal impact to increase the administrative capitation rate for the Medi-Cal VSP HMO services contract by $0.04 per member per month effective January 1, 2020, through June 30, 2020, is estimated at $171,000. Staff anticipates that the forecasted expense trend included in the Board-approved Fiscal Year 2019-20 Medi-Cal Operating Budget will be sufficient to cover the anticipated costs related to the recommended action. Upon approval, Staff will account for the approximate annualized increase of $342,000 in future operating budgets.

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Rationale for Recommendation

This increase will support the additional services required for the administration of the enhanced benefits and claims payment resulting from the reinstatement of adult routine vision benefits for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 1, 2019, Consider Authorizing Amendment to the Vision Service Plan HMO Service Contract.

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

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Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

s/s Michael Schrader *7/24/19*

Authorized Signature **Date**

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

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

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

Background

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

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

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

Discussion

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

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

Fiscal Impact
The recommended action is budget neutral.

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

8/28/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Ratifying a Revised Amendment with the California Department of Health Care Services

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

Recommended Action
Ratify Revised Amendment 40 of the Primary Agreement between CalOptima and the California Department of Health Care Services

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

Discussion

Amendment for the Medicaid and CHIP Managed Care Final Rule (Final Rule)

On May 6, 2016, the Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, CMS-2390-F (Final Rule). The Final Rule contains various provisions that State Medicaid Agencies, including DHCS, were required to implement by various deadlines beginning in July 2017.

DHCS has generally implemented the requirements of the Final Rule by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's contracts with Managed Care Plans (MCPs), including CalOptima. Due in part to the lengthy CMS review process, DHCS has implemented these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP contracts.

DHCS compiled changes to MCP contracts that were prompted by the Final Rule's issuance and that were required to be implemented in 2017 into a single amendment, referred to as the 2017 Final Rule Amendment. In June 2017, the CalOptima Board authorized the Chair to execute the 2017 Final Rule Amendment based on a draft amendment provided to MCPs by DHCS [*Attachment 2*]. As a result of being under CMS review for over two years and iterative changes made by DHCS and CMS, the content of the draft 2017 Final Rule Amendment has been updated since the CalOptima Board authorized execution of the amendment in June 2017.

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DHCS provided MCPs with an updated draft amendment on November 22, 2019 and the Board authorized execution of the amendment at its December 5, 2019 meeting [*Attachment 3*]. However, on that same day, DHCS notified MCPs that the version of the 2017 Final Rule amendment sent to the Plans in November 2019 was inadvertently missing required contract language. On December 20, 2019, DHCS sent a further revised 2017 Final Rule amendment to CalOptima, requesting signature and return of the amendment as soon as possible, but no later than January 13, 2020.

In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on January 2, 2020 and returned the signed amendment to DHCS in advance of the January 13, 2020 deadline. Staff requests the CalOptima Board of Directors' ratification of the Board Chair's execution of the revised Amendment A–40 to the Primary Agreement with DHCS.

The language contained in the updated amendment contains additional changes that DHCS is implementing to bring MCP contracts into compliance with the Final Rule. The updated amendment also includes changes that DHCS has characterized as "cleanup" of the contract's terms. The updates to the amendment generally formalize changes that DHCS has already implemented via sub-regulatory guidance. The amendment does not contain any rate changes or otherwise set any rates, although it does indicate that CalOptima will be eligible for an additional supplemental payment [*additional detail below*].

What follows is a description of the changes contained within the updated amendment, sorted by category:

Category	Final Rule or Cleanup	Requirement
Member Representation	Cleanup	-Include members receiving LTSS in Member Advisory Committee
Pharmacy Benefit	Cleanup	-Participate in State Pharmacy Rebate program and undertake related efforts -Formalize prescription drug continuity of care requirements in policies and procedures -Modify P&T Committee membership requirements
Prior Authorizations	Cleanup	-Require MCP to consult with requesting provider, when appropriate -Update decision timeframes
Provider Training	Cleanup	-Develop training on clinical protocols and evidence-based guidelines for out-of-network providers

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Covered Services	Cleanup	-Establishes MCP responsibility for medically necessary covered services that exceed services provided by LEAs, Regional Centers, or local governmental health programs -Establishes that MCPs shall ensure that services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the Covered Services are furnished and that reflects the Member's ongoing needs -Establishes that "Medically Necessary" includes all Covered Services that are reasonable and necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. -Expands language describing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, including requirement to ensure that EPSDT services are initiated in a timely manner -Establishes that medically necessary covered services provided in an inpatient psychiatric facility includes those provided to members admitted to an Institution for Mental Disease (IMD) -Establishes that Skilled Nursing Facility room and board only is covered when IMD services are provided to Members age 21 and under, and Members age 65 and over -Establishes that Federally Required Adult Dental Services (FRADs) and fluoride varnish are covered benefits
Memoranda of Understanding (MOUs)	Cleanup	-Execute an MOU with the County Department for alcohol and substance use disorder treatment services
Provider Compensation	Cleanup	-Prohibits payment of claims for Provider Preventable Conditions (PPC) or to excluded providers.
Supplemental Compensation	Cleanup	-Establishes MCP eligibility for supplemental maternity "kick" payment
Sub-Regulatory Guidance	Cleanup	-Establishes MCP obligation to follow applicable provisions of State Plan Amendments, All Plan Letters, Medi-Cal Provider Manual, and other sub-regulatory guidance issued or amended during the term of the contract

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Quality Improvement	Cleanup	-Authorize DHCS to request additional Performance Improvement Projects (PIPs) beyond the required two annual PIPs at its sole discretion
Access and Cultural Considerations	Cleanup	-Provide family planning services in a manner that protects and enables Member freedom to choose the method(s) used -Training shall promote access and delivery of services in a culturally competent manner to all
	Final Rule	-MCP must permit American Indian Members to access out-of-network American Indian Health Services providers
Encounters	Final Rule	-Establishes requirements related to Encounter data filing timeliness and completeness, as well as DHCS's requirement to audit MCP encounter data at least once every three years
Written Member Information	Final Rule	-Establishes process for MCPs to request to distribute written member information electronically -Establishes minimum font size requirements -Establishes provider directory content and format requirements
Fraud and Abuse	Final Rule	-Follow fraud and abuse requirements set forth in federal regulation
Contract Requirements	Final Rule	- Include special contract provisions related to payment set forth in federal regulation

Fiscal Impact
Funding related to the recommended action to ratify Amendment 40 of the Primary Agreement with DHCS to incorporate language required in the Final Rule is included in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. If the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Rationale for Recommendation
CalOptima's execution of the 2017 Final Rule amendment to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program.

Concurrence
Gary Crockett, Chief Counsel

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Attachment

1. Appendix summary of amendments to Primary Agreements with DHCS
2. Board Action 2017 0601_12._DHCS Primary Agreement Amendments
3. Board Action 2019 1205_06._DHCS Primary Agreement Amendments

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 7 | *Rev. 2/6/2020*

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

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

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019

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

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

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

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS)

Contact

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the Department of Health Care Services (DHCS) and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).
2. Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to rate changes.

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.

Amendment for Medicaid and CHIP Managed Care Final Rule (Final Rule)

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and CHIP Managed Care Final Rule [Medicaid Managed Care (CMS-2390-F)], which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. These regulations are sometimes referred to in aggregate as the "Mega Reg."

In the ensuing months, DHCS undertook an effort to plan to develop guidance to incorporate the requirements of the Final Rule, and it also began to draft amendments to its contracts with Managed Care Plans (MCPs), including CalOptima.

This Amendment to CalOptima's Primary Agreement with DHCS provides language changes for the addition of Final Rule requirements. The specific changes in the Amendment are summarized in the Discussion section below.

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Implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates additional amendments to the contract to address the following provisions of the Final Rule:

- External Quality Review;
- Managed Care Quality Strategy;
- Network Adequacy and Validation;
- Provider Screening and Enrollment;
- Annual Network Certification; and
- Quality Rating System for MCPs.

Amendment for Rate Changes

On April 3, 2017, DHCS submitted an amendment to CMS for approval that will revise CalOptima's Optional Expansion capitation rates for the period of January 1, 2015 to June 30, 2015. These rates have been revised to include the impact of the Hospital Quality Assurance Fee (QAF) required by Senate Bill (SB) 239.

Discussion

Amendment for Medicaid and CHIP Managed Care Final Rule (Final Rule)

On April 18, 2017, DHCS provided Managed Care Plans (MCPs), including CalOptima, with a copy of an amendment that it submitted to CMS for approval that is intended to bring its contracts with MCPs into alignment with the requirements set forth in the Final Rule. Once CMS concludes its review of DHCS's proposed amendment, DHCS will incorporate any required changes to the document and provide the amendment to CalOptima for prompt execution and return. If the amendment is not consistent with Staff's understanding as presented in this document or if it includes significant unexpected language or rate changes, Staff will return to the Board of Directors for further consideration.

At this time, the amendment does not include any rate changes or otherwise set any rates. However, the language contained in the amendment addresses a broad array of changes that DHCS is implementing to bring MCP contracts into compliance with the Final Rule. What follows is a brief summary of a number of the major changes contained within the amendment:

Requirement[1]	
Credentialing	Credentialing efforts must comply with DHCS guidance, including All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing, which incorporates a uniform credentialing and recredentialing policy for acute, primary, specialist, behavioral, substance use disorders, and long-term services and supports (LTSS) providers, as well as provider enrollment screening requirements.

[1] DHCS Planned Guidance for MCPs – Managed Care Final Rule Implementation Requirements

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Requirement[1]	
Grievances and Appeals	Members must exhaust all plan-level appeals prior to filing for a State Hearing. Members have 60 calendar days to file an appeal upon receipt of a Notice of Adverse Benefit Determination. Upon resolution of an appeal, a member has 120 calendar days to file a State Hearing. Expedited resolution of appeals must be completed within 72 hours.
Access and Cultural Consideration	Consider gender identity as a component of culturally competent care and may not discriminate on the grounds of gender identity.
Medicare Coordination	Participate in a Coordination of Benefits Agreement (COBA) between DHCS and the Medicare program through CMS, and agree to participate in Medicare's automated claims crossover process for Full Benefit Dual Eligible Dual-Eligible Beneficiary Members.
Drug Utilization Review (DUR)	Operate a DUR program that complies with the requirements of the Final Rule, including participating in the State's DUR Board, conducting a retrospective DUR and submit an annual report to DHCS of MCP DUR activities.
Formulary Requirements	Include in the Formulary the covered medications (generic and brand), on what tier the medication is, and post the Formulary in a machine readable file on the CalOptima website.
Medical Loss Ratio Requirements	Plans must calculate and report a Medical Loss Ratio (MLR) in a form and manner specified by DHCS.
Care Coordination	Make a best effort to screen all new incoming members within 90 calendar days of enrollment using the Health Information Form (HIF) / Member Evaluation Tool (MET).
Subcontracting and Delegation Requirements	Meet the subcontracting and delegation requirements, including requirements related to the content of written agreements with subcontractors, review of subcontractors' ownership and control disclosures, DHCS' expanded rights related to the audit and inspection of subcontractors, the monitoring of subcontracted and delegated functions, the monitoring of subcontractor data reporting, the requirements for subcontractors to implement and maintain procedures designed to detect and prevent Fraud, Waste, and Abuse, the requirement for subcontractors to adopt a compliance program, and the monitoring of subcontractor care coordination requirements.

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Requirement[1]	
Program Integrity	Data Certification Certify all data, information, and documentation submitted to DHCS is accurate, complete, and truthful to the MCP's best information, knowledge, and belief, in a form and manner specified by DHCS. Treatment of Recoveries Create an internal retention and documentation process for recovery of all overpayments and review quarterly for accuracy. Report annually to DHCS on the recoveries of overpayments through the rate setting process. CalOptima must report overpayments to network providers in excess of $25 million to DHCS.
Network Composition	Meet the requirement to contract with Rural Health Clinics, Federally Qualified Health Clinics, and Freestanding Birthing Centers, as applicable.
Record Retention	Retain records for a period of ten years, and impose this requirement on Subcontractors.
Terminology Changes	Update terms and definitions used in the contract.
Quality Improvement	Implement a Quality Assessment and Performance Improvement Program, and collect and submit performance measurement data.

In preparation for the additional requirements related to the Final Rule, CalOptima's Regulatory Affairs & Compliance Department provided CalOptima staff with detailed analyses of the initial related CMS Notice of Proposed Rulemaking (NPRM), the draft Final Rule, the Final Rule, guidance provided by DHCS, and revisions to the contract to ensure compliance with the Final Rule and related contract requirements. Staff is in the process of evaluating these requirements as well as the resources commitment that will necessary to achieve full compliance.
DHCS has further advised that it will require MCPs to submit deliverables related to the amendment in advance of the July 1, 2017 effective date of the contract. DHCS's requested deliverables include Policies & Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. Some of these deliverables will be due from CalOptima to DHCS prior to July 1, 2017. To the extent that CalOptima staff must provide information to DHCS to meet the 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.

Amendment for Rate Changes
DHCS's proposed amendment seeks to incorporate rate changes related to SB 239 to the Optional Expansion capitation rates for the period of January 1, 2015 to June 30, 2015. The revised optional expansion capitation rates for January 2015 to June 2015 relate to the QAF, and were sent to CalOptima in April 2017. SB 239 imposes a QAF from January 1, 2014 to December 31, 2016, and authorizes the framework for the existing QAF built into CalOptima's rates, which have been

approved numerous times by the CalOptima Board of Directors, including most recently in December 2016. This amendment revises the Optional Expansion rates for the QAF for the period of January 1, 2015 to June 30, 2015.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule into the Primary Agreement is included in the CalOptima FY 2017-18 Operating Budget pending Board approval. If the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

The revised Optional Expansion capitation rates for the period of January 1, 2015, through June 30, 2015 under SB 239 results in an average per member per month increase of $82.66. By statute, CalOptima will pass through to participating hospitals the full amount of supplemental hospital funds it receives from DHCS.

Rationale for Recommendation

CalOptima's execution of the Final Rule amendment to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program. Additionally, CalOptima's FY 2014-15 Operating Budget was based on the anticipated rates from DHCS. Therefore, execution of the rate amendment will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 12

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

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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

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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
A-26 . adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 Adjusts the 2013-2014 capitation rates for the Optional Expansion and Senate Bill (SB) 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into the 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

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 rate period of 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 to the Secondary Agreement.	December 4, 2014

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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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing and Directing Execution of Amendment(s) to the Primary Agreement with the California Department of Health Care Services

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

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 the California Department of Health Care Services (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

Amendment for the Medicaid and CHIP Managed Care Final Rule (Final Rule)

On May 6, 2016, the Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, CMS-2390-F (Final Rule). The Final Rule contains various provisions that State Medicaid Agencies, including DHCS, were required to implement by various deadlines, beginning in July 2017.

DHCS implemented the requirements of the Final Rule by issuing of sub-regulatory guidance like All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's contracts with Managed Care Plans (MCPs), like CalOptima. Due in part to the lengthy CMS review process, DHCS has implemented these requirements prior to their formal inclusion in MCP contracts.

DHCS compiled changes to MCP contracts that were prompted by the Final Rule's issuance and that were required to be implemented in 2017 into a single amendment, referred to as the 2017 Final Rule Amendment. In June 2017, the CalOptima Board authorized the Chair to execute the 2017 Final Rule Amendment based on a draft amendment provided to MCPs by DHCS. As a result of being under CMS review for over two years and iterative changes made by DHCS and CMS, the content of the draft 2017 Final Rule Amendment has been updated since the CalOptima Board granted signature authority in June 2017.

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Among the changes are updates to the Grievances and Appeals language to properly align with Title 42, Code of Federal Regulations (CFR), Section 438.402–424 and updates to the Medical Loss Ratio (MLR) language to ensure compliance with Title 42, CFR, Section 438.8. What follows is a brief summary of the major changes contained within the updated amendment:

	Requirement
Grievance and Appeals	Member Grievance and Appeal System: Follow grievance and appeal requirements including the use of all notice templates included in DHCS All–Plan Letter 17–006.
	Grievance Process: Members may file a grievance at any time to express dissatisfaction.
	Grievance and Appeal Log and Reporting: Submission of grievance and appeal reports in a form and manner specified by DHCS.
	Notice of Action (NOA): Formal letter informing Members of action taken and sent within regulatory timeframes. The NOA must include among other criteria, reason for the action taken and appeal rights.
	Appeal Process: Following receipt of the NOA, Members have 60 calendar days to a request for appeal, either orally or in writing. Members can file a State Fair Hearing (SFH) if the internal appeal process has been exhausted. Covered services can continue to be provided while the appeal is pending. Members can examine their case file considered during the appeals process.
	Responsibilities in Expedited Appeals: Members, Providers, or authorized representatives acting on behalf of the Member and with the Member's written consent, may file an expedited appeal either orally or in writing. Members must be provided a written notice within 72 hours from the receipt of an appeal.
	State Fair Hearings (SFHs): Members, Providers, or authorized representative may request a SFH after exhausting all-Plan level appeals. Upon resolution of an appeal, a Member has 120 calendar days to file a SFH. Expedited resolution of appeals must be completed within 72 hours.
Medical Loss Ratio (MLR)	Medical Loss Ratio (MLR): Follow MLR requirements in accordance with federal regulations.

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	MLR Reporting Year: Ratio of the numerator (Sum of incurred claims, expenditures for activities that improve health care quality and fraud prevention activities) divided by the denominator (adjusted premium revenue).
	Allocation of Expense: Inclusion of each expense under only one type of expense, unless a portion of the expense can be categorized under the definition of, or criteria for, different types of expenses.
	Credibility Adjustment: Can be added to a calculated MLR if the MLR Reporting Year is partially credible.
	Aggregation of Data by eligible member groups outlined in Final Rule amendment, or as otherwise directed by DHCS.
	MLR Reporting Requirements: Submission of an MLR Report for each MLR reporting year in a form and manner specified by DHCS.

It is important to note that these updates to the 2017 Final Rule Amendment simply formalize changes that DHCS has already implemented via sub-regulatory guidance.

On November 13, 2019, the DHCS informed Plans that CMS has concluded their review of the revised amendment. DHCS has informed MCPs that will be sending the revised amendments by November 25, 2019 and that it will request signature and return of the amendment as soon as possible. At this time, the amendment does not contain any rate changes or otherwise set any rates.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated Fiscal Year 2019-20 Operating Budget, approved by the Board on June 6, 2019. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

The contract language revisions related to the MLR is revenue neutral to CalOptima, as it does not materially change CalOptima's current MLR calculation methodology.

Rationale for Recommendation

CalOptima's execution of the 2017 Final Rule amendment to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. Board Action 2017 0601_12._DHCS Primary Agreement Amendments

/s/ Michael Schrader *11/26/2019*

Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 6

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

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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

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019

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

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

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	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
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS)

Contact

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the Department of Health Care Services (DHCS) and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).
2. Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to rate changes.

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.

Amendment for Medicaid and CHIP Managed Care Final Rule (Final Rule)

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and CHIP Managed Care Final Rule [Medicaid Managed Care (CMS-2390-F)], which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. These regulations are sometimes referred to in aggregate as the "Mega Reg."

In the ensuing months, DHCS undertook an effort to plan to develop guidance to incorporate the requirements of the Final Rule, and it also began to draft amendments to its contracts with Managed Care Plans (MCPs), including CalOptima.

This Amendment to CalOptima's Primary Agreement with DHCS provides language changes for the addition of Final Rule requirements. The specific changes in the Amendment are summarized in the Discussion section below.

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Implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates additional amendments to the contract to address the following provisions of the Final Rule:

- External Quality Review;
- Managed Care Quality Strategy;
- Network Adequacy and Validation;
- Provider Screening and Enrollment;
- Annual Network Certification; and
- Quality Rating System for MCPs.

Amendment for Rate Changes

On April 3, 2017, DHCS submitted an amendment to CMS for approval that will revise CalOptima's Optional Expansion capitation rates for the period of January 1, 2015 to June 30, 2015. These rates have been revised to include the impact of the Hospital Quality Assurance Fee (QAF) required by Senate Bill (SB) 239.

Discussion

Amendment for Medicaid and CHIP Managed Care Final Rule (Final Rule)

On April 18, 2017, DHCS provided Managed Care Plans (MCPs), including CalOptima, with a copy of an amendment that it submitted to CMS for approval that is intended to bring its contracts with MCPs into alignment with the requirements set forth in the Final Rule. Once CMS concludes its review of DHCS's proposed amendment, DHCS will incorporate any required changes to the document and provide the amendment to CalOptima for prompt execution and return. If the amendment is not consistent with Staff's understanding as presented in this document or if it includes significant unexpected language or rate changes, Staff will return to the Board of Directors for further consideration.

At this time, the amendment does not include any rate changes or otherwise set any rates. However, the language contained in the amendment addresses a broad array of changes that DHCS is implementing to bring MCP contracts into compliance with the Final Rule. What follows is a brief summary of a number of the major changes contained within the amendment:

Requirement[1]	
Credentialing	Credentialing efforts must comply with DHCS guidance, including All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing, which incorporates a uniform credentialing and recredentialing policy for acute, primary, specialist, behavioral, substance use disorders, and long-term services and supports (LTSS) providers, as well as provider enrollment screening requirements.

[1] DHCS Planned Guidance for MCPs – Managed Care Final Rule Implementation Requirements

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Requirement[1]	
Grievances and Appeals	Members must exhaust all plan-level appeals prior to filing for a State Hearing. Members have 60 calendar days to file an appeal upon receipt of a Notice of Adverse Benefit Determination. Upon resolution of an appeal, a member has 120 calendar days to file a State Hearing. Expedited resolution of appeals must be completed within 72 hours.
Access and Cultural Consideration	Consider gender identity as a component of culturally competent care and may not discriminate on the grounds of gender identity.
Medicare Coordination	Participate in a Coordination of Benefits Agreement (COBA) between DHCS and the Medicare program through CMS, and agree to participate in Medicare's automated claims crossover process for Full Benefit Dual Eligible Dual-Eligible Beneficiary Members.
Drug Utilization Review (DUR)	Operate a DUR program that complies with the requirements of the Final Rule, including participating in the State's DUR Board, conducting a retrospective DUR and submit an annual report to DHCS of MCP DUR activities.
Formulary Requirements	Include in the Formulary the covered medications (generic and brand), on what tier the medication is, and post the Formulary in a machine readable file on the CalOptima website.
Medical Loss Ratio Requirements	Plans must calculate and report a Medical Loss Ratio (MLR) in a form and manner specified by DHCS.
Care Coordination	Make a best effort to screen all new incoming members within 90 calendar days of enrollment using the Health Information Form (HIF) / Member Evaluation Tool (MET).
Subcontracting and Delegation Requirements	Meet the subcontracting and delegation requirements, including requirements related to the content of written agreements with subcontractors, review of subcontractors' ownership and control disclosures, DHCS' expanded rights related to the audit and inspection of subcontractors, the monitoring of subcontracted and delegated functions, the monitoring of subcontractor data reporting, the requirements for subcontractors to implement and maintain procedures designed to detect and prevent Fraud, Waste, and Abuse, the requirement for subcontractors to adopt a compliance program, and the monitoring of subcontractor care coordination requirements.

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Requirement[1]	
Program Integrity	Data Certification Certify all data, information, and documentation submitted to DHCS is accurate, complete, and truthful to the MCP's best information, knowledge, and belief, in a form and manner specified by DHCS. Treatment of Recoveries Create an internal retention and documentation process for recovery of all overpayments and review quarterly for accuracy. Report annually to DHCS on the recoveries of overpayments through the rate setting process. CalOptima must report overpayments to network providers in excess of $25 million to DHCS.
Network Composition	Meet the requirement to contract with Rural Health Clinics, Federally Qualified Health Clinics, and Freestanding Birthing Centers, as applicable.
Record Retention	Retain records for a period of ten years, and impose this requirement on Subcontractors.
Terminology Changes	Update terms and definitions used in the contract.
Quality Improvement	Implement a Quality Assessment and Performance Improvement Program, and collect and submit performance measurement data.

In preparation for the additional requirements related to the Final Rule, CalOptima's Regulatory Affairs & Compliance Department provided CalOptima staff with detailed analyses of the initial related CMS Notice of Proposed Rulemaking (NPRM), the draft Final Rule, the Final Rule, guidance provided by DHCS, and revisions to the contract to ensure compliance with the Final Rule and related contract requirements. Staff is in the process of evaluating these requirements as well as the resources commitment that will necessary to achieve full compliance.
DHCS has further advised that it will require MCPs to submit deliverables related to the amendment in advance of the July 1, 2017 effective date of the contract. DHCS's requested deliverables include Policies & Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. Some of these deliverables will be due from CalOptima to DHCS prior to July 1, 2017. To the extent that CalOptima staff must provide information to DHCS to meet the 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.

Amendment for Rate Changes
DHCS's proposed amendment seeks to incorporate rate changes related to SB 239 to the Optional Expansion capitation rates for the period of January 1, 2015 to June 30, 2015. The revised optional expansion capitation rates for January 2015 to June 2015 relate to the QAF, and were sent to CalOptima in April 2017. SB 239 imposes a QAF from January 1, 2014 to December 31, 2016, and authorizes the framework for the existing QAF built into CalOptima's rates, which have been

approved numerous times by the CalOptima Board of Directors, including most recently in December 2016. This amendment revises the Optional Expansion rates for the QAF for the period of January 1, 2015 to June 30, 2015.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule into the Primary Agreement is included in the CalOptima FY 2017-18 Operating Budget pending Board approval. If the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

The revised Optional Expansion capitation rates for the period of January 1, 2015, through June 30, 2015 under SB 239 results in an average per member per month increase of $82.66. By statute, CalOptima will pass through to participating hospitals the full amount of supplemental hospital funds it receives from DHCS.

Rationale for Recommendation

CalOptima's execution of the Final Rule amendment to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program. Additionally, CalOptima's FY 2014-15 Operating Budget was based on the anticipated rates from DHCS. Therefore, execution of the rate amendment will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 12

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

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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

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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
A-26 . adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 Adjusts the 2013-2014 capitation rates for the Optional Expansion and Senate Bill (SB) 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into the 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

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 rate period of 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 to the Secondary Agreement.	December 4, 2014

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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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
8. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment(s) to the Primary Agreement with the California Department of Health Care Services

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

Recommended Action
Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the Department of Health Care Services (DHCS) and CalOptima related to the Adult Expansion (AE) Risk Corridor.

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 December 13, 2019, the DHCS sent CalOptima contract language incorporating Adult Expansion (AE) Risk Corridor language for State Fiscal Year (SFY) 2017–18 into a contract amendment to the Primary Agreement with the DHCS.

The AE Risk Corridor language for SFY 2017–18 has been included as part of DHCS contract Package 60, which includes separate contract amendment requirements previously approved by the Board. A summary of the previous authority to execute the contract requirements of the amendment package and the current request for Board authority of the AE Risk Corridor language for SFY 2017–18 are outlined below.

Contract Language/Requirement	Board of Directors Authority
Mental Health Parity, Transportation and American Indian Health Services (AIHS)	December 7, 2017
Base Medi-Cal capitation rates, ACA Optional Expansion, Hyde (Abortion) Proposition 56 rates, Behavioral Health Treatment and Hepatitis- C supplemental payments, Hyde (Abortion) rates, Managed Long-Term Services and Supports (MLTSS) add-on rates, and Proposition 56 directed payments for the period of July 2017 to June 2018.	June 7, 2018

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Adult Expansion (AE) Risk Corridor language for SFY 2017–18	*Requested February 6, 2020*

The revised amendment includes updates related to the AE Risk Corridor. Specifically, the revised amendment extends the existing AE Risk Corridor requirements (approved by the CalOptima Board in November 2018) for a fourth period, from July 1, 2017 to June 30, 2018. The amendment also provides that DHCS will initiate the AE–MLR calculations for the fourth period no sooner than April 1, 2020. DHCS will consider paid claims data at least through March 31, 2020 for the fourth period. Lastly, the amendment contains updates to the definitions section to align with the updates in amendment. All other AE MLR requirements and related provisions are unchanged.

If upon receipt 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 further consideration.

Fiscal Impact

The recommended action to execute an amendment to the Primary Agreement with DHCS is expected to be budget neutral to CalOptima. The AE Risk Corridor based on the AE-MLR establishes lower (85%) and upper (95%) thresholds. CalOptima's AE-MLR during Fiscal Year (FY) 2017-2018 is expected to fall within the Risk Corridor range. As such, CalOptima staff does not anticipate that DHCS will recoup or pay additional funding related to the AE Risk Corridor requirements for the period of July 1, 2017 through June 30, 2018.

Rationale for Recommendation

DHCS has indicated that the additional year of AE Risk Corridor requirements is a priority of the Centers for Medicare & Medicaid Services (CMS). DHCS has informed Managed Care Plans (MCPs) that CMS indicated that the additional AE MLR period is a necessary prerequisite for CMS's approval of the FY 2017–18 rates developed by DHCS, and which DHCS has provided to MCPs. CalOptima has used those rates for budgetary planning purposes.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to Primary and Secondary Agreements with DHCS
2. Board Action 2017 1207_DHCS Contract Amendments_Primary K
3. Board Action 2018 0607_08._Authorize Chair to DHCS Amendment Rate Changes
4. Board Action 2018 1101_17._Ratify Amendment 33 to Primary DHCS Contract
5. AE Risk Corridor SFY2017-18 Contract Language

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 8 | *Rev. 2/6/2020*

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

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

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019

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

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

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

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement for the Medi-Cal Program with the California Department of Health Care Services (DHCS)

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement for the Medi-Cal program between DHCS and CalOptima (DHCS Medi-Cal Contract) related:
    a. To rate changes; and
    b. To incorporate language related to the Medicaid Mental Health Parity Rule, Transportation, and American Indian Health Services.

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 which has been amended numerous times. Amendments to the DHCS Medi-Cal Contract are summarized in the attached appendix, including Amendment 31, which extends the DHCS Medi-Cal Contract through December 31, 2020. The DHCS Medi-Cal Contract contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services to Medi-Cal beneficiaries.

Discussion

Rate Changes

DHCS has informed CalOptima that it submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) on August 31, 2017 for approval that will revise rates for Classic Medi-Cal, Affordable Care Act (ACA) Optional Expansion (OE), Behavioral Health Treatment (BHT) and Hepatitis-C supplemental payments, and Partial Dual/Medi-Cal only rates for the period of July 2015 to June 2016.

DHCS' proposed amendment seeks to incorporate revised rates related to the base Medi-Cal Classic and ACA OE rates for the period July 2015 to June 2016, with BHT and Hepatitis-C supplemental payments, and Partial Dual/Medi-Cal only rates.

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The revised capitation base rates for July 2015 - June 2016 were sent to CalOptima in September 2017. The revised rates for the period reflect the following:

- Impact of California Senate Bill (SB) 239 (Hospital Quality Assurance Fee (HQAF)) and California Assembly Bill (AB) 85 adjustments at the lower and upper bound;
- Final rate ranges with and without SB 78 which are inclusive of HQAF and AB 85, and displays the percentage blend of age-adjusted Adult and Seniors and Persons with Disabilities (SPD) rates used for rate development;
- Adjustments applied to Medi-Cal Classic midpoint rates to create base data for OE;
- Rate range development for plan-specific ACA OE rate ranges; and
- Hepatitis C supplemental payment rates effective July 2015 through June 2016. These rates include amounts for both 340B and non-340B pricing.

BHT revised supplemental payment rates for the period of July 1, 2015 through June 30, 2016 were sent to CalOptima in September 2017. These final BHT rates contain the following updates:

- Rate ranges with and without SB 78; and
- Rate development process from base data through to the final county-specific BHT rate ranges.

The revised Coordinated Care Initiative Non-Duals rates (or "Partial Dual/Medi-Cal only rates") for the period of July 1, 2015 through June 30, 2016 were sent to CalOptima in September 2017. The revised rates for the period reflect the following:

- Lower and upper bound rates with SB 239 adjustments by category of aid for Managed Long-Term Support Services (MLTSS) non-dual and partial-dual population;
- Capitation rate calculation sheets by category of aid for the MLTSS non-dual and partial-dual population; and
- Rate summaries by category of aid and in total, for the MLTSS non-dual and partial-dual population.

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 herein, or if it includes significant unexpected language changes, Staff will return to the Board of Directors with further recommendations.

<u>Amendment for Medicaid Mental Health Parity, Transportation, and American Indian Health Services</u>

On October 2, 2017, DHCS submitted an amendment to CMS for approval that will incorporate language regarding the Medicaid Mental Health Parity, transportation benefits, and American Indian Health Services into managed care plan (MCP) contracts, including CalOptima.

Medicaid Mental Health Parity
On March 30, 2016, CMS issued the Medicaid Mental Health Parity Final Rule (CMS–2333F), which applies certain requirements from the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 to coverage offered by Managed Care Organizations (MCOs). General

parity requirements include financial requirements and quantitative treatment limitations on mental health (MH) and substance use disorder (SUD) benefits, which cannot be more restrictive or be applied more stringently than medical/surgical (M/S) benefits. Non-quantitative treatment limitations on MH or SUD benefits in processes, strategies, evidentiary standards, or other factors must be comparable to, and applied no more stringently than, limitations applied to M/S benefits, in the same classification. Parity requirements apply to all Medi-Cal managed care plans (MCPs), including CalOptima.

The amendment's language is consistent with the requirements in DHCS sub-regulatory guidance in All Plan Letters (APLs) 17-016: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care and 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services. The amendment is intended to bring CalOptima's Primary Agreement with DHCS into compliance with mental health parity requirements on October 1, 2017, as required by Title 42, Code of Federal Regulations (CFR), Section 438.930.

Transportation
DHCS' proposed amendment also seeks to incorporate requirements related to transportation. The addition of this contract language is consistent with current APL guidance and SB 2394. Effective July 1, 2017, CalOptima began providing Non-Medical Transportation (NMT) for all CalOptima Medi-Cal members, subject to utilization controls and permissible time and distance standards, in order to obtain Medi-Cal covered services provided by CalOptima. Effective October 1, 2017, in part to comply with CMS–2333–F and to have a uniform delivery system, DHCS required that CalOptima begin providing NMT for all Medi-Cal services not covered under CalOptima's Primary Agreement with DHCS. These services include a range of carved-out services such as specialty mental health, substance use disorder, dental, and other benefits delivered through the Medi-Cal Fee-for-Service (FFS) program. CalOptima must also continue to cover emergency medical transportation and non-emergency medical transportation (NEMT), as well as referring and coordinating NEMT for carved-out services not covered under CalOptima's Medi-Cal contract with the DHCS. The amendment's language is consistent with the requirements in DHCS sub-regulatory guidance in APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services.

American Indian Health Services
Lastly, DHCS' proposed amendment seeks to incorporate payment requirements related to the American Indian Health Services Program. For services provided on or after January 1, 2018, MCPs, including CalOptima, shall reimburse American Indian Health Service programs at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service. However, MCPs shall also be entitled to receive a supplemental American Indian Health Service Program payment for qualified members who utilize services at American Indian Health Service Programs as reported by CalOptima. There are currently no Indian Health Service facilities operating in Orange County.

DHCS submitted the contract amendment to CMS for approval on October 2, 2017. 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 with further recommendations.

DHCS has further advised that once the contract amendment is finalized and sent to CalOptima for execution, it may require CalOptima to submit 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 deliverables that would ordinarily come to the Board for approval, including the revision or creation of certain P&Ps, staff will return to the Board for further consideration and/or ratification of staff action that was necessary to meet DHCS requirements.

Fiscal Impact

The final capitation rates for the period of July 2015 through June 2016 for Classic Medi-Cal and ACA OE rates under SB 239 result in an average per member per month increase of $36.53. By statute, CalOptima will pass through to eligible hospitals the full amount of supplemental HQAF funds it receives from DHCS.

Updates to the intergovernmental transfer (IGT) rate range for the period of July 2015 through June 2016 are budget neutral to CalOptima. Expenditures of IGT funds are for restricted, one-time purposes for providing enhanced benefits to existing CalOptima Medi-Cal members, and do not commit CalOptima to future budget allocations.

The revised capitation rates for Classic Medi-Cal, ACA OE, Hepatitis C, BHT, and Partial Dual/Medi-Cal only for the period of July 2015 through June 2016 under SB 78 are revenue neutral to CalOptima. By statute, CalOptima will return the full amount of MCO tax funds that it receives to DHCS.

Rationale for Recommendation

CalOptima's 2014-15 Operating Budget was based on the anticipated rates for FY 2015-16. The addition of language regarding the Medicaid Mental Health Parity Rule, transportation benefits, and American Indian Health Services to the DHCS Medi-Cal Contract is necessary to ensure compliance with the requirements of CMS 2333–F, SB 2394, and DHCS APLs 17-016 and 17-018.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 11

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

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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

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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

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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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

8. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreements with the California Department of Health Care Services (DHCS) Related to Rate Changes

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 to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to rate changes.

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

DHCS has informed Plans that it intends to submit an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) and Hyde (Abortion) Proposition 56 rates, Behavioral Health Treatment and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments for the period of July 2017 to June 2018 to managed care plan (MCP) contracts.

Rate Changes

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

- Base Medi-Cal Classic, ACA Optional Expansion (OE) and Hyde (Abortion) Prop. 56 rates for the period of July 2017 to June 2018, with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments.

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2017-2018

Base Classic Medi–Cal and ACA Optional Expansion Rates

The base Medi–Cal Classic and ACA OE capitation rates for July 2017 through June 2018 were first sent to CalOptima as draft rates in July 2017. DHCS sent CalOptima finalized rates in April 2018. Highlights regarding these rates are as follows:

- Rates contain final rate ranges including the MCO Tax and Physicians' Proposition 56 per member per month (PMPM) add–ons, detailed build-up of the rates by category of aid and category of service, and program changes applied in the rates.
- Rates include a build-up of health plan submitted base data and prior SFY 16–17 base data, rate summaries, State Fiscal Year (SFY) 16–17 Cost and Reimbursement Comparison Sheets (CRCS), base data adjustments, base data summaries, ACA OE CRCS details, and ACA OE risk adjustment calculation.

Behavioral Health Treatment (BHT) Payments

BHT supplemental payment rates for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in July 2017. These final BHT rates contain the following updates:

- Rates are set at the plan/county level which produces a stronger correlation between plan experience reported in the Calendar Year (CY) 2016 supplemental data request (SDR) and the final SFY 17–18 BHT supplemental payment rates.
- Adjustments made to health plan reported experience, which includes:
    - Blending individual health plan experience with larger populations to improve data credibility; and
    - Adjusting/smoothing data when falling outside reasonable ranges as observed in historical data reporting; and
    - Removing the last two months of experience (November and December 2016) from the base data due to under–reporting.

Hepatitis–C Payments

Hepatitis–C supplemental payment rates for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in October 2017. These final Hepatitis–C rates contain the following updates:

- Assumed ramp up results in Mavyret being 10% of therapies for the period of July 1, 2017 through December 31, 2017 and historically–priced therapies comprising 78% of therapies across a six–month period.
- Assumed ramp up results in Mavyret being 75% of therapies for the period of January 1, 2018 through June 30, 2018 and historically–priced therapies comprising 7%.

Non–Medical Transportation (NMT) Payments

Non–Medical Transportation (NMT) PMPM rate increments for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in September 2017. Both the Classic Medi-Cal and ACA Optional Expansion category of aid (COA) groups are included in these PMPM impacts. These final NMT PMPM rate increments include the following:

- Increase to the SFY 17–18 capitation rates due to the inclusion of NMT as a covered Medi-Cal benefit.

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- Impact of NMT to Medi-Cal managed care covered services effective July 1, 2017 and the impact of NMT to Medi-Cal managed care non-covered services effective October 1, 2017.
- General methodology used for the NMT PMPM increment consisted of calculating a fully mature NMT PMPM amount and subtracting out any NMT currently assumed to be in the rate.
- Considerations for ramp-up were utilized since it is not expected that the fully matured NMT PMPM will be achieved in the first year.
- Data from two other states (one more urban and one more rural) were utilized, which contains varying levels of detail which assisted with development of the fully mature NMT PMPM amount.
- To develop the amounts currently assumed in the rates, health plan questionnaire data and encounter data were utilized.

Proposition 56 Directed Payments

Proposition 56 increases the excise tax rate on cigarettes and tobacco products and allocates the resulting revenue, in part, to increase funding for existing healthcare programs administered by the DHCS. The California Budget Act of 2017 appropriated Proposition 56 funds for SFY 2017–18, including a portion to be used for directed payments for physician services in Medi-Cal managed care according to the payment methodology developed by DHCS.

Consistent with Title 42, Code of Federal Regulations (CFR), Section 438.6(c), MCPs and their delegated entities and subcontractors, as applicable, are required to make directed payments for qualifying services for 13 Current Procedural Terminology (CPT) codes in addition to other payments that eligible network providers receive from MCPs. Please note that Staff's proposed methodology for the distribution of these payments is addressed as a separate agenda item for the June 7, 2018 meeting of the CalOptima Board of Directors. The amount of the directed payments varies by CPT code as outlined below:

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

All applicable Evaluation & Management (E&M) services outlined above are eligible for this enhanced Prop. 56 funding except for services incurred by members with Medicare Part B coverage

(Full or Partial Duals), and services provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHP) and Cost–Based Reimbursement Clinics (CBRCs). No later than June 30, 2018, and on a quarterly basis thereafter, CalOptima must begin reporting data to DHCS on all directed payments made pursuant to DHCS APLs, either directly by CalOptima, or by CalOptima's delegated entities and subcontractors.

The draft SFY E&M Directed Payment Proposition 56 PMPM add–on rates were sent to CalOptima in January 2018 and finalized in April 2018 as part of CalOptima SFY 17–18 full capitation rates. The Intermediate Care Facility–Developmentally Disabled (ICF–DD) Prop. 56 program changes were also included as part of CalOptima's SFY 17–18 full capitation rates. Highlights regarding these rates are as follows:

- All applicable categories of aid (COA) are now included.
- Development of these add–ons utilized the supplemental data request (SDR) information provided by CalOptima and received encounter data associated with the Prop. 56 procedure codes.
- Adjustments to the final amounts do include offsets for Part B members.
- Rates do not include FQHC/RHC/CBRC/IHS utilization as these providers are exempt from Prop. 56.
- Rates contain CalOptima's projected member months by COA for SFY 17–18 along with the anticipated number of Prop. 56 impacted services.
- Rates include the E&M utilization per 1,000 members, the unit cost (average unit cost of the E&M add–on component that varies by E&M code) and the resulting E&M adjustment PMPM add–on amounts.
- The PMPM add–on amounts include an administrative load of 3.25% and an underwriting gain (UG) of 2.00%.
- Rates only reflect the 13 CPT codes outlined above.

Additionally, CalOptima received Hyde (Abortion) rate ranges and Hyde (Abortion) Proposition 56 add-ons in April 2018.

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

CalOptima received State Fiscal Year (SFY) 2017–18 CCI non-full dual rates in March 2018. Two 6–month rates were developed (July–December 2017 and January–June 2018) to account for the removal of IHSS effective January 1, 2018. For the January–June 2018 HCBS High/Low rates, the IHSS benefits costs were removed. However, to account for the continuing IHSS care coordination requirement, the administrative load associated with the IHSS benefit component was maintained on a per-member-per-month (PMPM) basis and a portion was reallocated in the "All Other" service category to account for the care coordination costs that CalOptima will incur for members that utilize IHSS services.

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

Fiscal Impact

Compared to SFY 2016-17 rates, the capitation rates for the July 1, 2017- June 30, 2018 period (the following year), are 4.4% or $8.88 per member per month lower for Classic Medi-Cal, and a 6.2% or

$27.94 per member per month lower for the Medi-Cal expansion membership. However, because rate decreases were anticipated and included in CalOptima's FY 2017-18 Medi-Cal Operating Budget, Staff projects the net impact to CalOptima will be revenue neutral for the July 1, 2017- June 30, 2018 fiscal year. Staff previously incorporated the rate decreases in the CalOptima FY 2017-18 Medi-Cal Operating Budget.

The revised capitation rates for July 1, 2017, through June 30, 2018, which includes updates for BHT and Hepatitis C supplemental payments, Abortion rates, MLTSS add-on rates, and CCI Non-Full Dual rates is projected to be revenue neutral to CalOptima. Staff previously incorporated the rate adjustments into the CalOptima FY 2017-18 Medi-Cal Operating Budget.

Rate increments for NMT services payments are expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that NMT revenues will be sufficient to cover the total NMT costs during SFY 2017-18. Staff previously incorporated the rate adjustment into the CalOptima FY 2017-18 Medi-Cal Operating Budget.

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

Rationale for Recommendation
CalOptima's 2016-17 operating budget was based on anticipated rates for FY 2017-18.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreements with DHCS

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

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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

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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

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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

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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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

17. Consider Ratifying a Revised Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS)

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400
Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Action

Ratify revised Amendment 33 of the Primary Agreement between CalOptima and DHCS.

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 September 27, 2018, the DHCS sent CalOptima a revised version of Amendment 33 (A–33) to the Primary Agreement with the DHCS. In that communication, DHCS requested that CalOptima sign and return the revised amendment as soon as possible, and no later than October 12, 2018.

The original version of the amendment was signed by the Chair of the CalOptima Board of Directors (Board) on November 2, 2017, pursuant to authority granted to him during the February 2017 meeting of the Board. The original version of the amendment established base capitation rates for July 2016 to June 2017, as well as supplemental rates related to Behavioral Health Treatment (BHT) and Hepatitis C treatment.

The revised amendment includes language changes related to the Adult Expansion (AE) Medical Loss Ratio (MLR). Specifically, the revised amendment retroactively extends the existing AE MLR requirements by one year, by adding a third period from July 1, 2016 to June 30, 2017. The amendment also provides that DHCS will initiate the AE MLR calculation no sooner than January 1, 2019, for the third period. All other AE MLR requirements and related provisions are unchanged.

As previously noted, DHCS requested that CalOptima sign and return the revised amendment as soon as possible, and no later than October 12, 2018. In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on October 4, 2018 and returned the signed Amendment A–33 to DHCS the next day. Staff requests the CalOptima Board of Directors' ratification of the Board Chair's execution of the revised Amendment A–33 to the Primary Agreement with DHCS.

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Fiscal Impact
The recommended action to ratify the revised A-33 of the Primary Agreement with DHCS is expected to be budget neutral to CalOptima. The AE MLR risk corridor establishes a threshold of 85%, which is below CalOptima's AE MLR during Fiscal Year (FY) 2016-17. As such, CalOptima does not anticipate that DHCS will recoup funding related to the AE MLR requirements for the third period of July 1, 2016, through June 30, 2017.

Rationale for Recommendation
DHCS has indicated that the additional year of AE MLR requirements is a priority of the Centers for Medicare and Medicaid Services (CMS). DHCS has informed Plans that CMS indicated that the additional AE MLR period is a necessary prerequisite for CMS's approval of the FY 2016–17 rates developed by DHCS, and which DHCS has provided to Plans. CalOptima has used those rates for budgetary planning purposes.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary and Secondary Agreements with DHCS

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 17

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

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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

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

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)

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A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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

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

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

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

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Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

14. Adult Expansion ~~Medical Loss Ratio and~~ Risk Corridor

A. Establishment of an Adult Expansion ~~Medical Loss Ratio~~Risk Corridor (AE Risk Corridor), based on an Adult Expansion Medical Loss Ratio (AE-MLR).

For Adult Expansion Members, DHCS shall make additional assumptions to the benefit of both the State and Contractor for this ~~risk mitigation~~AE-Risk Corridor provision using an AE-MLR. DHCS shall perform AE-MLR calculations for the incurred periods stated below. Incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses.

1) DHCS shall perform AE-MLR calculations for the incurred periods ~~(incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses)~~ of January 1, 2014 to June 30, 2015, the first period, July 1, 2015 to June 30, 2016, the second period, ~~and~~ July 1, 2016 to June 30, 2017, the third period, and July 1, 2017 to June 30, 2018, the fourth period.

2) For the first and second periods, DHCS or its designee will initiate the AE-MLR calculation no sooner than 12 months after the end of each incurred period. For the third period, DHCS or its designee will initiate the AE calculation no sooner than January 1, 2019. For the fourth period, DHCS or its designee will initiate the AE-MLR calculation no sooner than April 1, 2020.

3) DHCS will give consideration to paid claims data at least through June 30, 2016, for services incurred during the first period, at least through June 30, 2017, for the second period, ~~and~~ at least through December 31, 2018, for the third period, and at least through March 31, 2020, for the fourth period.

4) Contractor shall provide and certify the ~~AE-MLR~~AE Risk Corridor data and shall be subject to review or audit by DHCS or its designee.

5) The AE~~-MLR~~ Risk Corridor provision applies to this Contract only and will end with capitation and incurred dates as of June 30, ~~2017~~2018.

B. ~~AE-MLR Risk Corridor~~ Adult Expansion Medical Loss Ratio (AE-MLR)

This Contract shall provide an AE- rRisk ~~corridor~~ Corridor pertaining to AE-MLR for Adult Expansion Members.

1) Contractor shall be required to expend at least 85 percent of Net Capitation Payments received on Allowed Medical Expenses for Adult Expansion Members, for each ~~county~~rating region. If Contractor does not meet the minimum 85 percent AE-MLR threshold for a given ~~county~~rating region, then Contractor shall return to the State the difference between 85 percent of total Net Capitation Payments and actual Allowed Medical Expenses incurred for each ~~county~~rating region as directed by DHCS.

2) After completion of the AE-MLR calculation, if it is determined that Contractor's AE-MLR is less than 85 percent for a given ~~county~~rating region, then DHCS will notify Contractor of the Capitation Payments to be returned to the State.

3) Contractor shall remit to the State the full amount due within 90 calendar days of the date DHCS provides notice to Contractor of that amount.

4) Contractor protection is included for Allowed Medical Expenses above 95 percent of the total Net Capitation Payments received by Contractor for Adult Expansion Members, for each ~~county~~rating region.

   a) If Contractor's AE-MLR exceeds 95 percent ~~of total Net Capitation Payments under this Contract~~ for a given ~~county~~rating region, then DHCS shall make additional payment to Contractor.

   b) This additional payment from DHCS to Contractor will be the difference between ~~the~~ Contractor's Allowed Medical Expenses and 95 percent of Net Capitation Payments received for that ~~county~~rating region.

   c) DHCS shall remit this payment to Contractor within 90 days of completion of this calculation, or within 90 days of approval to claim the additional federal funds, whichever is later.

5) If the AE-MLR is between 85 percent and 95 percent ~~of total Net Capitation Payments to Contractor under this Contract~~, then there will not be an ~~MLR~~ AE Risk Corridor adjustment from Contractor to DHCS or from DHCS to Contractor.

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C. Final Rates of Payment

For Adult Expansion Members, the actual payment rate for providing Covered Services under this Contract may differ from the rates initially included in this Contract, or the negotiated rate.

1) Actual payments may be adjusted if an adjustment is required subject to the provisions of this AE ~~-MLR~~Risk Corridor methodology. Both Contractor and DHCS agree to accept the final payment levels that result from the AE ~~-MLR~~Risk Corridor methodology calculation.

2) As a payment corridor, it is explicitly provided that this payment provision may result in payment by Contractor to DHCS or by DHCS to Contractor.

3) In the event of a change in capitation rate for Adult Expansion Members, for each period provided in this Provision, an AE ~~-MLR~~Risk Corridor calculation in accordance with the requirements of this Provision shall be re-determined.

4) Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by Contractor to DHCS or by DHCS to Contractor.

D. AE ~~-MLR~~Risk Corridor Disputes

Contractor shall have the opportunity to appeal a determination, through an appeal process defined by DHCS, that the 85 percent AE-MLR threshold has not been met and provide evidence that the required minimum has been met.

Exhibit E, Attachment 1, DEFINITIONS

[Relevant DEFINED TERMS]

Adult Expansion Medical Loss Ratio (~~AE~~ AE-MLR) means the Allowed Medical Expenses for the Covered Services provided to Adult Expansion Members under this Contract divided by the amount of Medi-Cal managed care Net Capitation Payments ~~or revenues~~ recorded by Contractor, by ~~county~~rating region. The ~~AE~~ AE-MLR will be measured by the same ~~county~~rating region that was used in the development of the capitation rates paid to ~~the~~ Contractor, under this Contract. For the first, second, and third periods, t~~T~~he calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. For the fourth period, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d).

If a Staff Model Contractor does not account for Allowed Medical Expenses specifically by line of business and uses an allocation methodology, the AE-MLR shall be the average AE-MLR of all other Medi-Cal M~~m~~anaged C~~c~~are Health Plans ~~contractors~~ operating within the ~~county~~rating region in which Contractor operates. In such cases, the Staff Model Contractor's AE-MLR shall be excluded from the average AE-MLR.

Adult Expansion Member means a Member enrolled in aid codes L1, M1, and 7U as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y). Expenditures for services provided to Adult Expansion Members qualify for the enhanced federal medical assistance percentage described in that section.

Allowed Medical Expenses means Contractor's expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to Providers, payments required by Directed Payment Initiatives, and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the ~~AE MLR calculation~~first, second, and third periods, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as intergovernmental transfers ~~and~~, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, and Excluded

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State Taxes and Assessments, are excluded. For the fourth period, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d), are excluded.

B. Global sub ~~**Capitation Payment**~~ capitation payments made by Contractor, where entire Allowed Medical Expenses are shifted to another entity, gross or net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS, of the Net Capitation Payment for consideration within Allowed Medical Expenses.

C. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated ~~parties~~ party Providers within the same ~~county~~rating region. Related parties are defined by GAAP.

Directed Payment Initiative means a CMS-approved payment arrangement described in 42 C~~.~~F~~.~~R~~.~~ ~~§~~438.6(c) that directs certain expenditures made by ~~the~~ Contractor under this Contract.

Excluded Federal Taxes and Assessments means all federal taxes and assessments allocated to health insurance coverage, including but not limited to federal income taxes and the Patient Centered Outcomes Research Institute (PCORI) Fee.

Excluded State Taxes and Assessments means:

A. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State as applicable under this Contract;

B. Guaranty fund assessments;

C. Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State;

D. State income, excise, and business taxes other than premium taxes;

E. State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes; and

F. Payments made by a Federal income tax exempt issuer for community benefit expenditures, to the extent allowed pursuant to 45 CFR 158.162(b)(1)(vii).

Health Insurance Providers Fee (HIPF) means an annual fee starting in 2014 and paid by covered entities that provide health insurance for United States health risks

during each year as described under Section 9010 of the Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Medi-Cal Managed Care Plan Taxes mean the extension of the State sales tax to sellers of Medi-Cal Managed Care plans for the privilege of selling Medi-Cal related health care services at retail in California as described under Revenue and Taxation Code Sections 6174 through 6189, and any successor State managed care organization provider tax applicable to Contractor.

Net Capitation Payments means, for the first, second, and third periods, Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to Providers such as intergovernmental transfers, ~~and~~ Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. For the fourth period, Net Capitation Payments means Contractor's capitation revenues, including amounts related to Directed Payment Initiatives, less designated amounts included in capitation rates that Contractor is required to pay to Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d). For all periods, Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with GAAP.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Authorizing Extension of Federal Legislative Advocacy Services Contract with Akin Gump Straus Hauer & Feld LLP

Contact
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to exercise the option to extend the contract of Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services for one year, per the terms of the current contract, commencing February 21, 2020.

Background
As part of its Government Affairs program, CalOptima retains representatives in Washington D.C. to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for federal legislative advocacy services was issued on September 8, 2016 and a total of six (6) proposals were received. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts and a Board ad hoc committee, which recommended Akin Gump Straus Hauer & Feld LLP (Akin Gump). On February 2, 2017, the Board authorized the Chief Executive Officer to contract with Akin Gump for a three-year term, commencing on February 21, 2017, with two one-year options, each exercisable at CalOptima's sole discretion. Akin Gump's current contract term ends on February 20, 2020.

Discussion
Akin Gump has substantial knowledge and experience in health care issues important to CalOptima. The firm is also well established with the federal health industry associations with which CalOptima works. In addition to its monthly written report, Akin Gump has presented verbal updates at the request of staff, most recently at the December 2, 2019 Board of Directors' meeting.

As proposed, the recommended action is to extend Akin Gump's contract for an additional one-year term, per the option exercisable at CalOptima's discretion under the current contract. Akin Gump's contract fee is $10,000 per month. The fee includes phone, fax, in-office copying, regular postage, and printing. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of Akin Gump to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include, but

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are not limited to, written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact

The recommended action extends the contract with Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services from February 21, 2020 through February 20, 2021. Associated expenses for February 21, 2020 through June 30, 2020 are budgeted for under the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Management will include funding for the period of July 1, 2020 through February 20, 2021, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

Federal legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy in the coming year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 2, 2017, Consider Authorizing Selection and Contracting for Federal Legislative Advocacy Services

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection and Contracting with Vendor for Federal Legislative Advocacy Services

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

Recommended Actions
1. Approve recommend federal advocacy firm Akin Gump Strauss Hauer & Feld LLP to represent CalOptima for federal regulatory and advocacy services;
2. Authorize the Chief Executive Officer to execute applicable contract with the recommended firm;
3. Authorize expenditures of up to $32,000 from existing reserves for the additional costs in excess of the budget for federal legislative advocacy services for FY2016-17, to deliver all services detailed in the Request for Proposal (RFP) Statement of Work, with total expenditures not to exceed $10,000 per month.

Background
As part of its Government Affairs program, CalOptima retains representatives in Washington D.C. to assist in a wide array of areas, including tracking legislation, developing and maintaining relationships with the administration and applicable federal departments and regulatory agencies, members of Congress, legislative committee staff and consultants, and providing analysis and recommended actions pertaining to the federal budget.

CalOptima's contract with its current federal advocacy services firm was set to expire on January 7, 2017. On December 1, 2016, the Board authorized an extension of CalOptima's contract with CalOptima's current federal advocacy services firm for six (6) additional months, to allow time for the Board Ad Hoc and staff to recommend a federal advocacy firm to the full Board.

A Request for Proposal (RFP) for federal advocacy services was issued by CalOptima on September 8, 2016 and a total of six (6) proposals were received. An evaluation committee comprised of staff and two external stakeholder representatives reviewed the submitted proposals. Four of the firms were recommended for interviews before the Federal Advocacy RFP Ad Hoc evaluation committee of Supervisor Lisa Bartlett, Director Ron DiLuigi, Supervisor Andrew Do and Director Nikan Khatibi. After evaluation of proposals and in-person interviews conducted by the Board Ad Hoc, two top finalists were identified. Based on the "best and final offer" received by the two finalists, the Board Ad Hoc recommends Akin Gump Strauss Hauer & Feld LLP to provide federal legislative advocacy services for CalOptima. The RFP scope of work and score sheet summaries for the firms responding to the RFP are attached.

Discussion
The Board Ad Hoc is recommending Akin Gump Strauss Hauer & Feld LLP due to their proposal and represented grasp of the issues within the healthcare field. These issues included, but are not limited to, CalOptima specifically, and County Organized Health Systems (COHS) generally, the future

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potential changes regarding Affordable Care Act (ACA), and, future potential changes regarding Medicaid and Medicare.

Staff and the Ad Hoc believe Akin Gump will provide added value in the Agency's advocacy efforts. It was concluded that the firm has broad healthcare experience, a depth of resources and strong connections with key influencers within the healthcare field and the current administration that could be very beneficial to CalOptima as compared to the other proposals.

Staff will review the performance of the Akin Gump contract to ensure that the deliverables are being achieved. In addition to its monthly written report, it is anticipated that Akin Gump will present occasional verbal updates at the request of the Board or staff, at monthly Board of Directors' meetings.

Akin Gump Strauss Hauer & Feld LLP is also well established with the federal health industry associations that CalOptima works with.

The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $6,000 per month for federal advocacy services. Pursuant to the submitted proposal, Akin Gump Strauss Hauer & Feld LLP's proposed contract is priced at $10,000 per month beginning February 2017. Staff recommends Board authorization for up to $32,000 in expenditures from existing reserves for the additional costs above the budget for federal legislative advocacy services for FY 2016-17, as well as up to a two-month overlap (i.e., February and March 2017) between the current contract and future contract.

Fiscal Impact

The recommended action to authorize the expenditure of up to an additional $32,000 for federal legislative advocacy services through June 30, 2017, is unbudgeted. An allocation of $32,000 from existing reserves will fund this action to supplement the current Board approved budget. If the recommended vendor is approved, Staff will increase the projected federal legislative advocacy service expenses in the FY 2017-18 CalOptima Operating Budget.

Rationale for Recommendation

Federal advocacy efforts continue to be of importance to CalOptima given the stated health care-related priorities of the new presidential administration and congressional majority. There will be a number of important issues that require CalOptima's ongoing focus, including federal financing of the Medi-Cal program (including Medi-Cal expansion), reauthorization of the Children's Health Insurance Program (CHIP), and other issues related to the ACA.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Advocacy Services RFP Scoring Sheet
2. Federal Advocacy Services Scope of Work

/s/ Michael Schrader — *01/26/2017*

Authorized Signature — **Date**

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Summary

Federal Advocacy RFP 17-006

Firm Evaluation Scores

All firms were evaluated on a five point scale, 0-5.

	Proposal (25% of the overall score)	Interview (75% of the overall score)	Final Score
Akin Gump	3.60 x .25 = **0.90**	4.41 x .75 = **3.31**	**4.21* Recommended firm**
Potomac Partners DC	3.90 x .25 = **0.98**	4.41 x .75 = **3.31**	**4.29***
James F. McConnell	4.11 x .25 = **1.03**	3.33 x .75 = **2.38**	**3.40**
Waterman & Associates	3.29 x .25 = **0.82**	3.17 x .75 = **2.50**	**3.32**
Van Scoyoc Associates	3.22 x .25 = **0.81**		
Avancer Health Policy	2.70 x .25 = **0.68**		

*Submitted best and final offer

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Interview Evaluation

(75% of the overall score)

Finalist interviews were evaluated on a five point scale, 0-5.

	Presentations	Q&A	Overall Impression	Interview Total
Akin Gump	4.50 x .33 = **1.50**	4.50 x .33 = **1.50**	4.25 x .33 = **1.42**	**4.41**
Potomac Partners DC	4.50 x .33 = **1.50**	4.00 x .33 = **1.33**	4.75 x .33 = **1.58**	**4.41**
Waterman & Associates	3.00 x .33 = **1.00**	3.25 x .33 = **1.08**	3.75 x .33 = **1.25**	**3.33**
James F. McConnell	3.50 x .33 = **1.17**	3.00 x .33 = **1.00**	3.00 x .33 = **1.00**	**3.17**

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Proposal Evaluation

(25% of the overall score)

Proposals were evaluated on a five point scale, 0-5. Weighted scores are listed below.

	Experience (40% of overall score)	Pricing (10%)	Advocacy Plan (40%)	Organization (10%)	Grand Total (100%)
James F. McConnell	4.2 x .40 = **1.68**	4.5 x .10 = **0.45**	4.0 x .40 = **1.60**	3.8 x .10 = 0.38	**4.11**
Potomac Partners DC	3.9 x .40 = **1.56**	3.7 x .10 = **0.37**	3.8 x .40 = **1.52**	4.5 x .10 = 0.45	**3.90**
Akin Gump	3.8 x .40 = **1.52**	2.1 x .10 = **0.21**	3.7 x .40 = **1.48**	3.9 x .10 = 0.39	**3.60**
Waterman & Associates	3.3 x .40 = **1.32**	3.7 x .10 = **0.37**	3.2 x .40 = **1.28**	3.2 x .10 = 0.32	**3.29**
Van Scoyoc Associates	3.0 x .40 = **1.20**	2.2 x .10 = **0.22**	3.6 x .40 = **1.44**	3.6 x .10 = 0.36	**3.22**
Avancer Health Policy	3.1 x .40 = **1.24**	4.4 x .10 = **0.44**	2.0 x .40 = **0.80**	2.2 x .10 = 0.22	**2.70**

The top four firms advanced to the interview phase.

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A. Scope of Work

I. PURPOSE

CONSULTANT shall represent CalOptima's interests in Washington, D.C., and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive, mutually beneficial relationships, and providing CalOptima with necessary advocacy services.

II. REPORTING RELATIONSHIP

CalOptima Government Affairs leadership staff will be the primary CalOptima contacts and will direct the work of the CONSULTANT. All work determined to be in excess of the work specified herein will be approved by the primary contacts in conjunction with the CalOptima Vendor Management staff who shall then prepare an amendment to the Contract.

III. OBJECTIVE/DELIVERBLES

CONSULTANT shall:

1. Maintain regular contact with the Administration, members of Congress, specifically the Orange County congressional delegation, legislative staff, and committee staff to identify impending changes in laws, new program opportunities, and funding priorities that relate to CalOptima. When directed by CalOptima, the CONSULTANT shall also communicate with federal departments, agencies, boards, committees, committees and staff regarding identified issues.

2. As directed by CalOptima, brief Orange County congressional delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

3. Arrange meetings and briefings for CalOptima Board and staff with elected officials and legislative staff. The CONSULTANT shall be proactive in scheduling strategic, targeted meetings and briefings especially, but not limited to, times when CalOptima Board and staff are scheduled to be in Washington, D.C. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

4. Provide monthly, written reports which shall include a federal budget and legislative update, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the meetings the CONSULTANT had along with the issues discussed with members of Congress, specifically the Orange County congressional delegation, legislative staff, relevant committee staff as well as appropriate departments, agencies, boards, and commissions, committees, and staff. The reports shall be delivered on a schedule as directed by CalOptima staff, and may be included in the CalOptima board book and/or provided to board members.

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5. Provide in-person briefings, as directed by CalOptima staff, to the CalOptima board and executive staff.

6. Notify CalOptima of anticipated, introduced or amended federal legislation, and proposed regulations which could impact CalOptima. These activities include, but are not limited to:
   - Providing the bill number and brief summary of introduced or amended federal legislation;
   - Providing copies of legislation and committee analysis; and
   - Providing information relative to legislative hearings

Advocate for CalOptima's programs and positions regarding proposed legislation, proposed regulations, and funding priorities as directed.

Provide copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to the federal budget and any related documents (Congressional Budget Office analysis, etc.) as they become available.

CalOptima staff may prepare a formal annual review of CONSULTANT's work product at the end of each calendar year.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of an Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services

Contact
Kristin Gericke, Director, Clinical Pharmacy Management (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations (714) 246-8400

Recommended Action
Ratify Amendment to CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services, to revise prescription drug rebate provisions for CalOptima's Medi-Cal line of business.

Background
On May 7, 2015, the CalOptima Board of Directors (Board) authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options.

On October 4, 2018, the Board authorized an amendment to the PBM agreement by exercising CalOptima's first one-year extension option through December 31, 2019.

On February 7, 2019, the Board ratified revisions to the PBM agreement to include the collection of prescription drug rebates for CalOptima's Medi-Cal program.

More recently, on August 1, 2019, the Board authorized an amendment to the PBM agreement to extend the term through December 31, 2021.

Discussion
Pursuant to the primary agreement with the California Department of Health Care Services (DHCS), CalOptima had participated in the State Pharmacy Rebate program by submitting all pharmacy claims to DHCS on a monthly basis. DHCS, in turn, had managed collection of pharmacy rebates on an aggregate basis for all County Organized Health System (COHS) plans statewide.

With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, Medi-Cal managed care organizations became eligible to collect drug rebates for covered outpatient drugs dispensed to Medi-Cal members. The ACA made drug rebates applicable to both pharmacy-dispensed outpatient drugs and physician administered drugs. In addition, California statutory language restricting the COHS plans' ability to negotiate supplemental rebates with drug manufacturers was also removed via enactment of Senate Bill (SB) 870 on June 20, 2014, enabling COHS plans to negotiate rebates with drug manufacturers.

During its rate development meeting on October 25, 2018, DHCS informed CalOptima that the collection of prescription drug rebates by Medi-Cal managed care plans had gone from being optional to

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mandatory, and instructed CalOptima to make commensurate adjustments to its reported cost data to DHCS.

As such, CalOptima, together with MedImpact, developed a contract amendment to implement a prescription drug rebate program. The contract amendment provided rebates per paid claims. This payment rate includes rebate management services and increases the amount to $4.50 per paid claim. Although the amendment, effective June 1, 2019, included provisions for collection of prescription drug rebates for all paid claims, CalOptima was subsequently informed by MedImpact that, for the Medi-Cal line of business, rebates are only applicable to claims for diabetic test strips and those drugs for which a manufacturers' rebate is available.

Staff therefore subsequently amended CalOptima's agreement with MedImpact to clarify that, effective October 1, 2018, rebates will only apply to Medi-Cal claims for diabetic test strips and medications that qualify for a manufacturers' rebate (i.e., MedImpact pays CalOptima a minimum rebate guarantee of $4.50 per claim only for claims for diabetic test strips and those drugs for which a manufacturers' rebate is available—not for all Medi-Cal medications). The projected amount of rebate dollars collected is also being revised pursuant to this change to include only those claims.

Staff seeks ratification of this amendment to the MedImpact PBM contract effective June 1, 2019, to include updated language clarifying which claims are eligible for rebates.

Fiscal Impact

The recommended action to ratify an amendment to CalOptima's contract with MedImpact for PBM services clarifies that the prescription drug rebate provisions for the Medi-Cal line of business is not expected to have an additional fiscal impact on the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. Staff projects approximately $1.8 million for FY 2018-19 and $3.2 million for FY 2019-20 in prescription drug rebates.

Generally, revenue from rebates would decrease prescription drug costs in the short term, but such cost savings would be offset by a commensurate decrease in future Medi-Cal revenue. With the Governor's Executive Order N-01-019 to transition most Medi-Cal pharmacy services from managed care to fee-for-service (FFS) by January 1, 2021, DHCS is expected to adjust CalOptima's Medi-Cal revenue for pharmacy services accordingly in the future. While pharmacy services remain a managed care benefit, Staff plans to include PBM fees and potential rebates in future operating budgets. In addition, Staff will monitor pharmacy expenses and rebates prior to and during the transition period to Medi-Cal FFS.

Rationale for Recommendation

The above recommendation will provide clarification regarding applicability of rebates under CalOptima's MedImpact agreement.

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Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by this Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated February 7, 2019, Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services
5. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

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Attachment to February 6, 2020 Board of Directors Meeting – Agenda Item 10

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

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options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

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options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Kristin Gericke, Director, Pharmacy Management, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action
Ratify amendment of CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services to begin collecting Medi-Cal prescription drug rebates for utilization incurred effective October 1, 2018.

Background
At its May 7, 2015 meeting, the CalOptima Board of Directors (Board) authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options.

On October 4, 2018, the Board ratified extending the PBM agreement by exercising CalOptima's first one-year extension option through December 31, 2019. Under the provisions in the PBM agreement, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. In addition, MedImpact handles rebates for CalOptima's OneCare and OneCare Connect programs. However, CalOptima's agreement with MedImpact does not currently include the collection of prescription drug rebates for CalOptima's Medi-Cal program.

Discussion
Pursuant to the primary agreement with the California Department of Health Care Services (DHCS), CalOptima has participated in the State Pharmacy Rebate program by submitting all pharmacy claims to DHCS on a monthly basis. DHCS, in turn, has managed collection of pharmacy rebates on an aggregate basis for all County Organized Health System (COHS) plans statewide. Initially, the rebate program was implemented when the majority of Medi-Cal enrollees were in Fee-For-Service (FFS) arrangements, and DHCS was able to execute substantial rebate agreements with drug manufacturers for Medi-Cal covered drugs. The understanding was that COHS plans would not execute such agreements for drugs on the Medi-Cal Contract Drug List (CDL), so that DHCS could claim rebates for the drug products listed on the CDL and utilized by the COHS plans.

With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, Medi-Cal managed care organizations became eligible to collect drug rebates for covered outpatient drugs dispensed to Medi-Cal members. The ACA made drug rebates eligible for both pharmacy-dispensed outpatient drugs and physician administered drugs. In addition, California statutory language restricting the COHS plans' ability to negotiate supplemental rebates with drug manufacturers was

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removed by the enactment of Senate Bill (SB) 870 on June 20, 2014. The bill enabled COHS plans to negotiate rebates with drug manufacturers, with the understanding that DHCS will continue to submit plans' utilization when invoicing their supplemental contracts with drug manufacturers. In November 2015, DHCS sent additional guidance clarifying that:

> "if a COHS plan chooses to contract for medications currently contracted for by DHCS and listed on the CDL, they may do so…However, if a COHS plan successfully negotiates a supplemental rebate agreement with a drug manufacturer, then the Plan must notify DHCS and the department can no longer use the utilization for that drug (or drugs) when invoicing the manufacturers."

However, guidance provided by DHCS addressing the timeframe to implement SB 870 remained ambiguous. Language in the guidance stated:

> "the language that has always been in effect remains in effect for the time being…It will not become operational until the department officially implements the contracts applicable to both FFS and managed care drug formularies…That will not happen for quite some time."

As such, Medi-Cal managed care plans were aware of their eligibility to begin collecting rebates, but were uncertain when to begin implementation of such actions. Given this uncertainty, Management opted to maintain the existing operational procedures, whereby DHCS continued to collect drug rebates at the state level, until additional direction was given by the State.

At the rate development meeting on October 25, 2018, DHCS informed CalOptima that the collection of prescription drug rebates by Medi-Cal managed care plans was no longer optional, but required, and instructed CalOptima to make commensurate adjustments to their reported cost data to DHCS. By collecting rebates, plans will reduce their prescription drug costs by the amount of the rebates. However, savings to a plan's prescription drug expenses would be offset by a commensurate reduction in state revenue to the plan, since DHCS employs a cost-based methodology to develop a managed care plan's capitation rates.

As such, CalOptima began working with MedImpact on a contract amendment to implement a prescription drug rebate program. Staff has come to agreement with MedImpact on rates and contract terms and is working on a contract amendment to incorporate Medi-Cal prescription drugs within the existing rebate program already covered by the CalOptima-MedImpact agreement. The contract amendment replaces Exhibit B "Fee Schedule" with a guaranteed rebate per paid claim. This payment rate includes rebate management services, and increases to $4.50 per paid claim for Claim Years 4 and 5. Upon receiving Board authorization, Staff anticipates the collection of rebates to begin one hundred twenty (120) days after the end of the preceding quarter, for utilization incurred effective October 1, 2018, and thereafter until such time as the state provides the COHS plans with additional guidance on the Medi-Cal prescription drug benefit.

Fiscal Impact

The recommended action to amend CalOptima's contract with MedImpact for PBM services to collect prescription drug rebates for utilization incurred October 1, 2018, and after is projected to generate

$20.6 million in rebate dollars in Fiscal Year 2018-19, and $27.5 million on an annual basis. While the rebates effectively serve to decrease prescription drug costs, Staff anticipates that the cost savings will be offset by a commensurate decrease in future Medi-Cal revenue.

Rationale for Recommendation

The recommended action will allow CalOptima to comply with the DHCS's requirement for Medicaid managed care plans to collect prescription drug rebates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

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CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

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options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

Recommended Action
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Background
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Discussion

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Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

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options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA
BOARD OF DIRECTORS
NETWORK STRATEGY
FINAL REPORT
FEBRUARY 6, 2020

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Prepared by Pacific Health Consulting Group and Milliman, Inc.

Meeting Agenda

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Consulting Team

Pacific Health Consulting Group and Milliman

Pacific Health Consulting Group

Bobbie Wunsch
Founder and Partner

Tim Reilly
Founder and Partner

Milliman

Maureen Tressel Lewis
Healthcare Management Consultant

Barbara Culley
Healthcare Management Consultant

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Project Background and Approach

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Scope of Work

Network strategy analysis

- CalOptima's RFP was structured around a set of 12 individual tasks/questions.
  - 4 new tasks added during engagement as opportunity to secure additional provider and Board input.
  - There is some overlap and dependencies across the 12 tasks.
  - This presentation is structured to align similar topics and concepts across the individual tasks.

RFP Task	Key Task
Added task	Board Interviews
Added task	Board presentation: network payment models
Added task	Board presentation: models to motivate network outcomes
Added task	Provider Advisory Committee/provider interviews
RFP Task 1	Review actuarial methodology
RFP Task 2	Review Medical Loss Ratio (MLR) analysis
RFP Task 3	Evaluate pre-contracting criteria
RFP Task 4	Analyze membership limitation approach
RFP Task 5	Evaluate auto assignment
RFP Task 6	Research provider payment methodologies
RFP Task 7	Develop network performance evaluation tool
RFP Task 8	Research network models
RFP Task 9	Analyze member satisfaction implications
RFP Task 10	Analyze provider satisfaction implications
RFP Task 11	Review administrative cost allocation model
RFP Task 12	Analyze Health Needs Assessment
RFP requirement	Final presentation

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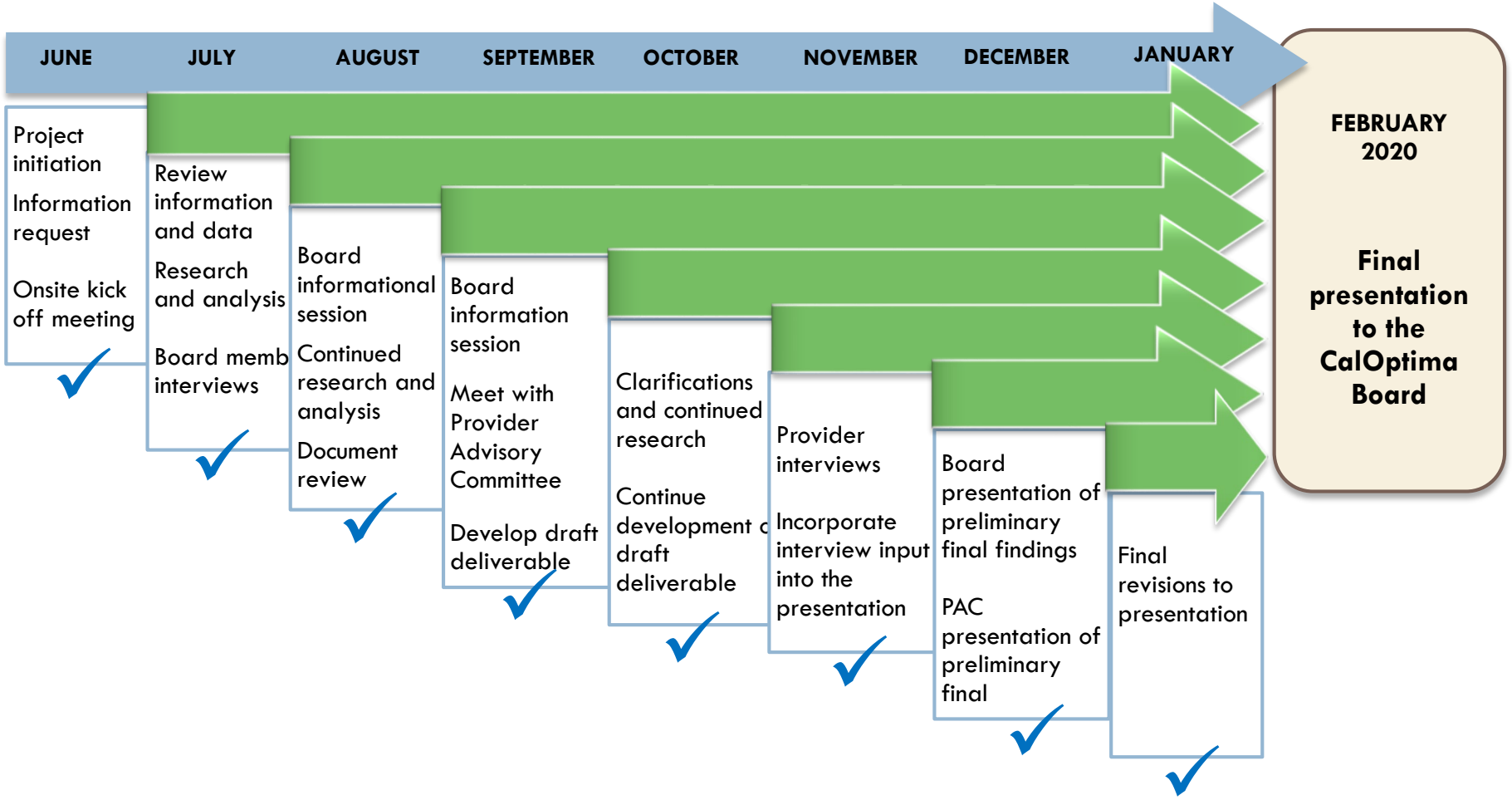
Project Approach

Structured project methodology and progress



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Initial Network Findings

High-level observations informed by multiple sources

- Multiple sources of information
  - Interviews
    - CalOptima staff interviews: 6/7
    - Board of Directors: 7/9, 8/1, 9/5, and 12/5
    - Provider Advisory Committee: 9/12 and 11/14
    - Provider interviews: 11/15 and 11/22
  - Materials and information
    - CalOptima documents, reports, and materials
    - Board minutes
    - Market practice information (numerous sources) - California market and national research
    - Comparison of CalOptima policies and practices with market are presented in Appendix

Observations

- Interviewees consistently stated a goal to use "best practices".
- CalOptima uses established network practices in most areas.
- Several key improvement opportunities exist and are discussed in this report.

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Provider Networks: Contracting and Organization, Population Characteristics, and Reimbursement

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Categorizing Network Models

Consistent models nationally and California

Nationally, and in California, most types of networks can be categorized in the following groups:

- **Direct Contracted:** Contracts with individual providers. Delivery system organized and directly contracted by health plan. Individual Physicians or Physician Groups are typically paid Fee For Service (FFS) and the health plan organizes a system around them.

- **Partially Delegated:** Contracts with entities that organize part of the delivery system and are delegated a wide scope of professional benefits and administrative functions. Capitation is usually the main reimbursement method for the entity. Typical entities are IPAs and Medical groups.

- **Fully Delegated:** Contracts with entities that organize a complete delivery system and are delegated a full scope of benefits and administrative functions. These entities are paid capitation. ACOs, PHCs, Dual Capitated Hospitals and Physician Groups, and other HMOs are typical participants. In California these entities must be licensed by DMHC.

Key features of basic network types

Direct Contracted Networks

- Health plan puts together a complete network of providers under contract.
- The health plan directly controls payments, quality programs, incentives, and utilization management (UM).
- Maximum control for plan and allows the network to be targeted to certain populations.
- Allows physicians to participate who may not be affiliated with organized physician entities.
- CalOptima's CCN Complex and CCN General are examples of these types of networks.

Key features of basic network types

Delegated Contracted Networks

- There are two types of Delegated Networks: Full and Partial.
- Delegated entity puts together a complete network of providers under contract.
- The delegated entity directly controls payments, quality programs, incentives, and UM.
- Maximum control for provider organized networks and allows decisions about care to be made by the provider closest to the patient.
- The goal is a more provider integrated system.
- CalOptima's delegates Kaiser, HMOs, PHCs, and SRGs are examples of these types of networks. Kaiser is fully delegated. The other networks are partially delegated and the services delegated vary across networks.

CalOptima Networks

Membership and payment summary

Model	Entities	Members	Percentage
Kaiser	1	44,557	6.0%
HMO*	3	118,215	16.0%
PHC**	3	210,235	28.7%
SRG	5	187,524	25.5%
CCN	-	77,333	10.0%
COD	-	98,873	13.8%
Total	**12**	**736,737**	**100.0%**

Model	Professional	Hospital	Pharmacy	Other Medical
Kaiser	Capitation	Capitation	Capitation	Capitation
HMO*	Capitation	Capitation	Fee-For-Service	Fee-For-Service
PHC**	Capitation	Capitation	Fee-For-Service	Fee-For-Service
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service
CCN	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service
COD	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service

* HMO – Comprised of one entity; assumes both professional and hospital risk. Not to be confused with industry terminology.

** PHC – Comprised of two entities; one for professional risk and one for hospital risk

Source: CalOptima Delivery System Review, September 6, 2018, Greg Hamblin

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CA MCMC Model Overview

Network models used in other MediCal plans

- **LA Care:** LA Care is primarily a Delegated Network. Sub contracting HMOs (Kaiser, Anthem, and Blue Shield) and capitated IPAs with Shared Risk make up 95% of the network. LA Care is expanding its Direct Network at this time.

- **Inland Empire Health Plan (IEHP):** IEHP uses all three types of networks but its enrollment is mainly split between Delegated IPAs and a Direct Network. Kaiser has a small market share as well. IEHP has been expanding its Direct Network, particularly after two of its IPAs had compliance problems.

- **Other County Organized Health Systems (COHS):** Most of the other COHSs' networks are heavily dominated by Direct Networks and only utilize other types of networks when important providers insist on a particular model.

IEHP and LA Care Networks

Enrollment distribution across networks

Enrollment by Network Type	Kaiser	HMO	Restricted License	Dual Cap/PHC	Cap IPA/SRG	Direct	Total
IEHP	112,392	0	8,548	0	554,531	508,074	1,183,545
LA Care	205,451	779,339	50,000	350,000	669,203	126,398	2,180,391

Enrollment Distribution	Kaiser	HMO	Restricted License	Dual Cap/PHC	Cap IPA/SRG	Direct	Total
IEHP	9.50%	0.00%	0.72%	0.00%	46.85%	42.93%	100.00%
LA Care	9.42%	35.74%	2.29%	16.05%	30.69%	5.80%	100.00%

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CalOptima Networks Comparison

Comparing enrollment distribution across three key plans

- Categorizing the networks to be comparable across plans

Enrollment by Network Type	HMO	Full Risk	Cap/Shared Risk	Direct	Total
IEHP	112,392	8,548	554,531	508,074	1,183,545
CalOptima	44,587	328,450	187,524	176,206	736,767
LA Care	984,790	400,000	669,203	126,398	2,180,391

Enrollment Distribution	HMO	Full Risk	Cap/Shared Risk	Direct	Total
IEHP	9.50%	0.72%	46.85%	42.93%	100.00%
CalOptima	6.05%	44.58%	25.45%	23.92%	100.00%
LA Care	45.17%	18.35%	30.69%	5.80%	100.00%

CalOptima Networks Comparison

Regional trends

- The southern California region uses more capitation and delegation than northern California.
- Comparisons across CalOptima, LA Care, and IEHP networks.
  - LA Care and CalOptima started out with heavily delegated networks.
  - CalOptima utilizes in a significant fashion three different network types. LA Care and IEHP's use of network types is more concentrated.
  - All three plans have increased their Direct Networks over time.
- National trends are moving to value-based-purchasing contracts.
  - The value-based payment system rewards providers for efficiency, financial performance, and quality of care.
  - It also incentivizes providers to manage total cost of care.

CalOptima Network Characteristics

Comparison across CalOptima networks

- The CalOptima Networks are difficult to compare since there is significant variation among them.
- CCN General Network members are older than average, and not surprisingly they have the highest risk score.
- The PHC Network members are younger by almost half from the average age and have the lowest risk score.
- The PHC Network is younger because the CHOC Health Alliance is primarily a children's network.

Network Characteristics

Member population characteristics

- The Networks can be described by their member populations. Among the characteristics to be considered:
  - Aid/Rate Categories
  - Average Age
  - Risk Scores

CalOptima Network	Aid/Rate Category					Ave Age	Risk Score
	SPD	MCE	Child	Adult	Total		
CCN General	**8%**	**45%**	*23%*	**24%**	100%	**33.4**	**1.06**
HMOs	6%	42%	32%	19%	100%	30.3	1.03
PHCs	*4%*	*18%*	**69%**	*9%*	100%	*16.8*	0.97
SRGs	6%	**45%**	32%	17%	100%	30.3	*0.95*
Grand Total	6%	35%	43%	16%	100%	26.4	1.00

Provider Payment Methodologies

Payment methodologies used by Health Networks

- CalOptima uses both fee-for-service and capitation to meet member and provider needs along a continuum of models.
  - A variety of models provides flexibility.
  - Each model has advantages and disadvantages.
  - CalOptima retains risk for high-cost services, e.g. pharmacy.

Model	Professional	Hospital	Pharmacy	Other Medical
Kaiser	Capitation	Capitation	Capitation	Capitation
HMO*	Capitation	Capitation	Fee-For-Service	Fee-For-Service
PHC**	Capitation	Capitation	Fee-For-Service	Fee-For-Service
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service
CCN	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service
COD	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service

* HMO – Comprised of one entity; assumes both professional and hospital risk
** PHC – Comprised of two entities; one for professional risk and one for hospital risk

Provider Payment Methodologies

Attributes of the current CalOptima practices

- **Capitation**
  - Health Network is paid a per member per month (PMPM) rate.
    - Rates are approximately based on CalOptima Fee-for-Service (FFS) payment policies, methodologies, and actual, historical incurred utilization and costs.
    - HMO/PHC has capitation for some professional and hospital services, with some high risk carve outs (children's hospital, services approved without financial risk) and re-insurance paid on a FFS basis.
    - SRG has capitation paid for some professional services, with some carve outs and re-insurance paid on FFS basis.
- **Fee-for-Service**
  - Providers are paid an established fee for each service.
    - FFS rates are based on CalOptima's payment policies, methodologies, and fee schedules.
    - CCN payments are all FFS.
- Provider feedback on changing contracted methodology is that they are constrained in changing network types (e.g. from shared to full risk, which must be approved by the Board).
- CalOptima is utilizing all payment models. Each model has strengths and disadvantages.

CalOptima Capitation % by Network

Health care expense by type varies significantly across CalOptima networks

- CalOptima's Networks are capitated at different levels.
- The more the Networks are delegated benefit responsibility, the more they are capitated
- Percent of CalOptima's Network expense (CY 2017) that is capitated:
  - CCN Complex 0%
  - CCN General 1.1%
  - HMO 65.9%
  - PHC 62.4%
  - SRG 32.4%
  - Total 40.3%

Reimbursement Options and Use

A wide variety of payment models are used nationally and in California

- **Fee-for-Service (FFS):** Payment set by procedure code fee schedule. Incentivizes volume of services.
- **Bundled Payment:** Payment based on the estimated cost of all services for a problem, e.g. knee replacement. Incentivizes efficiency and quality of care to avoid the costs of complications or readmission.
- **Pay for Performance (P4P):** Payment base on provider's performance on agreed quality measures, e.g. readmission rates.
- **Shared Savings:** Only up-side risk, rewarded but not required to cover deficits.
- **Shared Risk:**
  - Up-side Risk: Aligned incentives to realize and share savings achieved through quality care impacting cost and utilization.
  - Down-side Risk: Aligned risk to share excess costs due to over-budget utilization and costs. Incentivizes quality of care, coordination of services, and holistic care.
- **Capitation:** Providers are paid a set amount for each member for a period of time, e.g. per member per month. The set amount is paid regardless of whether the member seeks care or not.

Incentive Types, Funding, and Impact

California limits downside exposure for providers

Incentive	Funding Options	Anticipated Impact
Bonuses	Withhold/premium allocation	Bonus linked to outcomes can impact provider focus
Shared savings	Based on reduced costs and utilization (most California risk pools fall into this category)	Focus on quality and coordination of care to reduce readmissions and complications
Shared risk	Providers share downside when costs exceed the rate (limited in California)	Providers focus on outcomes to realize optimal care and efficiency which impact costs
Pay for Performance	Funded through savings realized by achieving performance goals, e.g. reduced readmissions	Aligned goals for quality of care and reduced costs

Incentive design elements

- Direct to providers, which allows tailoring of incentives
- Through delegated networks using contract expectations
- Providers understand incentive calculations and how to achieve incentives
- Targets and performance feedback are essential
- Timing for receiving incentives varies, e.g. quarterly versus annual

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AmeriHealth Caritas

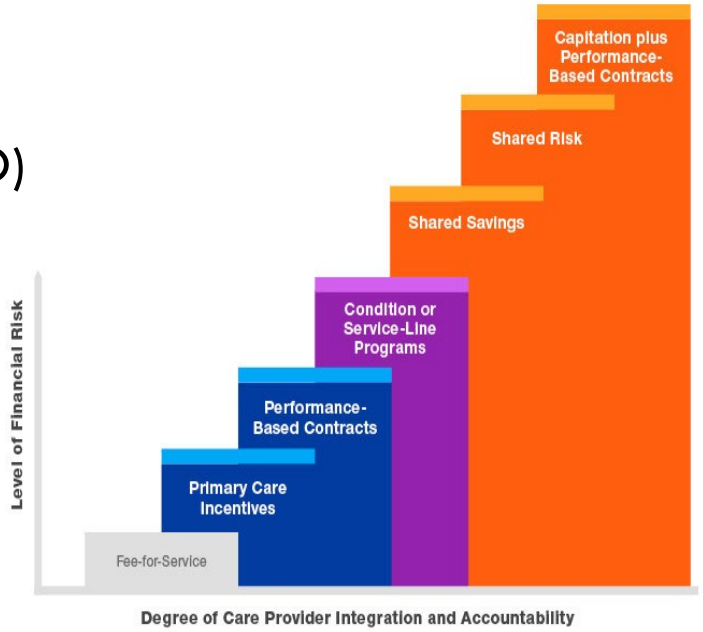
Managed Medicaid Managed Care Organization in 19 states

- Pay-for-performance bonuses to PCPs, specialists, hospitals, integrated delivery systems, and FQHCs.
- Shared savings bonus to integrated delivery systems in some areas.
  - Include trend and peer based measures on quality and efficiency measures, e.g. preventable admissions.
- Reward for timely, appropriate care and positive outcomes.
- Goal to reduce unnecessary inpatient and emergency utilization, improve outcomes, and decrease cost.
- Models include semi-annual capitation adjustments.
  - Upside only
  - Based on quality and cost guardrails
- Annual settlement parameters with interim payment stream.
- Performance metrics progress is available to providers via web-based dashboard.

United Healthcare

49.7 million lives Medicaid, Medicare, employer and individual plans

- Models range from Fee-for-Service to capitation.
- Provide support and resources to move providers toward value-based care models.
- Four network models:
  - Health Maintenance Organization (HMO)
  - Exclusive Provider Organization (EPO)
  - Preferred Provider Organization (PPO)
  - Point of Service (POS)



Source: https://www.uhc.com/valuebasedcare/how-value-based-care-benefits-you/for-care-providers

California Landscape

Regulatory considerations can influence payment models

- Directed payment, e.g. Proposition 56, mandates that the plan is required to pay providers a supplementary amount that sometimes exceeds Medicare.
  - Goal is for increased quality and other performance targets.
  - Plan statutorily required to complete, not delegates.
- Various approaches to incentive payment method.
  - Direct to providers, which allows tailoring for providers.
  - Through delegated networks using contracted expectations.
  - Independent of delegated networks.

Network Models

Specialized networks for unique populations and required services

- Considerations should be given to the types of networks needed as CalAIM (Medi-Cal Healthier California for All) transforms Medi-Cal Managed Care.
  - **High Cost and Dually Eligible:** CalOptima and other Plans have considered special networks for Renal Dialysis patients and other high cost patients as well as Dually eligible members where the plan does not hold the Medicare coverage.
  - **Institutionalized:** With the increased emphasis on LTC, networks specializing in the institutional populations should be considered (e.g. SNFists).
  - **Whole Person Care:** The transformation of Whole Person Care and the restructuring of Health Homes in MCMC may provide opportunities for new types of networks.
  - **Integrated Care Models:** DHCS is also encouraging the development of a more integrated model that includes Mental Health, Behavioral Health, and Dental Care.

Network Models

Reimbursement issues and considerations

- New reimbursement policies for these developing areas should also be considered and incorporated into the overall network strategy.
- For example:

> Should Acute Care hospital, Long Term Care (LTC) , and LTC support Services/ILOS and Enhanced Care Management services all be delegated and capitated to the networks?
>
> If not, how does the plan keep the services financially aligned?

Actuarial Methodology Analysis

Actuarial methodology and MLR comparative analysis

- Reviewed actuarial report on risk adjustment and expenses.
- Reviewed staff analysis of Medical Loss Ratios by actuarial determined risk scores.
- Compared the Network costs and FFS costs across the networks. Note: Risk Adjusted and Unadjusted comparisons considered.
- Reviewed appropriate capitation rate comparisons.

Actuarial Methodology

Typical market practices

- Network encounter data was repriced based on the direct network FFS rates schedules.
  - This analysis is updated periodically to consider Capitation Rate levels.
  - The capitation rates paid were higher than the repriced encounters. This is not an unusual outcome as encounter data is typically missing a significant volume, and as such, did not trigger a lowering of the capitation rates.
- Making sure the Networks are fairly and comparably reimbursed should be a goal unless there is a mission based goal to expand a certain type of contract by offering favorable rates.

Risk Adjustment and MLR

Comparison across CalOptima Networks

- There are significant differences in Risk Scores across the Networks which make MLR comparisons meaningless.
- MLR calculates the % of the revenue that is spent on payments to networks/providers. MLR does not include the necessary administrative costs inherent to plan operations.
  - 85% is usually seen as the minimally acceptable MLR, while public Plans usually are at a level close to 94%.

CalOptima Performance	CCN Complex	CCN General	HMO	PHC	SRG	TOTAL
Member Months	12,322	847,304	1,208,665	2,677,667	2,741,641	7,487,599
Imputed Risk Based Adjustment Factor	10.05	1.06	1.03	0.97	0.95	1.00

Risk Adjustment and MLR

Variation across networks and financial implications

- CalOptima is maximizing the payments to networks/provider through its contracts when compared to its revenue.
- It is important to understand that Risk Adjustment methodologies have limited predictability and should be considered a partial answer to the question of how much risk there is in a population.
- CalOptima MLR and risk adjustment results varied.
  - There was significant variation of costs and risk across the networks.
  - The Direct Networks had greater costs per member month and higher risk scores than the Delegated Networks.
  - These results are based on review of CalOptima's MLR. CalOptima should also review the delegates' MLRs to better understand Network performance.

Provider Networks: Protocols and Management

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Network Protocols

Policies and procedures to support network management

- Plan network management teams typically use a set of preapproved guidelines and processes to enable efficient and effective operations that support the overarching network strategy.
  - Processes are designed to be compliant with regulatory, accreditation, and other third party requirements.
  - Administrative procedures are clear and avoid unneeded complexity (and cost).
  - Day to day network management activities conducted by staff do not need Board participation or approval.
- These processes support a broad variety of network management activities such as:
  - Network participation requirements.
    - Contracting and delegation criteria
    - Network composition (e.g., number and type of providers, provider affiliations, panel size, PCP assignment)
  - Standard contracting terms and payment models.

Network Protocols

CalOptima practices and other plan trends

- CalOptima has procedural requirements that may not add value to network management, composition, or quality.
  - Using RFP for network participation ➡ administrative cost and complexity.
  - Complex pre-delegation audit ➡ barriers for network expansion.
  - Auto assignment primarily on safety net and quality metrics ➡ no tie to financial, access, or outcomes.
- Other plans nationally and in California have focused and streamlined practices to minimize or avoid these types of barriers.
  - Focus on complying with regulatory requirements without extra complexity.
  - Use financial, access, and outcomes measures to designed membership and related targets.
  - Board approved processes and criteria are used to conduct day to day network development and management, enabling Board to focus on mission, vision, and strategy goals.

Network Management

Using network data, analytics, and reporting in network performance management

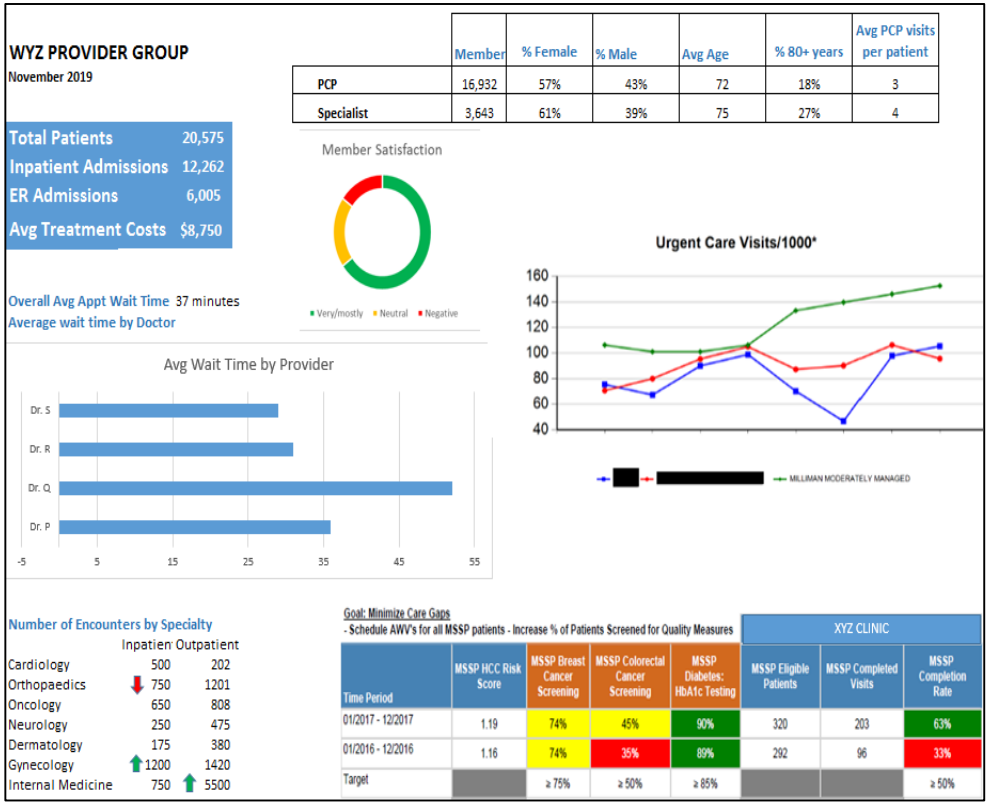
- Plans typically develop key performance reporting that is distributed electronically to providers with specific target goals.
  - Individual performance awareness in comparison to peer group.
  - Reporting metrics are holistic, e.g. financial, quality, utilization, and satisfaction.
  - Also supports requirement for plan oversight.
- Reporting is designed to align with provider needs.
  - Format and content are intuitive and aligned with performance goals.
  - Focused on the critical few measures with access to detail if needed.
  - Performance drives consequences, e.g. incentives or contracting duration.
- National direction toward greater transparency, e.g. public disclosure of some metrics.

Network Management

Current practices

- CalOptima creates quality metric related reporting – it has limited distribution.
- IEHP and LA Care send multi-faceted performance reports to providers.
  - Includes quantitative and qualitative results, e.g. the number of members, member utilization data (e.g., ER visits, admissions, etc.), financial results, encounter data per member per year by IPA, HEDIS measures achievement rate, goal rate.
  - LA Care is considering public disclosure of results.

Example report



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Network Vision and Strategy

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Network Vision and Strategy

Typical market practices

- Plans develop a network strategy as a framework for developing and maintaining the network of providers needed to support the plan's current and forecast membership.
- Network strategy should be tightly aligned with a plan's:
  - Mission statement
  - Strategic plan
  - Financial, quality, and access goals
  - Operating environment/market characteristics
- Network strategy details may shift over time, but should be integral to the overall network management model.

Example Network Vision

Network vision should be aligned with the mission statement

CalOptima mission statement:

Provide members with access to quality health care services delivered in a cost-effective and compassionate manner

STRATEGIC PRIORITIES

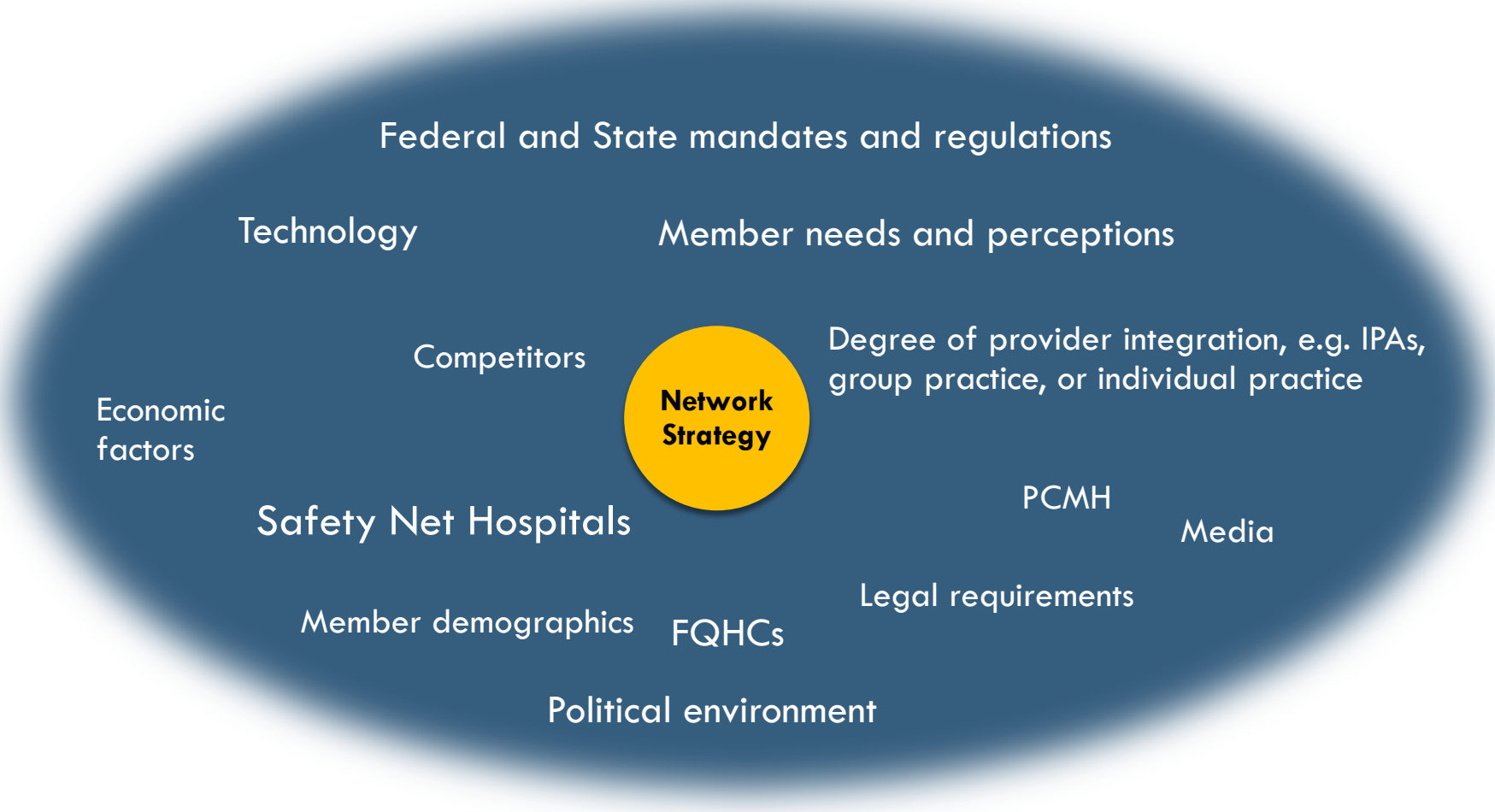
- Innovation
- Value
- Partnerships and Engagement

Network strategy vision (example):

Maximize the providers caring for Medi-Cal members to improve the overall quality and cost efficiency of the delivery system

Network Strategy

Network strategy is influenced by multiple factors unique to the plan environment



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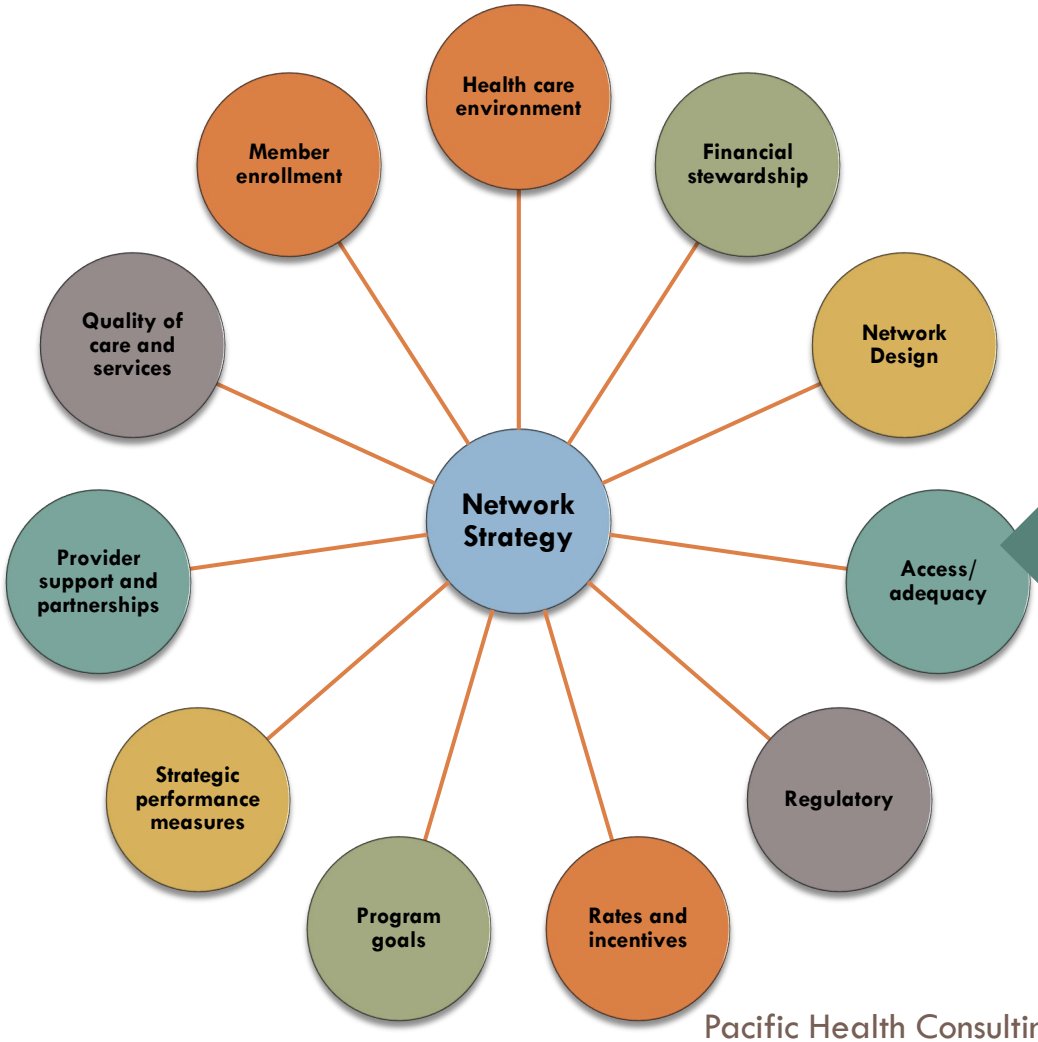
Network Strategy Components

Major elements comprising network strategy with detailed sub-topics for focus and planning



- Providers
- Specialists
- Location
- Co-location
- Health Plans
- Alternative medicine
- Facilities
- FQHC
- Etc.

- Cultural match
- Capacity
- Practice parameters, e.g. OB/GYN

Each component has additional layers. Individual components are not equally weighted.

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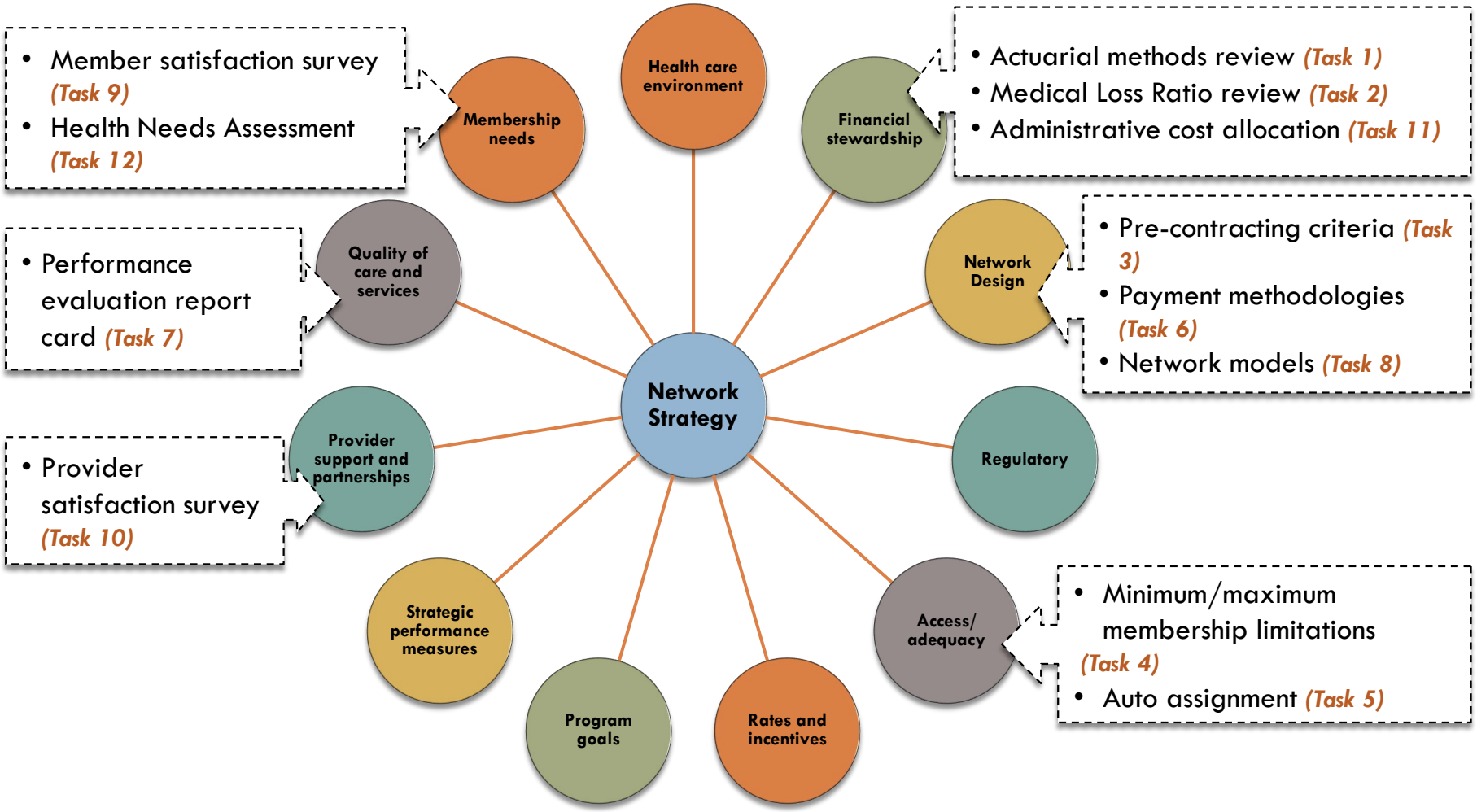
Engagement Scope of Work

The scope of work focused on selected components of a comprehensive network strategy



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Recommendations and Road Map

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Five Overarching Recommendations

Opportunities for improvement

- Begin with a CLEAR NETWORK VISION of CalOptima Board objectives for network access, adequacy, and cost and quality performance
- Create a comprehensive NETWORK STRATEGY DOCUMENT that supports the CalOptima mission and vision with prioritized activities to meet network cost and performance goals
- Add networks/IPAs to the network if needed to FILL HEALTH PLAN NEEDS, e.g. access, services, and specialties, and add any physician meeting criteria to the direct network
- REMOVE BARRIERS to contracting that add administrative costs, e.g. RFP process previously used
- INCREASE TRANSPARENCY AND ACCOUNTABILITY in network performance by reporting outcomes in relation to other networks with assistance to reach performance goals, particularly for essential service providers

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Network Vision and Strategy

Foundational elements for CalOptima network construct

Recommendations

- Begin with a clear network vision based on CalOptima Board objectives for network access, adequacy, and cost and quality performance.
- Document the network strategy and describe the rationale behind the strategy in a Board approved publically transparent document.
- Create a comprehensive network strategy that supports the CalOptima mission and vision.
  - Incorporate prioritized actions to meet network cost and performance goals.
  - Include quantitative goals (e.g., MLR goals, risk retained by plan and amount delegated to networks, etc.) as well as qualitative goals (e.g., quality and satisfaction).

Network Composition

Ensure networks meet current and anticipated future needs

Recommendations

- Add networks/providers to the network if needed to fill health plan needs, e.g. access, services, and specialties, and add any physician meeting criteria to the direct network.
  - Add physicians/groups when they significantly add to physician capacity.
  - Determine whether to modify network contracts (e.g. full or partial capitation, carved out services) to increase transparency and accountability, e.g. for total cost of care.
  - Consider how and whether to add specialty networks to meet special population requirements.
- Structure network payment models to support long term financial goals.
  - Capitation payments to Networks models should be targeted to keep total network % of premium at a level to allow CalOptima to retain sufficient administrative dollars and margin contribution. Overall MLR targets of 94% and ALR of under 5% are common for Public Plans.
  - Establish a connection between CalOptima reimbursement practices and DHCS policies. DHCS is adjusting payments based on proscribed goals. CalOptima's policies should align.

Contracting Criteria

Simplify and streamline processes

Recommendations

- Simplify pre-contracting by eliminating RFP process
  - RFP for network participation is atypical and increases administrative cost
  - Develop policies that clarify rationale and basis for adding providers to fill plan needs
  - Current standards for network participation stated in RFP are reasonable. Need for new physician capacity should be emphasized.
- Redesign contracting process
  - Simplify process by making easier for provider to contract.
  - Consider adding key criteria, e.g. percent open panel.
  - Differentiate between contracting criteria and "must pass" standards for delegation of admin functions.
  - Set contract duration based on cost and quality performance.
- Set criteria for bottom quartile corrective actions and duration to correct
  - E.g. if an issue remains uncorrected in three periods, the contract is terminated (provisional contracts).
  - Identify opportunities to work with existing contractors to their performance

Provider Payment Methodologies

Adapt to meet network and financial goals

Recommendations

- Continue to utilize all payment models tailored to providers and networks providing flexibility and providers and members choice, e.g. from fee-for-service to shared risk.
- Align payment approach with provider/network experience and integration sophistication, population needs, and CalOptima goals, e.g. bonuses for meeting targets in focused areas of performance improvement.
  - Consider a tiered incentive plan with individual physicians and the networks to incentivize desired outcomes.
  - Move providers/networks toward Value Based Payment plans (within the California constraints) to incentivize quality and reduced costs, share risk, and create alignment between provider and plan goals. Future increases in compensation should be value based.
  - Periodically review approach to high cost services, e.g. high tech radiology and high cost prescriptions. Incorporate incentives for managing utilization of high cost services that are frequent services where the provider/network has a degree of control.
  - Consider including LTC, support services, ILOS/Enhanced Care Management in delegated agreements.
- Incorporate total cost of care in provider reporting to increase transparency and accountability.

Network Protocols

Administrative processes and procedures to support network management

Recommendations

- Structure network protocols that support Board goals and enable staff to efficiently and effectively conduct network management.
  - Remove barriers to contracting that add administrative costs, e.g. RFP process and simplify contracting process.
  - Set clear goals for balance of membership assigned to Health Networks to ensure that at risk Health Networks have sufficient membership to spread risk.
  - Do not repeat Health Needs Assessment due to limited return on investment and increased risk of provider or member fatigue.
- Establishing Board approved processes and criteria will enable the Board to retain focus on CalOptima's overarching mission, vision, and strategy goals.

Membership Limitation Approach

Panel size and membership

Recommendations

- Continue no member limit for non-capitated providers.
- 5,000 minimum panel size seems reasonable for risk-based Health Networks.
  - Consideration should be given to keep valuable specialized Health Networks who don't reach required size within a reasonable timeframe to be converted to a non risk-based basis. For example a specialized network for homeless members might need a waiver from the 5,000 limit.
- No network is allowed a super majority of membership.
  - Continue limiting membership as a percent of total, with the top limit of 33% of membership.
  - Consider linking limits to cost and performance outcomes, e.g. better performing networks have a higher percentage of membership.
- Consider limiting the number of Health Networks with which individual providers can contract.
  - Providers in multiple Health Networks add unnecessary complexity.
  - Reaffirm which providers have open panels.

Auto Assignment Considerations

Continue practice to align assignment with higher performing providers

Recommendations

- Continue to direct members to higher quality Health Networks using the auto assignment methodology based on HEDIS scores
  - Share methodology with providers for transparency and accountability
  - Methodology first designates 45% to the safety net providers. This is consistent with other public plans. Assess definition of Safety Net.
  - Create tiers for higher assignment for higher performing Health Networks/providers on the basis of financial and quality outcomes
- Consider removing limit on assignment to CCN when over 10% if members continue to choose in significantly high numbers directly contracted physicians and the network maintains quality and cost metrics equal to the other networks
- Monitor to ensure all members are engaged with a PCP
  - Measure and monitor member retention as a performance indicator
  - Measure and monitor annual member utilization of their PCP

Network Analytics and Reporting

Reporting financial and outcomes metrics to enhance network performance

Recommendations

- Increase transparency with individual network performance comparison data.
  - Report both financial and outcomes in relation to other networks.
  - Provide assistance to reach performance goals, particularly for essential service providers.
  - Include performance metrics and targets in network contracts.
- Analyze data over time to identify trends and opportunities and to revise goals and criteria.
- Ensure that analytics incorporates review of Health Networks and individual provider performance.

Network performance evaluation tool

Develop tools to assist in evaluation in and across Networks

Recommendations

- Identify key metrics aligned with CalOptima mission.
  - Limit reviewed metrics to focus on leading and key measures.
  - Develop a holistic, balanced perspective, not just quality focus.
  - Set a target for every key metric.
  - Include NCQA metrics (State considering requiring).
- Leverage currently collected data to reduce administrative burden.
- Increase transparency with individual network performance comparison data compared to other network performance.
- Create multi-level reporting that provides appropriate detail to stakeholders.
- Analyze data over time to identify trends.
- Include performance metrics and targets in network contracts.
- Develop actions based on performance data.

Member Satisfaction

Evaluate survey results for actionable findings

Recommendations

- Continue current process for member satisfaction survey to meet regulatory requirements.
- Member surveys indicate ongoing concern with access to care.
  - CalOptima meets regulatory adequacy and access requirements.
  - Evaluate network strategies, e.g. contracting, incentives, and pre-contracting criteria to address real/perceived access barriers.

Provider Satisfaction

Evaluate survey results for actionable findings

Recommendations

- Continue current provider satisfaction survey to meet regulatory requirements.
  - Do not use supplementary surveys.
  - Continue oversight of delegated networks results and actions.
- Network staff lead multi-disciplinary teams to resolve areas of provider dissatisfaction, e.g. all behavioral health measures are low, and a significant decrease in satisfaction with education and training provided.
  - Include Health Networks' staff as necessary.
- Include provider satisfaction goals in Health Network contracts.
  - Network incentives for provider satisfaction goal attainment.
  - Link provider satisfaction to percentage of members assigned to the network.
- Share the survey results with Health Networks for engagement in quality improvement actions.

Administrative Cost Allocation Model

Allocation methodology reflects administrative services

Recommendations

- Review allocation methodology to affirm the design is equitable, meaningful, and provides distribution of funds consistent with both retained and delegated administrative functions.
  - Periodically re-evaluate model to ensure that total administrative expense is consistent with assigned tasks.
- Review current allocation model, adjust to reflect expected costs for actual delegated tasks.
  - Complete an administrative cost allocation review for each network relative to administrative tasks completed, e.g. delegated tasks versus non-delegated network scope of administrative tasks will vary.
- Consider the administrative cost spend at the delegated provider level.
  - DHCS is limiting inclusion of capitation expense in RDT where they believe there are administrative costs being passed on to delegate.
  - CMS is limiting admin cost inclusion in the MLR calculations.

Added Member Health Needs Assessment

A supplemental member needs survey was completed in March 2018

Recommendations

- Leverage existing tools.
  - State required Group Needs Assessment.
  - HEDIS, CAHPS, and data mining.
- Do not repeat supplemental Member Health Needs Assessment due to limited return on investment and increased risk of provider fatigue.
- Limited use of targeted assessments may be useful for specific populations, e.g. seniors for understanding Long Term Supports and Services needs and barriers.

Caveats

This presentation is subject to the terms and conditions of the Consulting Services Agreement between CalOptima and Pacific Health Consulting Group (PHCG) dated May 7, 2019.

This presentation has been prepared solely for the internal business use of and is only to be relied upon by the Board and management of CalOptima. These slides are for discussion purposes only. They should not be relied upon without benefit of the discussion that accompanied them.

Thank You

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Appendix

To be included in Final Report

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Selecting Vendor and Authorizing Contract for Real Estate Consulting Services

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

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with Newmark Knight Frank for real estate related services pursuant to the attached Scope of Work (SOW).

Background
At its January 6, 2011 meeting, the Board authorized the purchase of an office building located at 505 City Parkway West, Orange, California (i.e., 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 and a parking structure. At the time of the purchase, the expiration date for the Development Agreement was October 28, 2014; however, at the Board's October 2, 2014, it authorized an amended and restated Development Agreement with the City of Orange to extend the development rights for six years, through October 28, 2020.

At its February 3, 2011 meeting, the Board authorized the lease agreement for the CalOptima Program of All-Inclusive Care for the Elderly (PACE) building located at 13300 Garden Grove Boulevard in Garden Grove. The base lease term for the PACE building is for a period of ten years, which will expire in 2021.

At its October 3, 2019 meeting, the Board authorized the issuance of a Request for Proposal (RFP) for real estate related consultant services. The 10th floor improvements were completed on December 1, 2019, and staff anticipates that the 505 Building will reach full occupancy by June 30, 2020, based on the Fiscal Year 2019-20 budgeted head count.

Discussion
In accordance with CalOptima's standard RFP process, an RFP was issued and a total of three responses were received. The responses were reviewed by CalOptima's evaluation team consisting of the Chief Financial Officer, Director of Facilities, Director of Budget and Procurement, Manager of Purchasing, Intermediate Buyer, and Executive Director of Operations. All RFP responders were provided with a copy of the Scope of Work as part of the standard RFP process. The Scope of Work included the following services:

- Additional Office Space and Parking
    - Assist in providing market research, evaluation development feasibility and financial feasibility, and recommend options;

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  - 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; and
  - Create a parking map of available local parking for rent.

- PACE Lease
  - Represent CalOptima on the PACE lease renewal and examine the Garden Grove commercial real estate market to ascertain the proper renewal rate for the PACE lease renewal at fair market value and other options.

- Development Rights
  - Assist and advise on extending and revising the current Development Agreement. resent a written report and presentation for CalOptima's Board of Directors on the different options evaluated by Broker for construction, lease and purchase, along with the financial evaluation of the associated costs with each option, as well as evaluation of various models/options for development.

The evaluation team's final weighted scoring for the RFP was as follows:

Proposal Evaluation:

Vendor	Score
Newmark Knight Frank	21.85
Cushman & Wakefield	21.72
Jones Lang LaSalle	20.77

Demo Evaluation:

Vendor	Score
Newmark Knight Frank	23.91
Jones Lang LaSalle	23.60
Cushman & Wakefield	23.10

Based upon the weighted scores each vendor received, Newmark Knight Frank finished with the highest score at 45.76 of the evaluation. Cushman & Wakefield finished second with a score of 44.82. Jones Lang LaSalle finished third with a score of 44.37.

The evaluation team determined that Newmark Knight Frank's differentiators were:

- The vendor's proprietary system for tracking and updating project management needs;
- Experienced staff in modeling multiple variable needs when evaluating properties (e.g., member density);
- In-depth discussion during the interview regarding different scenarios, looking at properties from multiple perspectives, and inclusion of a detailed Return on Investment (ROI); and
- The pricing for future commission was most beneficial to CalOptima.

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Considering the status of the office space and parking capacity at the 505 Building, the upcoming PACE Lease renewal, and the potential value and uses of the Development Agreement, Management recommends the Board authorize the contract with Newmark Knight Frank for real estate related services.

Fiscal Impact

The proposed contract for real estate services with Newmark Knight Frank is an "at risk" contract. The contracted vendor will be compensated through possible future commissions only, therefore there is no additional fiscal impact to CalOptima's Operating Budget.

Rationale for Recommendation

Management believes that contracting with the highest scoring vendor, Newmark Knight Frank, will meet the goal of continuing to ensure that CalOptima has the appropriate space for business needs and is protecting its existing development rights. Staff reviewed qualified real estate vendor responses and identified the candidate believed to best meet CalOptima's needs for real estate services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. CalOptima – Real Estate Advisory, Development Consulting Brokerage Services Broker RFP Scope of Work
3. 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
4. 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
5. Board Action dated October 2, 2014, Consider Authorizing Extension of CalOptima Headquarters Building Site Development Agreement with the City of Orange
6. CalOptima Board Action dated October 3, 2019, Consider Authorizing the Issuance of a Request for Proposal(s) for CalOptima Real Estate Related Services

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Newmark Knight Frank	700 South Flower Street, Suite 2500	Los Angeles	CA	90017
Jones Lang LaSalle	4 Park Plaza, Suite 900	Irvine	CA	92614
Cushman & Wakefield	18111 Von Karman Avenue, Suite 1000	Irvine	CA	92612

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C. Scope of Work

CalOptima is a local public agency that owns a 10-story commercial office building located at 505 City Parkway West, Orange, CA 92868, herein referred to as the "505 Office Tower." CalOptima currently occupies all 10 floors in the building. We anticipate that the 505 Office Tower will be at capacity within the next twelve (12) months. CalOptima also has a Development Agreement with the City of Orange now in effect through October 28, 2020. The development rights include the possible construction of a second 10-story office tower and a parking structure at the 505 Office Tower site. CalOptima is interested in extending and broadening these Development Rights, and also in exploring and studying the cost and benefits of various mixed use and other options for future planning purposes.

In addition, CalOptima currently leases a single story, tilt-up building for its Program of All-Inclusive Care for the Elderly (PACE) located at 13300 Garden Grove Blvd., Garden Grove, CA 92843, herein referred to as "PACE." CalOptima's PACE lease will expire on December 21, 2021, and CalOptima is looking for advisory services in exploring other options, as well as brokerage services to leverage and negotiate a lease extension.

CalOptima is interested in contracting for a full range of Commercial Real Estate Advisory, Development Consulting, and Brokerage Services. CalOptima reserves the right to hire multiple vendors for these tasks. All services listed below in Section II.B. are required to be completed within sixty (60) days unless otherwise specified below.

CalOptima is looking for professional commercial real estate advisory, development consulting, and brokerage services to perform the above tasks, including, but not limited to, the scope of work below.

A. QUALIFICATIONS

1. All real estate professionals who will be assigned to the account must be Real Estate Advisory, Development Consulting and Brokerage Services ("broker") licensed pursuant to Business and Professions Code section 10130 et seq. and in good standing in the State of California.
2. Vendors must have knowledge of the local commercial real estate market and provide commercial real estate brokerage services in the Orange County area, from an office within thirty (30) miles of Orange County and must have a staff of at least five (5) brokers within thirty (30) miles of Orange County.
3. Broker Experience: The account executive(s) / lead broker who will be assigned must each have a minimum of ten (10) years of experience in providing commercial real estate brokerage services to clients.
4. Broker must have represented parties in at least (3) completed purchases or sale transactions within the last three (3) years.
5. Broker must have represented tenants in a minimum of ten (10) completed leasing transactions of at least 10,000 Rentable Square Feet (RSF) each for Class A or B commercial office space in the Orange County area within the last three (3) years.
6. For the Development Agreement Services outlined in B.2 below, Broker must be knowledgeable in real estate development and in the public agency processes to extend or amend Development Agreements to be considered for this Service. Vendor must provide detailed documentation outlining experience and knowledge of development agreements.
7. CalOptima reserves the right to award one or more Contracts for these services based on the experience of the firms who submit proposals. If you are not able to

provide one or more of the services listed below, please submit your proposal for the services you do qualify for, and CalOptima review proposals as such.

B. SERVICES

1. Additional Office Space and Parking

a. New Building Construction
   i) Broker shall perform detailed local and regional market and submarket research customized for this property, for the purpose of advising CalOptima about how current market conditions, trends and dynamics will likely affect the cost of construction of commercial office buildings, mixed use and other developments, and parking structures as well as the market value of the development of the property.
   ii) Broker shall obtain data on the approximate cost of construction of a commercial office building and parking structure.
   iii) Broker shall look at current market conditions, trends and dynamics to evaluate the highest and best use of the property.

b. Current Available Space Review
   i) Broker shall review the North Orange County commercial real estate market to determine the availability of Class A or B commercial office space available to be leased.
   ii) Broker shall review the North Orange County commercial real estate market to determine the availability of Class A or B commercial office space available to be purchased.
   iii) Broker shall use a five-mile radius regarding opportunities for space to lease or purchase.
   iv) Broker shall create a parking map illustrating the local parking availability for lease or purchase both on a short-term and long-term basis.
   v) Broker shall confirm all costs associated with the lease of each building under consideration and estimate the amount of tenant improvements and costs associated with having leased premises in move-in ready condition.
   vi) Broker shall identify and recommend a short-list of options for lease and for purchase for review. Should CalOptima decide to call for Proposals for space lease/purchase, Broker shall review and evaluate all submitted proposals and conduct due diligence to confirm the merits of any proposals received.

c. Real Estate Negotiations (Not required in the 60-day timeline)
   i) Upon approval to proceed, Broker shall develop, present and obtain pre-approval of the real estate negotiation strategies and principles from CalOptima, and conduct negotiations to secure the best possible real estate value for CalOptima in keeping with professional ethics and the market conditions. Broker shall provide all offers from landlords to CalOptima;
   ii) Broker shall prepare and/or coordinate the completion of required documentation to finalize the approved real estate transaction(s).

d. Deliverables
   i) Broker shall provide a financial analysis comparing construction options, lease options, and purchase options for Class A or B commercial office space and local parking.
   ii) Broker shall present a written report and presentation for CalOptima's Board of Directors on the different options evaluated by Broker for construction, lease and purchase, along with the financial evaluation of the

associated costs with each option, as well as evaluation of various models/options for development.

2. **PACE**
   a. Current Available Space Review
      i) Broker shall review the local Orange County market and evaluate availability of comparable space and associated costs with leasing and making tenant improvements.
      ii) Broker shall conduct a fair market value evaluation of the PACE Lease and provide a financial analysis comparing available space with the fair market value of the PACE Lease.
      iii) In evaluating the options related to additional office space and parking above, Broker shall evaluate the cost and cost differential of consolidating the PACE center and associated Tenant Improvements with the construction, lease or purchase of another property.
      iv) On a parallel track, Broker will evaluate, explore, and as appropriate, negotiate other options for future growth.
   b. Real Estate Negotiations (Not required in the 60-day timeline)
      i) Should CalOptima decide to move forward with renewal of the PACE Lease, Broker shall represent CalOptima on the negotiation of the PACE lease renewal and examine the Garden Grove commercial real estate market to ascertain a reasonable renewal rate for the PACE lease.
      ii) Upon approval to proceed, Broker shall develop, present and obtain pre-approval of the real estate negotiation strategies and principles from CalOptima, and conduct negotiations to secure the best possible real estate value for CalOptima in keeping with professional ethics and the market conditions. Broker shall provide all offers from landlords to CalOptima.
      iii) Broker shall prepare and/or coordinate the completion of required documentation to finalize the approved real estate transaction(s).
   c. Deliverables
      i) Broker shall present a written report and presentation for CalOptima's Board of Directors on the different options evaluated by Broker along with a financial analysis of the associated options.

3. **Development Rights**
   a. Broker shall assist CalOptima staff and advise on necessary steps to extend the current Development Agreement and to seek modifications to broaden the Development Agreement to allow for the highest and best use of the property while also meeting CalOptima's future real estate needs, for example:
      i. One option could be to estimate the construction costs associated with building a commercial office building and parking structure included in the Development Agreement and evaluating the financial viability and market predictions for leasing space in the commercial office building.
      ii. Another option could be to evaluate current market conditions and present recommendations on what the highest and best use of the property might be, along with the associated costs with the highest and best use of the property.
      iii. A third option could be to evaluate current market conditions and available space locally for purchase or lease to meet CalOptima's short term and long-term space needs.

iv. Beyond these three potential options, CalOptima will be looking to the selected vendor(s) to assist with developing and evaluating other potential options for development of the 505 Office Tower site.

b. As part of CalOptima's plan to seek an extension and also possibly broadening the scope of the Development Agreement, Broker shall prepare documents and assist with negotiating with the City of Orange. This section is not required in the 60-day timeline

C. VENDOR RESPONSIBILITIES

1. The successful bidder(s) will commence a pre-project meeting to gather data and understand the business needs and space requirements of CalOptima. The successful bidder will review all applicable documents, including, but not limited to, the current Development Agreement.
2. The successful bidder will be required to prepare reports setting forth options for consideration and prepare presentations to CalOptima senior management, CalOptima's advisory committees and/or the CalOptima Board of Directors, as requested by CalOptima.
3. The successful bidder will need to establish regular meetings with CalOptima's representatives to update CalOptima on the status of the successful bidder's work.
4. The successful bidder shall competently perform the services indicated in Paragraph B. above and shall avoid any conflicts of interest in the performance of such obligations.

D. CALOPTIMA'S RESPONSIBILITIES

1. CalOptima will designate a Single Point of Contact (SPOC) for any resulting Contract for these services.
2. CalOptima shall provide estimates on space and parking needs.
3. CalOptima shall be available to tour properties and review all proposals, including architectural drawings and space planning for occupancy.

E. DELIVERABLES

1. Broker will provide regular updates to CalOptima's SPOC.
2. Broker will provide a written status update of their findings within thirty (30) days from the start of the project.
3. Broker will provide the final written study as outlined above within sixty (60) days from the start of the project.
4. Broker will provide CalOptima Leadership with a final in-person presentation within sixty (60) days from the start of the project.
5. Broker shall present a written report and presentation for CalOptima's Board of Directors on the different options evaluated by Broker for construction, lease and purchase, along with the financial evaluation of the associated costs with each option, as well as evaluation of various models/options for development.

A Public Agency

CalOptima

Better. Together.

Real Estate

Special Board of Directors Meeting

January 6, 2011

Kim Cunningham, Chief Administrative Officer

Michael Engelhard, Chief Financial Officer

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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

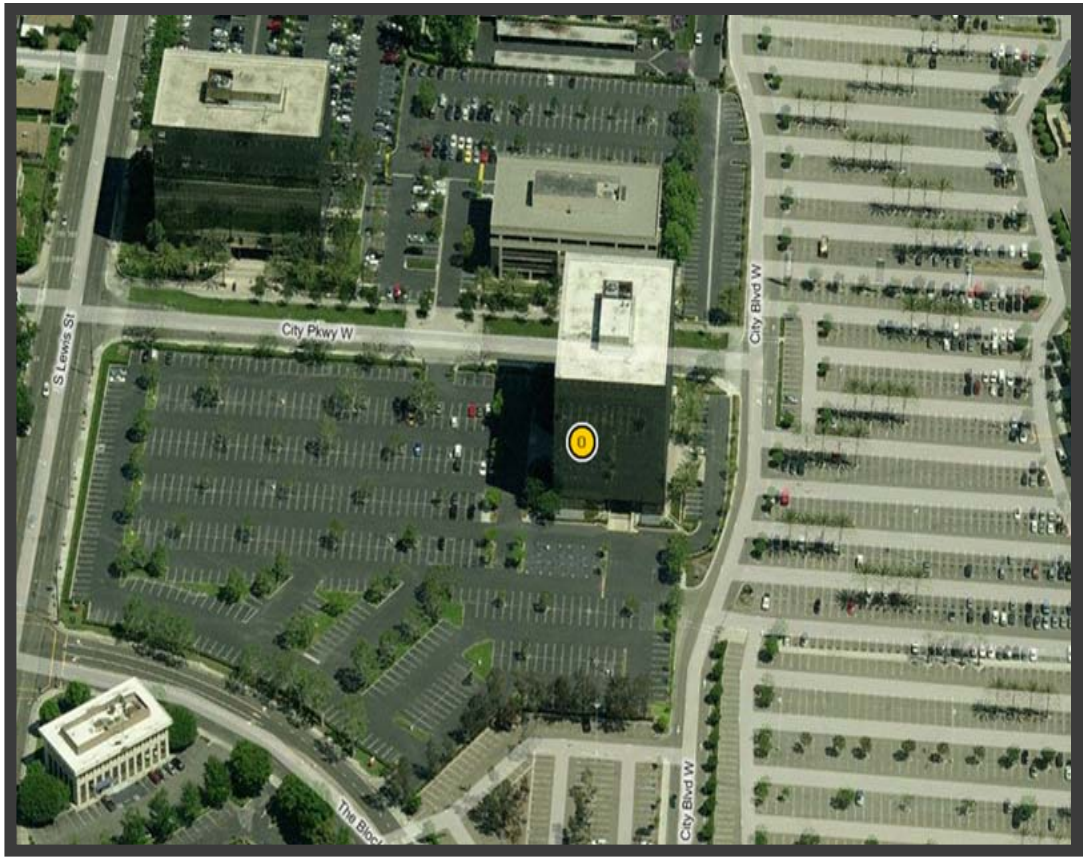
- Major concerns about current location:
  - Out of space today (without telework implementation, we would have had to lease more space elsewhere)
  - Current location cannot accommodate anticipated future growth up to 125,000-130,000 rentable square footage (RSF) by 2014
  - Parking is constrained;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



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

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)***

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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.

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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)***

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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

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

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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)***

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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

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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.

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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**

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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;

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(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.

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(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%).

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(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.

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(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.

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(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;

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(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.

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(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.

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(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

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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

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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

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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

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(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

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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

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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

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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.

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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

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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

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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

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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

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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.

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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

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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]

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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

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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 _____

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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)

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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.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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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

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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

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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

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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.

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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.

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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.

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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

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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**

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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.

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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

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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**

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Real Estate

Special Board of Directors Meeting
January 6, 2011

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

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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

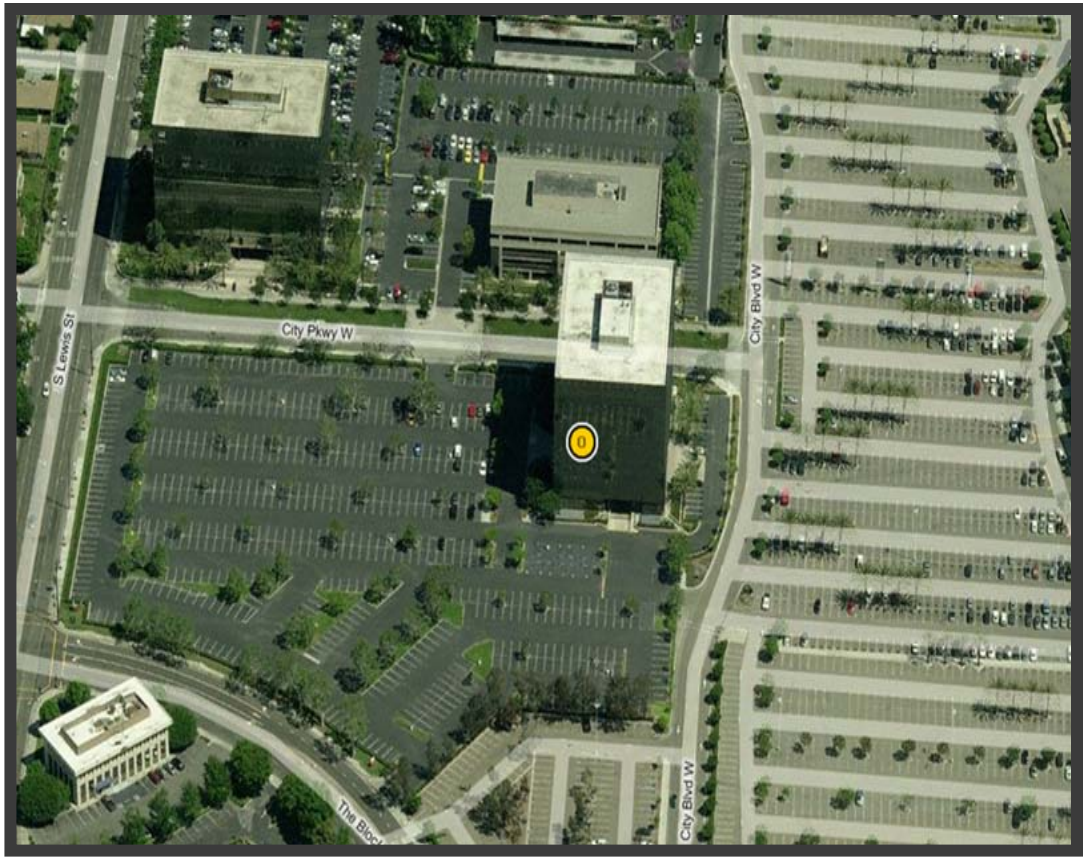
- Major concerns about current location:
  - Out of space today (without telework implementation, we would have had to lease more space elsewhere)
  - Current location cannot accommodate anticipated future growth up to 125,000-130,000 rentable square footage (RSF) by 2014
  - Parking is constrained;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



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

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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.

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.

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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**

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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;

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(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.

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(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%).

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(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.

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(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.

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(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;

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(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.

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(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.

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(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

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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

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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

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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

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(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

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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

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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.

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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

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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

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

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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.

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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

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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]

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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

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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 _____

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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)

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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.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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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

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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

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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.

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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.

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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

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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

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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**

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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:

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- 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

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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

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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**

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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.

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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.

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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**

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Space Planning

Board of Directors Meeting
March 3, 2016

Chet Uma, Chief Financial Officer
Ken Wong, Director, Budget and Procurement

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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

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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

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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

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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**

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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
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(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

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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

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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.

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(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%).

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(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.

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(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.

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(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;

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(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.

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(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.

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(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.

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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

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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 Cal.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

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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,

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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

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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.

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(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

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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.

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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

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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,

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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

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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

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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.

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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]

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

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

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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 _____

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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)

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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.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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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

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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

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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

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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.

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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.

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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

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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**

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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

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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

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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**

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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

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(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

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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

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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.

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(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%).

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(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.

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(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.

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(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;

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(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.

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(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.

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(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.

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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

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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 Cal.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

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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,

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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

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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.

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(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

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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.

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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

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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,

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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

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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

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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.

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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]

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

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

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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 _____

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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)

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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.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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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

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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

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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

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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.

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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.

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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

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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**

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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

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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

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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**

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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

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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

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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.

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(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%).

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(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.

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(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.

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(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;

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(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.

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(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.

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(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.

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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

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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 Cal.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

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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,

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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

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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.

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(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

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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.

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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

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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,

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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

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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

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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.

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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]

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

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

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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 _____

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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)

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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.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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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

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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

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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

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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.

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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.

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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

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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**

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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.

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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

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Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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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

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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**

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Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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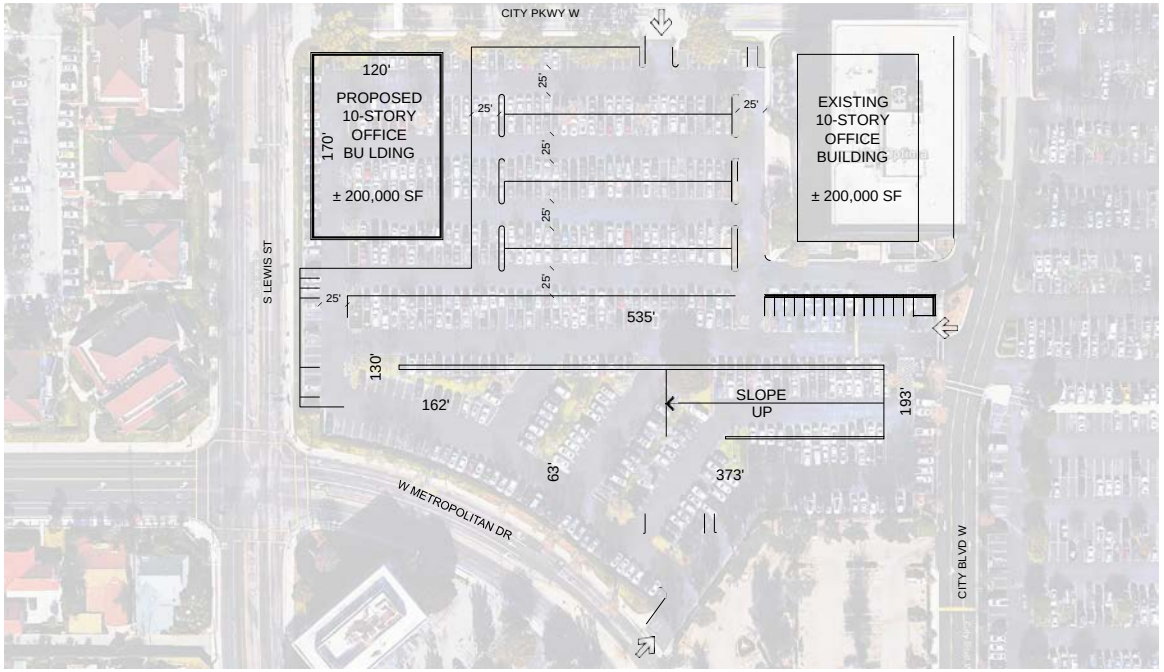
Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

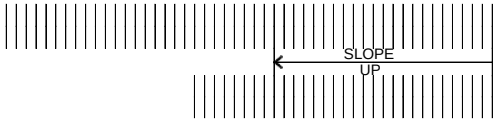
PROPOSED BUILDING: 200,000 SF

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

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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

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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**

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Conceptual Development Timeline

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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)***

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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.

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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)***

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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

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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

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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)***

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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

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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

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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

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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

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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**

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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

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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**

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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

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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

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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**

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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

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(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

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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

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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.

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(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%).

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(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.

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(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.

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(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;

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(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.

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(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.

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(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.

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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

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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 Cal.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

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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,

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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

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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.

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(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

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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.

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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

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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,

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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

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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

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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.

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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]

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

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

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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 _____

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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)

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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.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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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

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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

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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

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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.

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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.

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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

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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**

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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.

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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

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Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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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

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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**

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Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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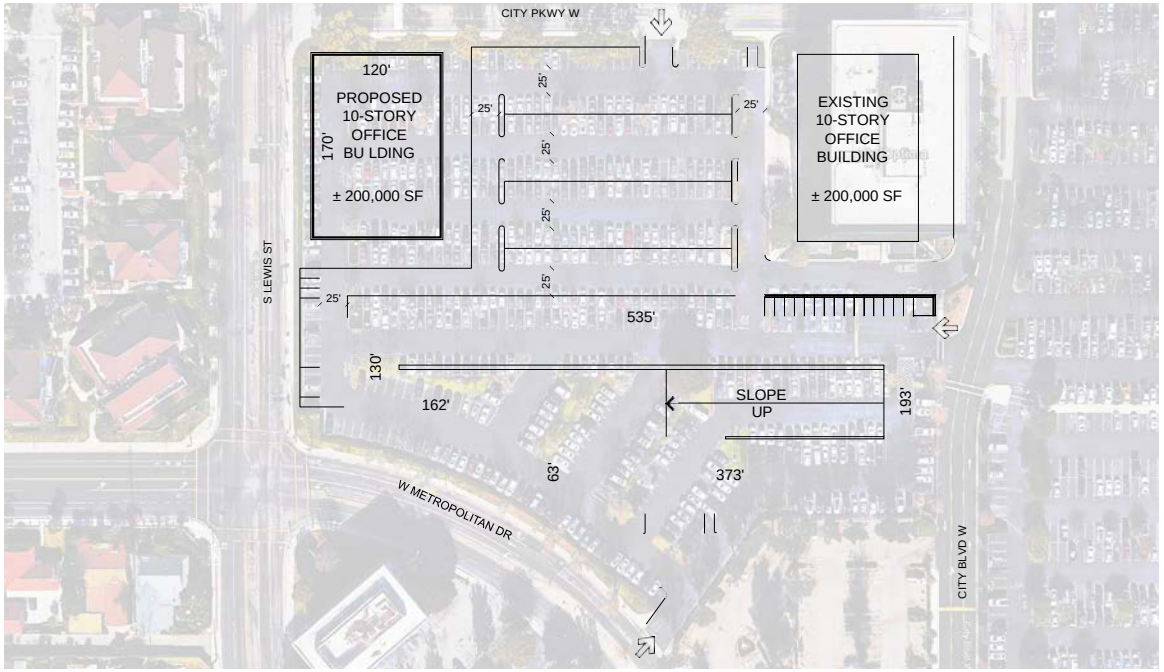
Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

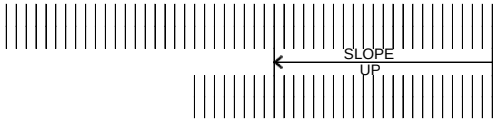
PROPOSED BUILDING: 200,000 SF

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

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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

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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**

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Conceptual Development Timeline

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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

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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.

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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.

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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

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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

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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.

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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.

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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.

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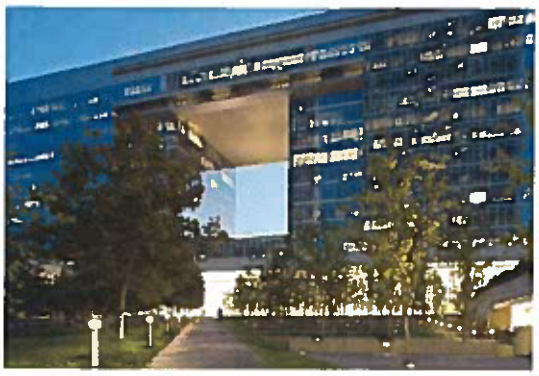
RESPONSE TO REQUEST FOR INFORMATION:

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

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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

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PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS
605 CITY PARKWAY WEST, ORANGE, CA

Trammell Crow Company

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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

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DEVELOPMENT TEAM (PRIMARY POINT OF CONTACT)

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.

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

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

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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

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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

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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

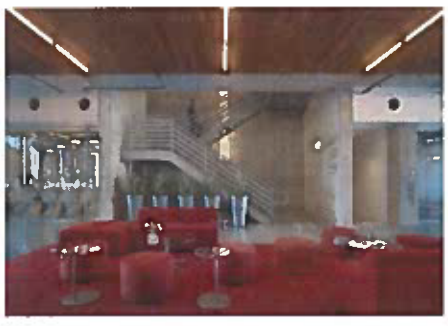
Development in Process	$6.5B
Pipeline	$4.1B
Operating	$0.2B
TOTAL	$10.8B

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.

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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..

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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.

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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.

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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.

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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

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TESTIMONIALS

Trammell Crow Company

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"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."

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Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, CA 92660
(949) 477-4700

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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

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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

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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.)

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A CalOptima Board Action Agenda Referral

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

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

Recommended Action(s)
Approve modification of the following Medical Policies and Procedures:

A. GG.1304: Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole-Child Model Program [Medi-Cal]
B. GG.1325: Continuity of Care for Members Transitioning into CalOptima Services [Medi-Cal]
C. GG.1425: Prescriber Restriction Program [Medi-Cal]

Background/Discussion
CalOptima regularly reviews its Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws as well as CalOptima operations.

> Medi-Cal: CalOptima contracts with the state of California, acting by and through the Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries. In addition to the Medi-Cal contract, CalOptima is required to comply with applicable Federal Medicaid and state Medi-Cal laws, regulations and other guidance including, Policy Letters and All Plan Letters (APL) issued by the DHCS Medi-Cal Managed Care Division and other guidance that may be issued by DHCS or other agencies applicable to CalOptima's delivery of Medi-Cal services.

CalOptima also updates its Policies and Procedures to comply with new regulatory programs including, but not limited to, the Whole Child Model which was implemented on July 1, 2019.

> Whole Child Model (WCM): 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. Beginning July 1, 2019 CCS services were incorporated into CalOptima, except for the Medical Therapy Program which will continue to be administered by the County.

Below is information regarding additional policies that require modification including revisions related to WCM, as well as some clarification related to existing operations:

A. ***GG.1304: Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole-Child Model Program [Medi-Cal]*** establishes coverage and continuity of care guidelines for a Member who is involuntarily required to change a Health Network or Provider. CalOptima revised this policy pursuant to the CalOptima annual review process to ensure policy compliance with the

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implementation of the WCM program and the DHCS APL 18-023: California Children's Services Whole Child Model Program and to improve the clarity of the policy. Revisions include, but are not limited to, actions required for a WCM Member if his or her Health Network becomes ineligible to participate in the WCM Program, WCM Member's right to petition for an extension of Continuity of Care period and to appeal if an unfavorable determination is received, and requiring a Health Network that no longer meets the WCM network certification requirements to provide written notice to CalOptima.

B. ***GG.1325: Continuity of Care for Members Transitioning into CalOptima Services [Medi-Cal]*** establishes Continuity of Care guidelines and the process to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima. CalOptima revised this policy pursuant to the CalOptima annual review process to ensure policy compliance with the implementation of the WCM program, the DHCS APL 18-023: California Children's Services Whole Child Model Program and DHCS APL 18-008 (Revised): Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care. Revisions include, but are not limited to, a description of an existing relationship between a CCS Provider(s) who are not contracted with CalOptima and a CalOptima WCM Member and the WCM Member's right to petition for an extension of the Continuity of Care period and to appeal if an unfavorable determination is received. The policy also includes Continuity of Care provisions for Members who received Pediatric Palliative Care Waiver Program Services that are also covered by Medi-Cal.

C. ***GG.1425: Prescriber Restriction Program [Medi-Cal]*** describes the criteria and process by which a Member is assigned to a designated prescriber to receive controlled substance medications through the Prescriber Restriction Program. CalOptima revised this policy pursuant to the CalOptima annual review process to clarify the circumstances under which a Member may be placed into the program, the designation of the Member's Primary Care Provider as the assigned designated prescriber, and establishes the Member's right to request a change in the his or her assigned designated Provider in certain situations.

Fiscal Impact

The recommended action to revise existing policies and procedures is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

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.

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Concurrence
Gary Crockett, Chief Counsel

Attachments

1. GG.1304: Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole-Child Model Program [Medi-Cal] (redline and clean)
2. GG.1325: Continuity of Care for Members Transitioning into CalOptima Services [Medi-Cal] (redline and clean)
3. GG.1425: Prescriber Restriction Program [Medi-Cal] (redline and clean)
4. Board Action April 4, 2019, Consider Actions Related to CalOptima's Whole-Child Model (WCM) Program
5. Board Action May 2, 2019, Consider Approval of Modifications to CalOptima's Policy and Procedure Related to CalOptima's Whole-Child Model Program
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. DHCS APL 18-008 (Revised): Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care
8. Board Action dated February 7, 2003, Approve CalOptima continuity of care guidelines for health network Medi-Cal members required to involuntarily change health networks.
9. Board Action dated October 4, 2018 Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model and Annual Policy Review

/s/ Michael Schrader — *01/28/2020*
Authorized Signature — **Date**

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Policy ~~#:~~:	GG.1304
Title:	**Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole-Child Model Program**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	02/04/~~03~~20
~~Last~~ Review Date:	03
~~Last Revised Date:~~	~~10/01/18~~ ~~10/01/18~~T BD

I. PURPOSE

This policy establishes coverage and continuity of care guidelines for a **Member** who is involuntarily required to change a **Health Network** or **Provider**.

II. POLICY

A. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member**.

B. CalOptima may require a **Member** to change his or her **Health Network** involuntarily due to special circumstances including, but not limited to, (i) the termination or non-renewal of the **Health Network's** Contract for Health Care Services~~.~~, or (ii) with respect to a **California Children's Services (CCS)**-eligible **Member**, his or her **Health Network** is ineligible to participate in the **Whole Child Model (WCM)** program.

C. A **Receiving Health Network** shall assume full responsibility for a Member's care upon the **Affected Member's** effective date with the **Receiving Health Network** when the **Member** is involuntarily required to change **Health Networks**.

D. In the event of ~~section~~Section II.B of this Policy~~, CalOptima~~, a **Receiving Health Network** shall ensure the provision of **Covered Services** to an **Affected Member** without disruption or delay, including, but not limited to:

1. A **Member** who is in an active treatment plan;

2. A **Member** who has medical supply or other needs that affect the **Member's** quality of life or activities of daily living;

3. A **Member** who is in the process of evaluation for certain services; and

4. A **Member** who has other medical care needs.

E. In the event that a **Member** is required to change **Health Networks**, CalOptima and the **Receiving Health Network** shall collaborate to coordinate the provision of current and future **Covered Services** for the **Affected Member**.

F. To ensure that inappropriate disruptions or delays in **Covered Services** do not occur during an **Affected Member's** transition to a **Receiving Health Network**, CalOptima and the **Receiving Health Network** shall make **Continuity of Care** decisions, in accordance with the guidelines set forth in this ~~Policy~~policy and based on the potential best medical outcome for the **Affected Member**.

G. For a **California Children's Services (CCS)**-eligible **Member** transitioning to CalOptima's **WCM** program who is required to change to a new **Health Network** that is participating in the **WCM** program, the **Receiving Health Network** shall ensure the following:

1. **WCM Continuity of Care** is available to the **CCS**-eligible **Member** in accordance with the requirements of APL 18-023: California Children's Services Whole Child Model and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services, as follows:

   a. **Specialized or Customized Durable Medical Equipment (DME)**;

   b. **Continuity of Care** for case management with the **CCS**-eligible **Member's** existing **CCS** public health nurse (applicable only to **WCM** Members who transitioned into CalOptima's **WCM** program on July 1, 2019); and

   c. Authorized prescription drugs that is part of the therapy for the **CCS-eligible Condition** of the **CCS**-eligible **Member**.

2. The **CCS**-eligible **Member** is provided with written notice explaining the **Member's** right to request an extension of the **Continuity of Care** period and the **WCM** appeal process for **Continuity of Care** limitations, in accordance with CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

3. The **CCS**-eligible **Member** is allowed to receive services for the **Member**'s **CCS-eligible Condition** from a **CCS Provider** outside of the **Receiving Health Network** for **Continuity of Care** purposes, in accordance with the requirements of Section III.D of this policy, or if there are no **CCS Providers** that meet the **Member's CCS** medical needs within the **Receiving Health Network**'s network.

4. The **CCS**-eligible **Member** is permitted through **Continuity of Care** to continue to receive services from a provider in the **Member's** previous **Health Network**, including their assigned primary care provider, for up to twelve (12) months, in accordance with the requirements of APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

~~G.~~H. In the event that the guidelines set forth in this Policy do not address an **Affected Member's** particular continuity of care circumstance or need during the **Affected Member's** transition from a **Health Network**, CalOptima's Chief Medical Officer (CMO), or his or her **Designee**, shall render

final ~~arbitration~~determination of a **Health Network's** decision regarding the authorization of **Covered Services**.

~~H.~~I. To ensure the **Continuity of Care** for an **Affected Member**, a **Receiving Health Network** shall coordinate the **Affected Member's Covered Services** and the payment of **Covered Services** to a **Provider** when the prior **Health Network** authorized the **Affected Member's** care with the existing **Provider** and there is an existing course of treatment. The **Receiving Health Network** shall reimburse a **Non-Contracted Provider** in accordance with the provisions of this Policy.

~~I.~~J. A **Receiving Health Network** shall notify an **Affected Member** of its decision to approve, modify, delay, or deny a request for authorization of **Continuity of Care**, in accordance with the guidelines set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~J.~~K. CalOptima or a **Health Network** may require a **Member** to change his or her **Health Network** or **Provider** involuntarily due to special circumstances including, but not limited to, suspensions, decertifications, or non-renewal of a **Health Network** or **Provider's** contract with **CalOptima** or a **Health Network**, including termination, suspensions, and decertifications from the Medi-Cal program as effectuated by DHCS.

1. CalOptima or a **Health Network** shall ensure the safe transition to a new **Provider** for services as necessary and in accordance with this Policy.

~~K.~~L. **Health Networks** shall notify CalOptima of **Provider** termination, in accordance with CalOptima Policies DD.2012: Member Notification of Change in Availability or Location of Covered Services, EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

1. For the purposes of the WCM program, to ensure compliance with applicable statutory, regulatory, and contractual requirements, a **Health Network** shall provide written notice to CalOptima immediately after it is known to the **Health Network** or, by exercising reasonable diligence, would have been known to the **Health Network** that the **Health Network** no longer meets the WCM network certification requirements.

III. PROCEDURE

A. Identification of an **Affected Member** and the **Affected Member's** Needs

1. CalOptima shall work in collaboration with the terminating or non-participating **Health Network** to ensure identification of an **Affected Member** who is involuntarily required to change **Health Networks** and identify those **Members** who are in need of care coordination of **Covered Services** within a **Health Network**.

2. CalOptima shall provide a **Receiving Health Network** with information about an **Affected Member's Continuity of Care** needs as the information becomes available.

3. A **Receiving Health Network** shall evaluate an **Affected Member's** need for **Covered Services** and may authorize appropriate **Covered Services** for the **Affected Member** in a timely manner in order to not delay or interrupt the **Affected Member's** active treatment plan, in accordance with the provisions of this Policy.

B. Notice to **Affected Members** of **Health Network** termination or a **Health Network's** non-participation in the **WCM** program.

1. CalOptima shall send written notice of **Health Network** termination or a **Health Network's** non-participation in the **WCM** program to **Affected Members** no later than thirty (30) calendar days prior to the termination date of a Health Network Contract for Health Care Services~~.~~ or the effective date of non-participation in the **WCM** program.

2. CalOptima shall obtain approval from the ~~Department of Health Care Services (~~DHCS~~)~~ of the written notice prior to sending the notice of **Health Network** termination or a **Health Network's** non-participation in the **WCM** program to **Affected Members**.

C. CalOptima and a **Health Network** shall use the following **Continuity of Care** guidelines to provide continued **Covered Services** to an **Affected Member** so as to not cause an interruption or delay for the **Affected Member**:

1. A **Receiving Health Network** shall provide an **Affected Member**, who satisfies the **Continuity of Care** requirements set forth in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services, with **Continuity of Care** with an existing out-of-network provider for the remaining duration of the original **Continuity of Care** period.

~~1.~~2. A **Receiving Health Network** shall honor an authorization for a **Scheduled Elective Surgery** for an **Affected Member** authorized by the terminating **Health Network**, unless the **Receiving Health Network** is able to arrange comparable services without delay or interruption to the **Affected Member**, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~2.~~3. A **Receiving Health Network** shall allow an **Affected Member** who is in the course of oncology treatment to continue his or her course of treatment with the **Affected Member's** existing **Provider** as set forth below:

a. The **Receiving Health Network** shall evaluate an **Affected Member's** oncology treatment plan and determine whether it is appropriate to transfer the **Affected Member's** oncology care services safely to another **Provider** without delay or interruption to the active treatment plan.

b. If the **Receiving Health Network** determines that transferring the **Affected Member's** oncology care to another **Provider** may potentially result in an adverse medical outcome or detrimentally affect the **Affected Member**, the **Receiving Health Network** shall authorize the **Affected Member's** oncology services under the **Affected Member's** existing **Provider** until the active treatment plan is completed.

~~3.~~4. A **Receiving Health Network** shall allow an **Affected Member**, who is in the process of a transplant evaluation to complete transplant care services with the **Affected Member's** existing **Provider**. Transplant coordination of care for an **Affected Member** shall be managed, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

~~4.~~5. A **Receiving Health Network** shall allow an **Affected Member**, who is receiving acute inpatient services on the effective date of the **Receiving Health Network** change and is expected to have a remaining length of stay less than or equal to three (3) calendar days, to continue his or her acute care stay in the current inpatient setting.

~~5.~~6. A **Receiving Health Network** shall authorize an **Affected Member**, who has a remaining length of stay in an acute inpatient setting of more than three (3) calendar days, to stay in the existing acute inpatient setting until the **Receiving Health Network** can arrange for the safe transfer of the **Affected Member** to another acute care facility that can provide comparable services.

~~6.~~7. If it is necessary for an **Affected Member** to reschedule post-surgical physician visits after the effective date of the **Receiving Health Network** change, the **Receiving Health Network** shall authorize the **Affected Member's** remaining post-surgical visits which were included under a previous global authorization with the surgeon who performed the surgery pursuant to community standards and **Medical Necessity**.

~~7.~~8. A **Receiving Health Network** shall authorize continued obstetrical services for an **Affected Member**, including delivery and the immediate postpartum period, with the Affected Member's existing **Provider** and hospital if the **Affected Member** is in her second (2nd) or third (3rd) trimester of pregnancy.

~~8.~~9. If an **Affected Member** is receiving dialysis services, a **Receiving Health Network** shall authorize continued dialysis services with the Affected Member's existing dialysis center and nephrologist until the **Receiving Health Network** has evaluated the **Affected Member's** dialysis treatment plan and arranged for the **Affected Member's** safe transfer to another dialysis center or nephrologist without a delay or interruption in service.

~~9.~~10. If an **Affected Member** has a scheduled diagnostic and **Ancillary Service** on a date after the **Affected Member's** effective date of the Health Network change, the **Receiving Health Network** shall authorize the diagnostic or **Ancillary Service** with the previously scheduled **Provider** unless the **Receiving Health Network** is able to arrange comparable services with another **Provider** without a delay or interruption in service.

11. If an **Affected Member** receives injectables as part of an active treatment plan, a **Receiving Health Network** shall ensure that the prescribed injectables are continued without delay or interruption in accordance with the **Affected Member's** active treatment plan until the **Receiving Health Network** has re-evaluated the **Affected Member's** active treatment plan~~, including potential referrals and coordination with California Children's Services (CCS).~~.

12. If an **Affected Member** receives long term acute care services, a **Receiving Health Network** shall authorize the long term care acute care services at the **Affected Member's** existing facility until the **Receiving Health Network** has re-evaluated the **Affected Member** and

provides for the safe transfer of the **Affected Member's** care to an alternate facility, with consideration of family or guardian wishes.

13. A **Health Network** that authorizes the purchase of **Durable Medical Equipment (DME)** for an **Affected Member** shall pay for the cost of the **DME** even if the delivery of the **DME** occurs after the **Affected Member's** effective date of the **Health Network** change.

14. A **Receiving Health Network** shall continue to provide an **Affected Member** with the same medical supplies, quantities, or equipment without disruption or delay in services until the **Receiving Health Network** has evaluated the **Affected Member's** medical supply needs.

15. If, after consultation with the CalOptima CMO, or his or her **Designee**, the CMO determines certain services are required and the **Receiving Health Network** refuses to provide them, the CMO may authorize these services on behalf of the **Receiving Health Network**.

16. If a **Receiving Health Network** modifies, delays, denies, or takes any other action that triggers **Aid Paid Pending** an appeal, the **Receiving Health Network** shall follow **Member** notification requirements and related provisions, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

17. If CalOptima or a **Health Network** requires a **Member** to change his or her **Provider** involuntarily due to suspensions, decertifications, or non-renewal of a **Health Network** or **Provider's** contract with CalOptima or a **Health Network**, including termination, suspensions, and decertifications from the Medi-Cal program as effectuated by DHCS, CalOptima or a **Health Network** shall coordinate with the receiving **Provider** for ongoing services and treatment.

    a. CalOptima or a **Health Network** shall ensure the terminated, suspended, or decertified **Provider** does not receive payment for Medi-Cal services provided on or after the effective date of action in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

    b. CalOptima or a **Health Network** shall communicate the notification to the ~~affected~~**Affected Member** in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

18. A **Receiving Health Network** shall pay for the **Covered Services** furnished to an **Affected Member** by the **Affected Member's** existing **Provider** as authorized by the terminating **Health Network** to maintain **Continuity of Care** in accordance with this ~~Policy~~policy. The **Receiving Health Network** shall pay a **Non-Contracted Provider** for such items and services at the Medi-Cal Fee Schedule rate or, if inpatient services, at the CalOptima rate.

D. For a **CCS**-eligible **Member** transitioning to CalOptima's **WCM** program who is required to change to a new **Health Network** participating in the **WCM** program, the following **Continuity of Care** requirements shall apply:

1. The **Receiving Health Network** shall allow, upon request, the **CCS**-eligible **Member** to maintain access to **CCS Providers** with whom the **Member** has an existing relationship for up

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to twelve (12) months, in accordance with Welfare and Institutions Code section 14094.13, under the following conditions:

a. The **CCS**-eligible **Member** has seen the out-of-network **CCS Provider** for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or the initial assigned **Health Network** assumed responsibility for the **Member's CCS** care under the **WCM** program.

b. The out-of-network **CCS Provider** accepts the **Receiving Health Network's** rate for services offered or the applicable Medi-Cal or **CCS** fee-for-service rate, whichever is higher, unless the out-of-network **CCS Provider** enters into an agreement on an alternative payment methodology mutually agreed to by the out-of-network **CCS Provider** and the **Receiving Health Network**.

c. The **Receiving Health Network** confirms that the out-of-network **CCS Provider** meets applicable professional standards, including **CCS** standards, and has no disqualifying quality of care issues.

d. The out-of-network **CCS Provider** has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

e. The out-of-network **CCS Provider** provides treatment information to the **Receiving Health Network**, to the extent authorized by the State and federal patient privacy provisions.

2. The **CCS**-eligible **Member** may petition the **Receiving Health Network** for an extension of the **Continuity of Care** period. If the **Receiving Health Network** does not approve the extension, the **CCS**-eligible **Member** may appeal this decision in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1510: Appeal Process.

E. CalOptima may impose **Sanctions** on a **Health Network**, including and without limitation, financial penalties or termination, in accordance with CalOptima Policy HH.2002Δ: Sanctions, when the **Health Network** fails to comply with the requirements of this Policy.

F. CalOptima or a **Health Network** shall notify an **Affected Member** of **Provider** termination, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

G. CalOptima or a **Health Network** shall provide continued **Covered Services** to an **Affected Member** so as to not cause an interruption or delay using the following continuity of care guidelines:

1. CalOptima or a **Health Network** shall ensure continuation of treatment through the current period of active treatment, not to exceed twelve (12) months ~~.~~except as provided in Section III.D.2. of this Policy for **Members** eligible with the **WCM** program.

2. CalOptima or a **Health Network** shall ensure continuation of care through the postpartum period for a Member in their second (2nd) or third (3rd) trimester of pregnancy.

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

Not Applicable

~~V. REFERENCES~~
V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2012: Member Notification of Change in Availability or Location of Covered Services
D. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
E. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
F. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~F.~~G. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
H. CalOptima Policy GG.1510: Appeal Process
~~G.~~I. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
~~H.~~J. CalOptima Policy HH.2002Δ: Sanctions
~~I. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care~~
~~J.~~K. Department of Health Care Services All Plan Letter (APL) 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
L. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

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

A. 01/31/18: Department of Health Care Services
B. 10/14/15: Department of Health Care Services
C. 09/11/13: Department of Health Care Services
D. 11/10/09: Department of Health Care Services

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

A. 02/04/03: 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	02/04/2003	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2007	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2010	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2012	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2013	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Reviewed	07/01/2014	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	07/01/2015	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2016	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	11/01/2017	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	10/01/2018	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	TBD	GG.1304	Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole Child Model Program	Medi-Cal

IX. GLOSSARY

Term	Definition
Affected Member	A Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include, but are not limited to the termination or non-renewal of a Health Network Contract.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
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 (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 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.
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	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.
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.

Term	Definition
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
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. For purposes of this policy, a Health Network shall include 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.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima, a Physician Medical Group, or a Health Network.
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.
Receiving Health Network	A Health Network to which a Member is transitioning.
Scheduled Elective Surgery	Non-urgent or non-emergent procedures to treat disease, injury, or deformity by physical operation or manipulation, which are requested by the treating physician and authorized by the Health Network to occur within sixty (60) days after transitioning to the Receiving Health Network.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
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.

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Policy:	GG.1304
Title:	**Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole-Child Model Program**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	02/04/2003
Review Date:	TBD

I. PURPOSE

This policy establishes coverage and continuity of care guidelines for a **Member** who is involuntarily required to change a **Health Network** or **Provider**.

II. POLICY

A. CalOptima or a **Health Network** shall ensure **Continuity of Care** for a **Member**.

B. CalOptima may require a **Member** to change his or her **Health Network** involuntarily due to special circumstances including, but not limited to, (i) the termination or non-renewal of the **Health Network's** Contract for Health Care Services, or (ii) with respect to a **California Children's Services (CCS)**-eligible **Member**, his or her **Health Network** is ineligible to participate in the **Whole Child Model (WCM)** program.

C. A **Receiving Health Network** shall assume full responsibility for a Member's care upon the **Affected Member's** effective date with the **Receiving Health Network** when the **Member** is involuntarily required to change **Health Networks**.

D. In the event of Section II.B of this Policy, a **Receiving Health Network** shall ensure the provision of **Covered Services** to an **Affected Member** without disruption or delay, including, but not limited to:

1. A **Member** who is in an active treatment plan;

2. A **Member** who has medical supply or other needs that affect the **Member's** quality of life or activities of daily living;

3. A **Member** who is in the process of evaluation for certain services; and

4. A **Member** who has other medical care needs.

E. In the event that a **Member** is required to change **Health Networks**, CalOptima and the **Receiving Health Network** shall collaborate to coordinate the provision of current and future **Covered Services** for the **Affected Member**.

F. To ensure that inappropriate disruptions or delays in **Covered Services** do not occur during an **Affected Member's** transition to a **Receiving Health Network**, CalOptima and the **Receiving**

Health Network shall make **Continuity of Care** decisions, in accordance with the guidelines set forth in this policy and based on the potential best medical outcome for the **Affected Member**.

G. For a **California Children's Services (CCS)**-eligible **Member** transitioning to CalOptima's **WCM** program who is required to change to a new **Health Network** that is participating in the **WCM** program, the **Receiving Health Network** shall ensure the following:

1. **WCM Continuity of Care** is available to the **CCS**-eligible **Member** in accordance with the requirements of APL 18-023: California Children's Services Whole Child Model and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services, as follows:

   a. **Specialized or Customized Durable Medical Equipment (DME)**;

   b. **Continuity of Care** for case management with the **CCS**-eligible **Member's** existing **CCS** public health nurse (applicable only to **WCM** Members who transitioned into CalOptima's **WCM** program on July 1, 2019); and

   c. Authorized prescription drugs that is part of the therapy for the **CCS-eligible Condition** of the **CCS**-eligible **Member**.

2. The **CCS**-eligible **Member** is provided with written notice explaining the **Member's** right to request an extension of the **Continuity of Care** period and the **WCM** appeal process for **Continuity of Care** limitations, in accordance with CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

3. The **CCS**-eligible **Member** is allowed to receive services for the **Member**'s **CCS-eligible Condition** from a **CCS Provider** outside of the **Receiving Health Network** for **Continuity of Care** purposes, in accordance with the requirements of Section III.D of this policy, or if there are no **CCS Providers** that meet the **Member's CCS** medical needs within the **Receiving Health Network**'s network.

4. The **CCS**-eligible **Member** is permitted through **Continuity of Care** to continue to receive services from a provider in the **Member's** previous **Health Network**, including their assigned primary care provider, for up to twelve (12) months, in accordance with the requirements of APL 18-008: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care and CalOptima Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Services.

H. In the event that the guidelines set forth in this Policy do not address an **Affected Member's** particular continuity of care circumstance or need during the **Affected Member's** transition from a **Health Network**, CalOptima's Chief Medical Officer (CMO), or his or her **Designee**, shall render final determination of a **Health Network's** decision regarding the authorization of **Covered Services**.

I. To ensure the **Continuity of Care** for an **Affected Member**, a **Receiving Health Network** shall coordinate the **Affected Member's Covered Services** and the payment of **Covered Services** to a **Provider** when the prior **Health Network** authorized the **Affected Member's** care with the existing **Provider** and there is an existing course of treatment. The **Receiving Health Network** shall reimburse a **Non-Contracted Provider** in accordance with the provisions of this Policy.

J. A **Receiving Health Network** shall notify an **Affected Member** of its decision to approve, modify, delay, or deny a request for authorization of **Continuity of Care**, in accordance with the guidelines set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

K. CalOptima or a **Health Network** may require a **Member** to change his or her **Health Network** or **Provider** involuntarily due to special circumstances including, but not limited to, suspensions, decertifications, or non-renewal of a **Health Network** or **Provider's** contract with **CalOptima** or a **Health Network**, including termination, suspensions, and decertifications from the Medi-Cal program as effectuated by DHCS.

1. CalOptima or a **Health Network** shall ensure the safe transition to a new **Provider** for services as necessary and in accordance with this Policy.

L. **Health Networks** shall notify CalOptima of **Provider** termination, in accordance with CalOptima Policies DD.2012: Member Notification of Change in Availability or Location of Covered Services, EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

1. For the purposes of the WCM program, to ensure compliance with applicable statutory, regulatory, and contractual requirements, a **Health Network** shall provide written notice to CalOptima immediately after it is known to the **Health Network** or, by exercising reasonable diligence, would have been known to the **Health Network** that the **Health Network** no longer meets the **WCM** network certification requirements.

III. PROCEDURE

A. Identification of an **Affected Member** and the **Affected Member's** Needs

1. CalOptima shall work in collaboration with the terminating or non-participating **Health Network** to ensure identification of an **Affected Member** who is involuntarily required to change **Health Networks** and identify those **Members** who are in need of care coordination of **Covered Services** within a **Health Network**.

2. CalOptima shall provide a **Receiving Health Network** with information about an **Affected Member's Continuity of Care** needs as the information becomes available.

3. A **Receiving Health Network** shall evaluate an **Affected Member's** need for **Covered Services** and may authorize appropriate **Covered Services** for the **Affected Member** in a timely manner in order to not delay or interrupt the **Affected Member's** active treatment plan, in accordance with the provisions of this Policy.

B. Notice to **Affected Members** of **Health Network** termination or a **Health Network's** non-participation in the **WCM** program.

1. CalOptima shall send written notice of **Health Network** termination or a **Health Network's** non-participation in the **WCM** program to **Affected Members** no later than thirty (30) calendar days prior to the termination date of a Health Network Contract for Health Care Services or the effective date of non-participation in the **WCM** program.

2. CalOptima shall obtain approval from the DHCS of the written notice prior to sending the notice of **Health Network** termination or a **Health Network's** non-participation in the **WCM** program to **Affected Members**.

C. CalOptima and a **Health Network** shall use the following **Continuity of Care** guidelines to provide continued **Covered Services** to an **Affected Member** so as to not cause an interruption or delay for the **Affected Member**:

1. A **Receiving Health Network** shall provide an **Affected Member**, who satisfies the **Continuity of Care** requirements set forth in CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services, with **Continuity of Care** with an existing out-of-network provider for the remaining duration of the original **Continuity of Care** period.

2. A **Receiving Health Network** shall honor an authorization for a **Scheduled Elective Surgery** for an **Affected Member** authorized by the terminating **Health Network**, unless the **Receiving Health Network** is able to arrange comparable services without delay or interruption to the **Affected Member** in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

3. A **Receiving Health Network** shall allow an **Affected Member** who is in the course of oncology treatment to continue his or her course of treatment with the **Affected Member's** existing **Provider** as set forth below:

   a. The **Receiving Health Network** shall evaluate an **Affected Member's** oncology treatment plan and determine whether it is appropriate to transfer the **Affected Member's** oncology care services safely to another **Provider** without delay or interruption to the active treatment plan.

   b. If the **Receiving Health Network** determines that transferring the **Affected Member's** oncology care to another **Provider** may potentially result in an adverse medical outcome or detrimentally affect the **Affected Member**, the **Receiving Health Network** shall authorize the **Affected Member's** oncology services under the **Affected Member's** existing **Provider** until the active treatment plan is completed.

4. A **Receiving Health Network** shall allow an **Affected Member**, who is in the process of a transplant evaluation to complete transplant care services with the **Affected Member's** existing **Provider**. Transplant coordination of care for an **Affected Member** shall be managed, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

5. A **Receiving Health Network** shall allow an **Affected Member**, who is receiving acute inpatient services on the effective date of the **Receiving Health Network** change and is expected to have a remaining length of stay less than or equal to three (3) calendar days, to continue his or her acute care stay in the current inpatient setting.

6. A **Receiving Health Network** shall authorize an **Affected Member**, who has a remaining length of stay in an acute inpatient setting of more than three (3) calendar days, to stay in the existing acute inpatient setting until the **Receiving Health Network** can arrange for the safe transfer of the **Affected Member** to another acute care facility that can provide comparable services.

7. If it is necessary for an **Affected Member** to reschedule post-surgical physician visits after the effective date of the **Receiving Health Network** change, the **Receiving Health Network** shall

authorize the **Affected Member's** remaining post-surgical visits which were included under a previous global authorization with the surgeon who performed the surgery pursuant to community standards and **Medical Necessity**.

8. A **Receiving Health Network** shall authorize continued obstetrical services for an **Affected Member**, including delivery and the immediate postpartum period, with the Affected Member's existing **Provider** and hospital if the **Affected Member** is in her second (2nd) or third (3rd) trimester of pregnancy.

9. If an **Affected Member** is receiving dialysis services, a **Receiving Health Network** shall authorize continued dialysis services with the Affected Member's existing dialysis center and nephrologist until the **Receiving Health Network** has evaluated the **Affected Member's** dialysis treatment plan and arranged for the **Affected Member's** safe transfer to another dialysis center or nephrologist without a delay or interruption in service.

10. If an **Affected Member** has a scheduled diagnostic and **Ancillary Service** on a date after the **Affected Member's** effective date of the Health Network change, the **Receiving Health Network** shall authorize the diagnostic or **Ancillary Service** with the previously scheduled **Provider** unless the **Receiving Health Network** is able to arrange comparable services with another **Provider** without a delay or interruption in service.

11. If an **Affected Member** receives injectables as part of an active treatment plan, a **Receiving Health Network** shall ensure that the prescribed injectables are continued without delay or interruption in accordance with the **Affected Member's** active treatment plan until the **Receiving Health Network** has re-evaluated the **Affected Member's** active treatment plan.

12. If an **Affected Member** receives long term acute care services, a **Receiving Health Network** shall authorize the long term care acute care services at the **Affected Member's** existing facility until the **Receiving Health Network** has re-evaluated the **Affected Member** and provides for the safe transfer of the **Affected Member's** care to an alternate facility, with consideration of family or guardian wishes.

13. A **Health Network** that authorizes the purchase of **Durable Medical Equipment (DME)** for an **Affected Member** shall pay for the cost of the **DME** even if the delivery of the **DME** occurs after the **Affected Member's** effective date of the **Health Network** change.

14. A **Receiving Health Network** shall continue to provide an **Affected Member** with the same medical supplies, quantities, or equipment without disruption or delay in services until the **Receiving Health Network** has evaluated the **Affected Member's** medical supply needs.

15. If, after consultation with the CalOptima CMO, or his or her **Designee**, the CMO determines certain services are required and the **Receiving Health Network** refuses to provide them, the CMO may authorize these services on behalf of the **Receiving Health Network**.

16. If a **Receiving Health Network** modifies, delays, denies, or takes any other action that triggers **Aid Paid Pending** an appeal, the **Receiving Health Network** shall follow **Member** notification requirements and related provisions, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

17. If CalOptima or a **Health Network** requires a **Member** to change his or her **Provider** involuntarily due to suspensions, decertifications, or non-renewal of a **Health Network** or **Provider's** contract with CalOptima or a **Health Network**, including termination, suspensions,

and decertifications from the Medi-Cal program as effectuated by DHCS, CalOptima or a **Health Network** shall coordinate with the receiving **Provider** for ongoing services and treatment.

a. CalOptima or a **Health Network** shall ensure the terminated, suspended, or decertified **Provider** does not receive payment for Medi-Cal services provided on or after the effective date of action in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

b. CalOptima or a **Health Network** shall communicate the notification to the **Affected Member** in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

18. A **Receiving Health Network** shall pay for the **Covered Services** furnished to an **Affected Member** by the **Affected Member's** existing **Provider** as authorized by the terminating **Health Network** to maintain **Continuity of Care** in accordance with this policy. The **Receiving Health Network** shall pay a **Non-Contracted Provider** for such items and services at the Medi-Cal Fee Schedule rate or, if inpatient services, at the CalOptima rate.

D. For a **CCS**-eligible **Member** transitioning to CalOptima's **WCM** program who is required to change to a new **Health Network** participating in the **WCM** program, the following **Continuity of Care** requirements shall apply:

1. The **Receiving Health Network** shall allow, upon request, the **CCS**-eligible **Member** to maintain access to **CCS Providers** with whom the **Member** has an existing relationship for up to twelve (12) months, in accordance with Welfare and Institutions Code section 14094.13, under the following conditions:

a. The **CCS**-eligible **Member** has seen the out-of-network **CCS Provider** for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or the initial assigned **Health Network** assumed responsibility for the **Member's CCS** care under the **WCM** program.

b. The out-of-network **CCS Provider** accepts the **Receiving Health Network's** rate for services offered or the applicable Medi-Cal or **CCS** fee-for-service rate, whichever is higher, unless the out-of-network **CCS Provider** enters into an agreement on an alternative payment methodology mutually agreed to by the out-of-network **CCS Provider** and the **Receiving Health Network**.

c. The **Receiving Health Network** confirms that the out-of-network **CCS Provider** meets applicable professional standards, including **CCS** standards, and has no disqualifying quality of care issues.

d. The out-of-network **CCS Provider** has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

e. The out-of-network **CCS Provider** provides treatment information to the **Receiving Health Network**, to the extent authorized by the State and federal patient privacy provisions.

2. The **CCS**-eligible **Member** may petition the **Receiving Health Network** for an extension of the **Continuity of Care** period. If the **Receiving Health Network** does not approve the

extension, the **CCS**-eligible **Member** may appeal this decision in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1510: Appeal Process.

E. CalOptima may impose **Sanctions** on a **Health Network**, including and without limitation, financial penalties or termination, in accordance with CalOptima Policy HH.2002Δ: Sanctions, when the **Health Network** fails to comply with the requirements of this Policy.

F. CalOptima or a **Health Network** shall notify an **Affected Member** of **Provider** termination, in accordance with CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services.

G. CalOptima or a **Health Network** shall provide continued **Covered Services** to an **Affected Member** so as to not cause an interruption or delay using the following continuity of care guidelines:

1. CalOptima or a **Health Network** shall ensure continuation of treatment through the current period of active treatment, not to exceed twelve (12) months except as provided in Section III.D.2. of this Policy for **Members** eligible with the **WCM** program.

2. CalOptima or a **Health Network** shall ensure continuation of care through the postpartum period for a Member in their second (2nd) or third (3rd) trimester of pregnancy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy DD.2012: Member Notification of Change in Availability or Location of Covered Services
D. CalOptima Policy EE.1101Δ: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory
E. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
F. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
G. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
H. CalOptima Policy GG.1510: Appeal Process
I. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
J. CalOptima Policy HH.2002Δ: Sanctions
K. Department of Health Care Services All Plan Letter (APL) 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
L. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)
M. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVAL(S)

A. 01/31/18: Department of Health Care Services
B. 10/14/15: Department of Health Care Services
C. 09/11/13: Department of Health Care Services
D. 11/10/09: Department of Health Care Services

VII. BOARD ACTION(S)

A. 02/04/03: Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	02/04/2003	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2007	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2010	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2012	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2013	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Reviewed	07/01/2014	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	07/01/2015	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2016	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	11/01/2017	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	10/01/2018	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	TBD	GG.1304	Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole Child Model Program	Medi-Cal

IX. GLOSSARY

Term	Definition
Affected Member	A Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include, but are not limited to the termination or non-renewal of a Health Network Contract.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
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.
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 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.
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	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.
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.

Term	Definition
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
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. For purposes of this policy, a Health Network shall include 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.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima, a Physician Medical Group, or a Health Network.
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.
Receiving Health Network	A Health Network to which a Member is transitioning.
Scheduled Elective Surgery	Non-urgent or non-emergent procedures to treat disease, injury, or deformity by physical operation or manipulation, which are requested by the treating physician and authorized by the Health Network to occur within sixty (60) days after transitioning to the Receiving Health Network.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
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.

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Policy ~~#:~~:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/~~15~~2015
~~Review Date:~~	~~10/04/18~~
Revised Date:	~~10/04/18~~TBD

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following~~. There is an existing relationship with~~:

   a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

   b. ~~b~~An out-of-network California Children's Services (CCS) Provider if the CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima or a Health Network assumed responsibility for the Member's CCS care under the Whole Child Model (WCM) program;

   c. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

d. An out-of-network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; ~~and~~or

e. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept ~~CalOptima,~~the higher of CalOptima's or a Health Network's rates, the Medi-Cal FFS rates, ~~whichever is higher;~~or the CCS FFS rates (which apply only to the existing out-of-network CCS Provider), as applicable. Notwithstanding the foregoing, the Existing Out-of-Network Provider may enter into an agreement on an alternative payment methodology mutually agreed to by the Existing Out-Of-Network Provider and CalOptima or a Health Network, as applicable.

3. The Existing Out-of-Network Provider meets applicable professional standards ~~and~~, including, as applicable, CCS standards (which apply only to the existing out-of-network CCS Provider).

~~3.~~4. The Existing Out-of-Network Provider has no disqualifying quality of care issues~~;~~. For purposes of this subsection, a quality of care issue means CalOptima or a Health Network can document its concerns with the Existing Out-of-Network Provider's quality of care to the extent the provider would not be eligible to provide services to any other Members of CalOptima or a Health Network.

~~4.~~5. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS~~;~~.

~~5.~~6. The Existing Out-of-Network Provider is a California State Plan-approved provider~~;~~.

~~6.~~7. The Existing Out-of-Network Provider ~~supplies~~provides CalOptima or a Health Network, with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan ~~as~~, to the extent allowed under federal and state privacy laws and regulations~~; and~~.

~~7.~~8. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the ~~California Children's Services (~~CCS~~)~~ Program and transitioned into the ~~Whole Child Model (~~WCM~~)~~ program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal ~~beneficiary~~Member a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008 (Revised~~).:~~): Continuity of Care for Medi-Cal ~~Beneficiaries~~Members Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population-Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, ~~or~~ Specialty Care Provider, or CCS Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the

qualifying period stated in Section II.C.1~~.~~ and include the last date upon which services were provided~~.~~.

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a ~~Provider~~provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP, Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and as required and in accordance with All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal

Members Who Transition into Medi-Cal Managed Care (Revised), within seven (7) calendar days of the completion of a Continuity of Care request~~:~~.

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

    a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section II.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is

licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

   a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

   b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

   c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

   a. Effective ~~January~~upon the DHCS-approved implementation date, no sooner than July 1, 2019, CalOptima or a Health Network shall provide Continuity of Care rights for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS ~~provider~~Provider for up to twelve (12) months in accordance with Section II.C.~~1.~~ of this Policy. At its discretion, CalOptima or a Health Network may extend the Continuity of Care period beyond the twelve (12) months.

   b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

      i. Specialized or Customized DME

         a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

         b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-~~Eligible~~eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

c. Appealing Continuity of Care Limitations

i. CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if ~~the MCP~~CalOptima or a Health Network denies the petition. The appeals process notice must include the following information:

a) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

~~b)~~ ~~A eligible~~CalOptima or a Health Network shall inform a Member, during the ~~Member's family or designated caregiver~~appeal process, of their right to request a State Hearing after the internal appeal process has been exhausted or should have been exhausted in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

9. Pediatric Palliative Care (PPC) Waiver Transitions

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for an eligible Member ~~may appeal~~with his or her Existing Out-of-Network Provider who provided PPC Waiver Program services to the Member for services that are also covered by Medi-Cal under Early and Periodic Screening, Diagnostic and Treatment (ESPDT) in accordance with Section II.C. of this Policy.

~~a.~~b. CalOptima or a Health Network is not required to provide Continuity of Care ~~limitation~~for services that were exclusive to the ~~Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.~~ PPC Waiver Program and that are not covered by Medi-Cal under EPSDT.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

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

Not Applicable

~~V. REFERENCES~~
V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1401: Pharmacy Authorization Process
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
~~E.~~F. CalOptima Policy GG.1301: Comprehensive Case Management
~~F.~~G. CalOptima Policy GG.1209: Population- Based Care: Disease Management
~~G.~~H. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
~~H.~~I. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
~~I.~~J. CalOptima Policy GG.1401: Pharmacy Authorization Process
~~J.~~K. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
L. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~K.~~M. California Health and Safety Code, §1374.73
~~L.~~N. California Health and Safety Code, §1373.96
~~M.~~O. California Welfare and Institutions Code ~~§§§~~ 14094.13~~(a) (d), 14094.13(d)~~
~~N.~~P. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
~~O.~~Q. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal ~~Beneficiaries~~Members Who Transition into Medi-Cal Managed Care (Revised)
~~P.~~R. Department of Health Care Services, All Plan Letter (APL) 18-~~011~~023: California Children's Services Whole Child Model Program

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

A. 01/18/19: Department of Health Care Services
~~A.~~B. 10/18/18: Department of Health Care Services
~~B.~~C. 09/20/18: Department of Health Care Services

~~C.~~D. 06/26/18: Department of Health Care Services
~~D.~~E. 01/31/18: Department of Health Care Services
~~E.~~F. 07/11/17: Department of Health Care Services
~~F.~~G. 08/23/16: Department of Health Care Services
~~G.~~H. 05/15/15: Department of Health Care Services

VII. BOARD ACTION(S)

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

~~REVIEW/~~

VIII. REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	TBD	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
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.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) Service Provider	There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
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 (CCS~~)~~ ~~Eligible~~)-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.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.

Term	Definition
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 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.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, CCS Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
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.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
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).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

Term	Definition
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: 1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. 2. Psychiatric inpatient hospital services. 3. Targeted Case Management. 4. Psychiatrist services. 5. Psychologist services. 6. EPSDT supplemental Specialty Mental Health Services.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.
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.

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Policy: GG.1425
Title: **Prescriber Restriction Program**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 08/01/2016
Revised Date: TBD

I. PURPOSE

This policy describes the criteria and process by which a Member is assigned to a Designated Prescriber to receive controlled substance medications through the Prescriber Restriction Program.

II. POLICY

A. The Chief Medical Officer (CMO) or Designee may place a CalOptima Member to a Designated Prescriber to obtain controlled substance medications, in an outpatient setting, if:

a. The Member obtains controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that the Selected Member have obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Subject to the exceptions set forth in this policy, a Selected Member shall only obtain prescription medication services from his or her Designated Prescriber during the Lock-in Period.

C. The Designated Prescriber shall be the Selected Member's Primary Care Physician (PCP).

D. Pharmaceutical services may be provided to a Selected Member pursuant to a prescription from a Prescriber other than the Designated Prescriber for emergency situations in accordance with CalOptima Policies GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies; and GG.1639: Post-Hospital Discharge Medication Supply.

E. A Prescriber restriction shall be effective for a period of twelve (12) calendar months.

1. Thirty (30) calendar days prior to the end of the Selected Member's restricted period, CalOptima's Pharmacy Management Department staff shall review authorizations, claims, and other documentation related to the restriction and discuss the case with the Member's appropriate Provider(s).

2. The CMO or Designee may continue the restriction for a Member for an additional period of twelve (12) calendar months if:

a. The Selected Member continues to obtain controlled substance medications from prescribers other than the Designated Prescriber(s); or

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b. Upon continued recommendation by Providers, Health Network staff, or CalOptima staff using the Controlled Substances Utilization Review and Evaluation System (CURES) report.

F. Requests to place a Member on a restricted status may be made to the CalOptima Pharmacy Management Department by Providers, Health Network staff, or CalOptima staff.

G. The restriction on a Member for controlled substance medications shall not affect the eligibility of the Member to receive other Medi-Cal benefits, or apply in any instance where an emergency exists which requires immediate treatment.

H. The following information will be utilized when evaluating a request for restricted status:

1. Review of pharmacy claims data for the Member in question and review of claims/encounter data on the Member's usage of specific services.

2. Communication with Prescribers about the Member's use of drugs and the current and/or historical usage of medications, and possible efforts by the physician(s) to monitor/manage the drug usage.

I. CalOptima shall inform a Selected Member that it shall deny payment for controlled substance prescriptions for pharmaceutical services by any Prescriber other than the Designated Prescriber, except as otherwise provided in this Policy.

III. PROCEDURE

A. Identification of Selected Members

1. CalOptima may identify a Member as a Selected Member for the Provider Restriction Program if:

a. Pharmacy claims utilization reports indicate the Member has filled controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that the Member has obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Member Notification

1. Upon identification of a Selected Member, CalOptima shall provide the Selected Member with a written notice thirty (30) calendar days prior to the Selected Member's scheduled participation in the Prescriber Restriction Program. The notice shall:

a. Inform the Selected Member of their participation in the Prescriber Restriction Program;

b. The Member's Designated Prescriber and Prescriber restriction dates; and

c. The right to file a complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program.

C. For Cause Requests

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1. A Selected Member may request a change to their restricted status by contacting the CalOptima Customer Service Department if the Selected Member identifies that participation in the Prescriber Restriction program would present an access or quality of care issue(s) that affects his/her ability to obtain needed Covered Services or that subject the Selected Member to unnecessary medical risk.

2. A Selected Member may request to change his or her assigned Designated Prescriber based upon:

   a. A change in the Selected Member's PCP; or

   b. Identification of access or quality of care issues that affect the Selected Member's ability to obtain needed controlled substance prescriptions or that subject the Selected Member to unnecessary medical risk.

D. Member Rights

1. A Selected Member shall have the right to file a Complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint and HH.1108: State Hearing Process and Procedures.

2. If a Selected Member requests a State Hearing with regard to the proposed Prescriber Restriction, the Selected Member's Lock-in Period shall not commence until after the issuance of a final decision upholding the proposed action.

IV. ATTACHMENT(S)

A. Medication Case Review Form
B. Member Notice
C. Prescriber Notice

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
C. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy HH.1108: State Hearing Process and Procedures
F. Title 42, Code of Federal Regulations (C.F.R), §440.230(d)

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)

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Effective	08/01/2016	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	04/01/2017	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	10/01/2018	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	TBD	GG.1425	Prescriber Restriction Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
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.
Designated Prescriber	For the purposes of this policy as the Prescriber of record at which a Selected Member shall fill all prescriptions during the Lock-in Period. The Designated Prescriber shall be the member's primary care physician.
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.
For Cause	For the purposes of this policy, as reasons for which a Selected Member may change a Designated Prescriber or be exempt from the requirements of this policy.
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.
Lock-in Period	For the purposes of this policy as the twelve (12)-month period of time during which a Selected Member shall remain restricted to a Designated Prescriber.
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 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.
Selected Member	For the purposes of this policy, as a Member whom CalOptima identifies for assignment to a Designated Prescriber in accordance with the terms and conditions of this policy.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program.

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Policy ~~#~~: GG.1425
Title: **Prescriber Restriction Program**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 08/01/2016
~~Last Review Date:~~ ~~10/01/18~~
~~Last~~ Revised Date: ~~10/01/18~~TBD

I. PURPOSE

This policy ~~outlines~~describes the criteria and process by which a Member is assigned to a Designated Prescriber to receive ~~prescription~~controlled substance medications through the Prescriber Restriction Program.

II. POLICY

A. ~~Pursuant to the terms and conditions of this Policy, a CalOptima Member may be placed on a restricted status for prescription medication services in an outpatient setting based on a determination by the~~ The Chief Medical Officer (CMO~~)~~) or Designee~~,~~ may place a CalOptima Member to a Designated Prescriber to obtain controlled substance medications, in an outpatient setting, if:

a. The Member obtains controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that ~~such services~~the Selected Member have obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

~~A.~~B. Subject to~~been used inappropriately by~~ the ~~Member.~~ exceptions set forth in this policy, a Selected Member shall only obtain prescription medication services from his or her Designated Prescriber during the Lock-in Period.

C. The Designated Prescriber shall be the Selected Member's Primary Care Physician (PCP).

~~B.~~D. Pharmaceutical services may be provided to a Selected Member ~~by~~pursuant to a prescription from a Prescriber other than the Designated Prescriber for emergency situations in accordance with CalOptima Policies GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies; and GG.1639: Post-Hospital Discharge Medication Supply.

~~C.~~E. A Prescriber restriction shall be effective for a period of twelve (12) calendar months.

1. Thirty (30) calendar days prior to the end of the Selected Member's restricted period, CalOptima's Pharmacy Management Department staff shall review authorizations, claims, and other documentation related to the restriction and discuss the case with the Member's appropriate Provider(s).

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2. The CMO~~,~~ or Designee~~,~~ may continue the restriction for a Member for an additional period of twelve (12) calendar months if:

   a. The Selected Member continues to obtain controlled substance ~~prescriptions~~medications from ~~four (4)~~prescribers other than the Designated Prescriber(s); or ~~more Prescribers in a two (2) month period; or~~

   b. Upon ~~referral~~continued recommendation by Providers, Health Network staff, or CalOptima staff~~.~~ using the Controlled Substances Utilization Review and Evaluation System (CURES) report.

~~D.~~F. Requests to place a Member on a restricted status may be made to the CalOptima Pharmacy Management Department by Providers, Health Network staff, or CalOptima staff.

~~E.~~G. The restriction on a Member for ~~prescription~~controlled substance medications shall not affect the eligibility of the Member to receive other Medi-Cal benefits, or apply in any instance where an emergency exists which requires immediate treatment.

~~F. Subject to the exceptions set forth in this Policy, a Member shall only obtain pharmaceutical services from his or her Designated Prescriber during the Lock-in Period.~~

~~G.~~H. The following information will be utilized when evaluating a request for restricted status:

1. Review of pharmacy claims data for the Member in question and review of claims/encounter data on the Member's usage of specific services.

2. Communication with Prescribers about the Member's use of drugs and the current and/or historical usage of medications, and possible efforts by the physician(s) to monitor/manage the drug usage.

~~H.~~I. CalOptima shall inform a Selected Member that it shall deny payment for controlled substance prescriptions for pharmaceutical services by any Prescriber other than the Designated Prescriber, except as otherwise provided in this Policy.

III. PROCEDURE

A. Identification of Selected Members

1. CalOptima may identify a Member as a Selected Member for the Provider Restriction Program if:

   a. Pharmacy claims utilization reports indicate the Member has filled controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

   b. Upon referral by ~~Providers~~providers, Health Network staff, or CalOptima staff~~.~~ demonstrating that the Member has obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Member Notification

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1. Upon identification of a Selected Member, CalOptima shall provide the Selected Member with a written notice thirty (30) calendar days prior to the Selected Member's scheduled participation in the Prescriber Restriction Program. The notice shall:

   a. Inform the Selected Member of their participation in the Prescriber Restriction Program; ~~and~~

   b. The Member's Designated Prescriber and Prescriber restriction dates; and

   ~~b.~~c. The right to file a complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program.

C. For Cause Requests

1. A Selected Member may request a change to their restricted status by contacting the CalOptima Customer Service Department if the Selected Member identifies that participation in the Prescriber Restriction program would present an access or quality of care ~~issues~~issue(s) that affects his/her ability to obtain needed Covered Services or that subject the Selected Member to unnecessary medical risk.

2. A Selected Member may request to change his or her assigned Designated Prescriber based upon:

   a. A change in the Selected Member's PCP; or

   b. Identification of access or quality of care issues that affect the Selected Member's ability to obtain needed controlled substance prescriptions or that subject the Selected Member to unnecessary medical risk.

D. Member Rights

1. A Selected Member shall have the right to file a Complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program~~,~~ in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint and HH.1108: State Hearing Process and Procedures.

2. If a Selected Member requests a State Hearing with regard to the proposed Prescriber Restriction, the Selected Member's Lock-in Period shall not commence until after the issuance of a final decision upholding the proposed action.

IV. ATTACHMENT(S)

A. Medication Case Review Form
B. Member Notice
C. Prescriber Notice

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
C. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
D. CalOptima Policy HH.1102: CalOptima Member Complaint

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E. CalOptima Policy HH.1108: State Hearing Process and Procedures
F. Title 42, Code of Federal Regulations (C.F.R), §440.230(d)

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	08/01/2016	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	04/01/2017	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	10/01/2018	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	TBD	GG.1425	Prescriber Restriction Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
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.
Designated Prescriber	~~Defined herein for~~For the purposes of this policy as the Prescriber of record at which a Selected Member shall fill all prescriptions during the Lock-in Period. The Designated Prescriber shall be the member's primary care physician.
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.
For Cause	~~Defined herein for~~For the purposes of this policy, as reasons for which a Selected Member may change a Designated Prescriber or be exempt from the requirements of this policy.
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.
Lock-in Period	~~Defined herein for~~For the purposes of this policy as the twelve (12~~)~~)-month period of time during which a Selected Member shall remain restricted to a Designated Prescriber.
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 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.
Selected Member	~~Defined herein for~~For the purposes of this policy, as a Member whom CalOptima identifies for ~~participation in the~~assignment to a Designated Prescriber ~~Restriction Program~~ in accordance with the terms and conditions of this policy.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. ~~All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless~~

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	~~the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.~~

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Policy: GG.1425
Title: **Prescriber Restriction Program**
Department: Medical Affairs
Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: 08/01/2016
Revised Date: TBD

I. PURPOSE

This policy describes the criteria and process by which a Member is assigned to a Designated Prescriber to receive controlled substance medications through the Prescriber Restriction Program.

II. POLICY

A. The Chief Medical Officer (CMO) or Designee may place a CalOptima Member to a Designated Prescriber to obtain controlled substance medications, in an outpatient setting, if:

a. The Member obtains controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that the Selected Member have obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Subject to the exceptions set forth in this policy, a Selected Member shall only obtain prescription medication services from his or her Designated Prescriber during the Lock-in Period.

C. The Designated Prescriber shall be the Selected Member's Primary Care Physician (PCP).

D. Pharmaceutical services may be provided to a Selected Member pursuant to a prescription from a Prescriber other than the Designated Prescriber for emergency situations in accordance with CalOptima Policies GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies; and GG.1639: Post-Hospital Discharge Medication Supply.

E. A Prescriber restriction shall be effective for a period of twelve (12) calendar months.

1. Thirty (30) calendar days prior to the end of the Selected Member's restricted period, CalOptima's Pharmacy Management Department staff shall review authorizations, claims, and other documentation related to the restriction and discuss the case with the Member's appropriate Provider(s).

2. The CMO or Designee may continue the restriction for a Member for an additional period of twelve (12) calendar months if:

a. The Selected Member continues to obtain controlled substance medications from prescribers other than the Designated Prescriber(s); or

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b. Upon continued recommendation by Providers, Health Network staff, or CalOptima staff using the Controlled Substances Utilization Review and Evaluation System (CURES) report.

F. Requests to place a Member on a restricted status may be made to the CalOptima Pharmacy Management Department by Providers, Health Network staff, or CalOptima staff.

G. The restriction on a Member for controlled substance medications shall not affect the eligibility of the Member to receive other Medi-Cal benefits, or apply in any instance where an emergency exists which requires immediate treatment.

H. The following information will be utilized when evaluating a request for restricted status:

1. Review of pharmacy claims data for the Member in question and review of claims/encounter data on the Member's usage of specific services.

2. Communication with Prescribers about the Member's use of drugs and the current and/or historical usage of medications, and possible efforts by the physician(s) to monitor/manage the drug usage.

I. CalOptima shall inform a Selected Member that it shall deny payment for controlled substance prescriptions for pharmaceutical services by any Prescriber other than the Designated Prescriber, except as otherwise provided in this Policy.

III. PROCEDURE

A. Identification of Selected Members

1. CalOptima may identify a Member as a Selected Member for the Provider Restriction Program if:

a. Pharmacy claims utilization reports indicate the Member has filled controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period; or

b. Upon referral by providers, Health Network staff, or CalOptima staff demonstrating that the Member has obtained controlled substances from multiple prescribers as per the Controlled Substances Utilization Review and Evaluation System (CURES) report.

B. Member Notification

1. Upon identification of a Selected Member, CalOptima shall provide the Selected Member with a written notice thirty (30) calendar days prior to the Selected Member's scheduled participation in the Prescriber Restriction Program. The notice shall:

a. Inform the Selected Member of their participation in the Prescriber Restriction Program;

b. The Member's Designated Prescriber and Prescriber restriction dates; and

c. The right to file a complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program.

C. For Cause Requests

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1. A Selected Member may request a change to their restricted status by contacting the CalOptima Customer Service Department if the Selected Member identifies that participation in the Prescriber Restriction program would present an access or quality of care issue(s) that affects his/her ability to obtain needed Covered Services or that subject the Selected Member to unnecessary medical risk.

2. A Selected Member may request to change his or her assigned Designated Prescriber based upon:

   a. A change in the Selected Member's PCP; or

   b. Identification of access or quality of care issues that affect the Selected Member's ability to obtain needed controlled substance prescriptions or that subject the Selected Member to unnecessary medical risk.

D. Member Rights

1. A Selected Member shall have the right to file a Complaint and request a State Hearing if the Selected Member disputes participation in the Prescriber Restriction Program in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint and HH.1108: State Hearing Process and Procedures.

2. If a Selected Member requests a State Hearing with regard to the proposed Prescriber Restriction, the Selected Member's Lock-in Period shall not commence until after the issuance of a final decision upholding the proposed action.

IV. ATTACHMENT(S)

A. Medication Case Review Form
B. Member Notice
C. Prescriber Notice

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
C. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy HH.1108: State Hearing Process and Procedures
F. Title 42, Code of Federal Regulations (C.F.R), §440.230(d)

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)

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Effective	08/01/2016	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	04/01/2017	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	10/01/2018	GG.1425	Prescriber Restriction Program	Medi-Cal
Revised	TBD	GG.1425	Prescriber Restriction Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
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.
Designated Prescriber	For the purposes of this policy as the Prescriber of record at which a Selected Member shall fill all prescriptions during the Lock-in Period. The Designated Prescriber shall be the member's primary care physician.
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.
For Cause	For the purposes of this policy, as reasons for which a Selected Member may change a Designated Prescriber or be exempt from the requirements of this policy.
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.
Lock-in Period	For the purposes of this policy as the twelve (12)-month period of time during which a Selected Member shall remain restricted to a Designated Prescriber.
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 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.
Selected Member	For the purposes of this policy, as a Member whom CalOptima identifies for assignment to a Designated Prescriber in accordance with the terms and conditions of this policy.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program.

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MEDICATION CASE REVIEW

Reviewer: **Date:**
Initial Review Date: **Revaluation Date:**

Member Name:	DOB:
CIN:	Health Network:
Reason for Review:	
Medical Problems/Comments:	
ER Activity / Phone Log Activity:	
PCP: Other Prescriber:	PCP Phone: Other Phone:
Medications:	
PCP / Prescriber Comments:	
Recommendation of PCP / Prescriber:	
CalOptima Comments:	
Chief Medical Officer/Medical Director Review	
☐ Prior Authorization required for all Controlled Medications ☐ Prior Authorization required for Specific Medications Medications:	
Chief Medical Officer/Medical Director Signature	
Effective Dates of Restricted Status:	

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[date]

Dear CalOptima Member:

Did you know that certain prescriptions can become addictive or are dangerous if they are overused? These drugs are called "controlled medications." Some examples of these drugs are narcotics, sedatives and amphetamines.

As the Chief Medical Officer at CalOptima, I work with our primary care doctors to make sure our members receive prescriptions that are appropriate for treating their health problems.

CalOptima recently reviewed your prescription records. As a result, your primary care doctor and I are concerned about your use of controlled medications (or other specific drug). Because of this concern, CalOptima has placed the prescriber part of your Medi-Cal medication coverage on "Restricted Status."

Restricted Status means that if you get a prescription from someone other than your designated prescriber, CalOptima must review and approve your prescriptions — before they are filled — through the prior authorization (PA) process for all controlled medications (or other specific drug). Your designated prescriber is (Dr. FIRST NAME LAST NAME).

Before this restriction ends, your case will be reviewed by CalOptima to determine if the Restricted Status should continue or be removed. Please contact CalOptima Customer Service if you have questions about your Restricted Status or about the prescription approval process.

Sincerely,

Chief Medical Officer
CalOptima

If you disagree with your placement on Restricted Status, you may call CalOptima Customer Service at **1-714-246-8500** or toll-free at **1-888-587-8088** to file a grievance. You also have the right to request a State Fair Hearing if you would like to appeal a decision made by CalOptima. To request a State Fair Hearing, call the State Department of Social Services at 1-800-952-5253.

[date]

RE: Member Name
Birth date:
CIN #:

Effective Dates of Restricted Status:
From:
To:

Dear Provider:
CalOptima recently reviewed this member's prescription and pharmacy records. As a result, we are concerned about the use of controlled medications (or other specific drug). Because of the concern of overuse of controlled medications, CalOptima has restricted controlled substance prescriptions to

- ☐ Prior Authorization required for all Controlled Medications
- ☐ Prior Authorization required for Specific Medications:

Please contact the CalOptima Pharmacy Management Department at 714-246-8471 if you have any other questions concerning this member.

Sincerely,

Chief Medical Officer, CalOptima

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

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

Background

The California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children under age 21 who meet eligibility criteria based on financial and medical conditions. Department of Health Care Services (DHCS) is incorporating CCS services into Medi-Cal Managed Care Plan (MCP) contracts for County Organized Health Systems (COHS) on a phased-in basis.

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. DD.2006: Enrollment In/ Eligibility with CalOptima (redline and clean versions)
2. DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process (redline and clean versions)
3. GG.1125: Cancer Clinical Trials (redline and clean versions)
4. GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices (redline and clean versions)
5. Board Action December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date
6. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program
7. DHCS All Plan Letter 18-011 California Children's Services Whole-Child Model Program

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

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   a. Is diagnosed with hemophilia;

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

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

~~B.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENT(S)

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVAL(S)

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

VII. BOARD ACTION(S)

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

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

VIII. REVIEW/REVISION HISTORY

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

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~~X.~~IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a ~~Member~~member is eligible to receive Medi-Cal ~~Covered Services~~covered services.
California Children's Services Program	~~For the purposes of this policy, the~~The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~persons~~individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (***PCP***) to manage the care of the ~~Member~~member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~Members~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A ~~Member~~member who receives all ~~Covered Services~~covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for ~~Members~~members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division ~~of~~Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of ~~Covered Services.~~covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

***** 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

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.

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.

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).

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

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

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.

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

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
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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 ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander*
☐ American Indian/Alaska Native *complete Item 9
Print Name of Enrolled/Principal Tribe

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 declines information ☐ Unsuitable due to age
☐ Patient has not been assessed ☐ Psychologically unfit ☐ 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.

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~~.~~.

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

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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.

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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.

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

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

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

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

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

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

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

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

        i. Cystic Fibrosis;

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

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

A. Health Network Selection Form
B. CalOptima Introductory Letter

V. REFERENCES

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

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

VI. REGULATORY AGENCY APPROVALS

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

VII. BOARD ACTIONS

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

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

IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~ individuals under the age of twenty-one (21) years who have CCS ~~Eligible Conditions~~eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the ~~Members~~members.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CCS-Eligible Conditions	~~Conditions~~Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations~~, Section 41800~~ sections 41515.2 through ~~4187.6 including, but not limited to:~~ ~~1. Infectious and parasitic diseases;~~ ~~2. Neoplasms;~~ ~~3. Endocrine, nutritional, and metabolic diseases;~~ ~~4. Disease of blood and blood-forming organs;~~ ~~5. Diseases of the nervous system;~~ ~~6. Diseases of the eye;~~ ~~7. Diseases of the ear and mastoid process;~~ ~~8. Diseases of the circulatory system;~~ ~~9. Diseases of the respiratory system;~~ ~~10. Diseases of the digestive system;~~ ~~11. Diseases of the genitourinary system;~~ ~~12. Complications of pregnancy, childbirth, and puerperium;~~ ~~13. Diseases of the skin and subcutaneous tissue;~~ ~~14. Diseases of the musculoskeletal and connective tissue;~~ ~~15. Congenital anomalies;~~ ~~16. Certain causes of Perinatal morbidity and mortality; and Accidents, poisonings, violence, and immunization reactions~~41518.9..
Continuity of Care	Services provided to a ~~Member~~member rendered by an out-of-network provider with whom the ~~Member~~member has pre-existing provider relationship.

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

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

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

    a. Introductory/welcome letter;

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

    c. Health Information Form;

    d. CalOptima **Member** Handbook;

    e. CalOptima **Member** Identification Card;

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

    g. **Health Network** report card;

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

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

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

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

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

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

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

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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:

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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

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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.

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PRI-037-105

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HEALTH NETWORK (HN) SELECTION FORM

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

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

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

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

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

E-mail Address:

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

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

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Dear Member:

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

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

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

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

If you have questions or need help in choosing a health network, please call CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TTY/TDD users can call **1-800-735-2929**. You can also visit our website at www.caloptima.org.

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

[HEALTH_NETWORK]   [HN_PHONE]

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

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

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** VOID **

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** VOID **

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

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

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1-800-735-2929

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

I. PURPOSE

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

II. POLICY

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

B. Routine patient care costs:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

A. A Provider~~,~~ or Practitioner~~,~~ shall obtain prior authorization for reimbursement of routine patient care costs related to a **CalOptima Direct** or **CCN Member's** participation in a cancer **Clinical Trial,** in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

B. A **Provider**, or **Practitioner**, shall obtain prior authorization for reimbursement of routine patient care costs related to a **Health Network Member's** participation in a cancer **Clinical Trial**, in accordance with the policies established by the **Member's Health Network**.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. DHCS California Children's~~'~~ Services (CCS) Numbered Letter (NL) ~~37-1992~~ 37-1292: Coverage of Experimental and/or Investigational Services
~~C.~~D. CalOptima Health Network Service Agreement
~~D.~~E. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~E.~~F. CalOptima Three-Way Agreement with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~G. Health and Safety Code, §1370.6
~~G.~~H. Medicare National Coverage Determination 100-03, July 9, 2007

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~~H.~~I. Welfare and Institutions Code, §14087.11

VI. REGULATORY AGENCY APPROVALS

A. 02/29/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	11/01/2002	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	05/01/2007	GG.1125	Cancer Clinical Trials	Medi-Cal
Revised	11/01/2015	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1125	Cancer Clinical Trials	Medi-Cal OneCare OneCare Connect

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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.

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Policy #: GG.1125
Title: **Cancer Clinical Trials**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 11/01/02
Revised Date: TBD

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect

I. PURPOSE

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

II. POLICY

A. CalOptima and its **Health Networks** shall cover routine patient care costs, as defined in Section II.B. of this policy, associated with a **Member's** participation in a Phase I, Phase II, Phase III, or Phase IV cancer **Clinical Trial**, if the **Member** and the cancer **Clinical Trial** meet the requirements set forth herein..

B. Routine patient care costs:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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

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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

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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;

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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

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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

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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.

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Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.

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Policy #:	GG.1515
Title:	**Criteria for Medically Necessary Automobile Orthopedic Positioning Devices**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/1999
Revised Date:	04/04/2019

I. PURPOSE

This policy defines the Durable Medical Equipment (DME) guidelines and Medical Necessity criteria for reimbursement of Medically Necessary Automobile Orthopedic Positioning Devices (AOPDs) provided to Members.

II. POLICY

A. An AOPD is a Covered Service under the Whole-Child Model (WCM) program or the CalOptima Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services program when the device meets the criteria and conditions set forth in this policy.

B. Purchase of an AOPD shall require Prior Authorization by CalOptima or the Member's Health Network to be eligible for reimbursement.

C. CalOptima or a Health Network shall provide reimbursement for only one (1) AOPD per Member.

D. A request for reimbursement of an AOPD shall be accompanied by all required documentation.

E. CalOptima or a Health Network shall not authorize the purchase of standard commercially available car seats, vests, or harnesses that are required by California state law for children under six (6) years of age and under sixty (60) pounds.

F. CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for children that are not California Children's Services (CCS)-eligible but require a specially adapted AOPD because of a medical condition under the EPSDT Services program.

G. No sooner than the Department of Health Care Services (DHCS)-approved WCM program effective date, CalOptima or a Health Network will review for Medical Necessity and, if indicated, will authorize the purchase of an AOPD for CCS-eligible individuals enrolled in the WCM program, in accordance with CalOptima Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program.

1. For WCM members, an AOPD shall be evaluated for Medical Necessity in accordance with all current CCS DME Guidelines as provided in CCS Numbered Letters.

III. PROCEDURE

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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

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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

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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.

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Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

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Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

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WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

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4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

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integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

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Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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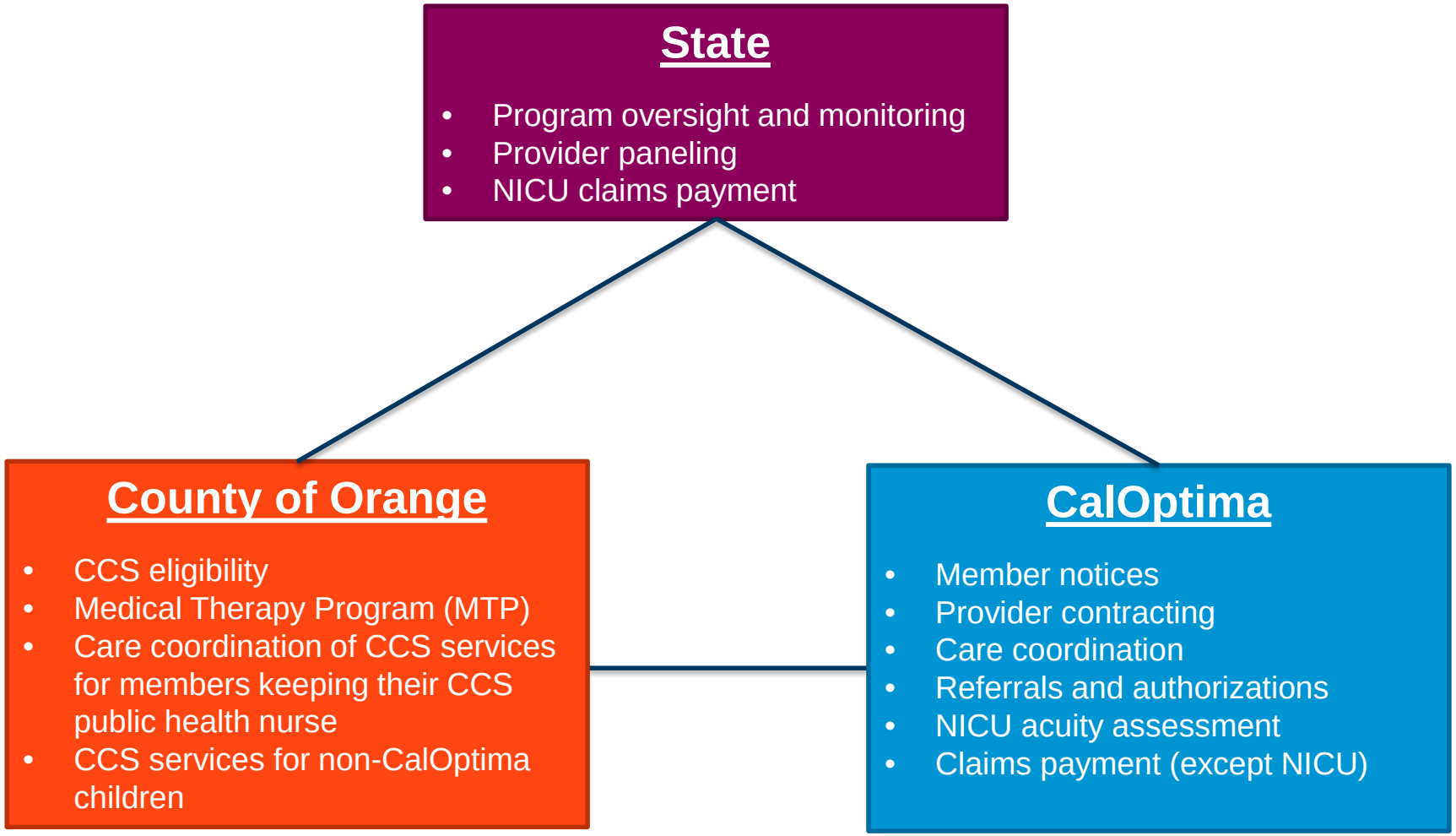
Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

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

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

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and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

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.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. 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.

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

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

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.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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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

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 23, 2018

ALL PLAN LETTER 18-023
SUPERSEDES ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program. This APL supersedes APL 18-011.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[4] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs will authorize care that is consistent with CCS program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as continuity of care (C.O.C.), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – No sooner than July 1, 2019	
CalOptima	Orange

POLICY:
Starting July 1, 2018, as designated above, MCPs assumed full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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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

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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.

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[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).

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.

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[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;

- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

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[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   Risk Assessment
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

Individual Care Plan
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

WCM Transitioning Members
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

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[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

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[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

5. Consider Approval of Modifications to CalOptima's Policy and Procedure Related to CalOptima's Whole-Child Model Program

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to modify existing Policy and Procedure in connection with Whole-Child Model program as follows:

A. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs [Medi-Cal, OneCare, OneCare Connect].

Background and Discussion

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. 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 28, 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.

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

A. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs outlines the criteria and process for coverage of durable medical equipment (DME) for a member, excluding wheelchair rental, purchase, and repairs. CalOptima revised this policy pursuant to the CalOptima review process to ensure alignment with current operations to include continuity of care with a specialized or customized DME provider for up to 12 months in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. This policy is in alignment with the California Children's Services Whole Child Model program requirements.

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

Fiscal Impact
Management will include all projected revenues and expenses associated with the WCM program in the Fiscal Year 2019-20 Operating Budget. Therefore, the fiscal impact of the recommended action to modify CalOptima Policy GG.1502 is a budgeted item and is not expected to have an additional fiscal impact in the current year.

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs [Medi-Cal, OneCare, OneCare Connect]
2. GG.1325: Continuity of Care for Members Transitioning into CalOptima Service [Medi-Cal]
3. DHCS All Plan Letter 18-023 California Children's Services Whole-Child Model Program

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

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Policy #:	GG.1502
Title:	**Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2000
~~Last Review Date:~~	~~08/01/17~~
~~Last~~ Revised Date:	05/02/2019~~08/01/17~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of **Durable Medical Equipment (DME)** for a **Member**, excluding wheelchair rental, purchase, and repairs.

II. POLICY

A. CalOptima or a **Health Network** shall provide **DME** for a **Member** when **Medically Necessary**.

B. CalOptima or a **Health Network** shall define **Medically Necessary** as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, **DME** prescribed for a **Member** may be a **Covered Service** when it is **Medically Necessary** to:

1. Preserve bodily functions essential to **Activities of Daily Living (ADL)** or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a **Member** through the stabilization of the **Member's** condition or the prevention of additional deterioration of the **Member's** medical status, or functional ability.

C. The following items are not **Covered Services**:

1. Modification of automobiles or other highway motor vehicles, with the exception of **Automobile Orthopedic Positioning Devices (AOPDs)**, in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Alterations or improvements to real property, except when authorized for home dialysis services;

3. Books or other items of a primarily educational nature;

4. Air conditioners, air filters or heaters;

5. Food blenders;

6. Reading lamps or other lighting devices;

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7. Bicycles, tricycles, or exercise equipment, except as otherwise permitted in this Ppolicy;

8. Television sets;

9. Orthopedic mattresses, recliners, rockers, seat lift chairs (for Medi-Cal only), or other furniture items;

10. Waterbeds;

11. Household items;

12. Items required solely for, educational, or vocational needs; and

13. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

D. CalOptima or a **Health Network** shall not grant an authorization for **DME**, if a household or furniture item will adequately serve the **Member's** medical needs.

E. CalOptima or a **Health Network** shall limit authorization for **DME** to the lowest cost item that meets a **Member's** medical needs.

F. If a **Member** has a speech, language or hearing disorder, CalOptima, or a **Health Network**, shall authorize an Augmentation and Alternative Communication Device (AAC) for the **Member** when the following conditions are met:

1. A licensed speech and language pathologist conducts an assessment of the **Member's** medical need for AAC.

2. A physical or occupational therapist conducts an assessment of the **Member's** medical need for AAC if the **Member** has physical limitations which may impact his or her ability to use the AAC.

G. CalOptima or a **Health Network** will provide **Continuity of Care** with a **Specialized or Customized Durable Medical Equipment (DME)** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

~~G.~~H. CalOptima or a **Health Network** may authorize the following **DME** for a **Member** who is an inpatient in a **Skilled Nursing Facility (SNF)** or **Intermediate Care Facility (ICF)**:

1. Equipment that is necessary for the continuous care and unusual medical needs of the **Member**. A **Member** may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics, as such, shall not constitute an unusual medical condition.

2. Canes, crutches, wheelchair cushions, and walkers that are custom made or modified to meet the unusual medical needs of the **Member** and the need is expected to be permanent.

3. Suction and position pressure apparatuses that a **Member** will continuously use or must be immediately available to the **Member** for one (1) month or more.

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~~H.~~I. CalOptima or a **Health Network** shall authorize **DME** for a **Member**, in accordance with the following provisions:

1. A **Practitioner** shall obtain prior authorization for the following:

   a. Purchase of **DME** when the ~~cumulative~~total cost of items purchased within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month;

   b. Repair or maintenance of **DME** when the ~~cumulative~~total cost of the repair and maintenance of items within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month. The cost of repairs shall not exceed the replacement value of the item being repaired;

   c. Rental of **DME** when the ~~cumulative~~total cost of renting items within a **DME** category group exceeds five hundred dollars ($500) within a fifteen (15) month period. This includes any daily amount that an individual item, or combination of a similar group of items, exceeds the five hundred dollar ($500) threshold. The fifteen (15) month period begins on the date the first item is rented;

   ~~d. Provision of oxygen when more than the equivalent of two (2) H tanks are provided during one (1) calendar month; and~~

   d. Rental or purchase of an oxygen delivery system;

   e. Purchase, rental, repair, or maintenance of any unlisted devices or equipment, regardless of the dollar amount for any individual item or the ~~cumulative~~total cost.

2. CalOptima or a **Health Network** may audit **DME** authorization requests for appropriateness and accuracy, as necessary.

~~I.~~J. A **Member** is responsible for the appropriate use and care of **DME** purchased for the **Member's** benefit.

~~J.~~K. A **DME** provider shall ensure that the **DME** provided to a **Member** is appropriate for the **Member's** medical needs. A **DME** provider shall, at no cost to CalOptima, or a **Health Network**, adjust, modify, or replace the **DME**, as necessary, when the **DME** provided does not:

1. Meet the **Member's** medical needs and the **Member's** medical condition has not changed since the date the **DME** was originally provided; or

2. Meet the **Member's** functional needs when in actual use.

K. CalOptima or a **Health Network** shall consider **DME** to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented **DME**. CalOptima, or the **Health Network**, shall provide no further reimbursement to the **DME** provider for the use of such **DME**, unless payment is for the subsequent repair and maintenance of the **DME**, as authorized by CalOptima, or the **Health Network**.

L. Effective no sooner than July 1, 2019, CalOptima or a **Health Network** shall be responsible for authorization and claims processing for the rental, purchase and repair of **Specialized or Customized DME** for Whole Child Model (WCM) **Members** whose custom **DME** is **Medically Necessary** to treat or ameliorate the effects of their **California Children's Services (CCS)-eligible Condition**. **Specialized or Customized DME** may include, but is not limited, to devices to assist

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in standing, ambulating, or positioning parts of the body to improve or maintain function, or to prevent the development of conditions that may result from inadequate support or positioning of the individual's anatomy.

M. With respect to the WCM program, CalOptima and the **Health Networks** shall ensure compliance with all current and applicable:

1. State and federal laws and regulations, as well as contractual requirements;

2. California Department of Health Care Services (DHCS) guidance, including All Plan Letter 18-023: California Children's Services Whole Child Model;

3. CCS programs guidelines, including CCS program regulations, regulations related to WCM program. CCS Numbered Letters, and CCS program information notices, in developing criteria for use by their respective chief medical officer or the equivalent and any other care management staff.

a. When applicable CCS clinical guidelines to not exist, CalOptima and the **Health Networks** shall use evidence-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible condition**.

b. Any CCS Numbered Letters that fall within the Index Category of Authorizations/Benefits, as identified by DHCS, are applicable to CalOptima and the **Health Networks**. For these applicable CCS Numbered Letters, including those referenced in Section V. of this Policy, CalOptima and the **Health Network** shall assume the role of the county or state CCS program as described in the CCS Numbered Letters.

III. PROCEDURE

A. A **Practitioner** shall identify a **Member** who has a **Medical Necessity** for **DME** and issue a written prescription to the **Member** for the purchase, rental, repair, or maintenance of the **DME**. Such prescription shall include:

1. Full name, address, telephone number, and signature of the prescribing **PCP**, or **Provider**;

2. Date of prescription;

3. Specific item(s) prescribed;

4. Estimated length of time the **DME** is determined to be **Medically Necessary**; and

5. **Member's** medical condition or diagnosis necessitating the **DME**, including:

a. **Member's** medical status and functional limitation(s); and

b. Description of how the requested **DME** is expected to improve the medical status or functional ability of the **Member**, stabilize the **Member's** medical condition, or prevent additional deterioration of the **Member's** medical status or functional ability.

B. A **Practitioner** shall obtain authorization to provide **DME** to a **Member** by submitting a request form with a copy of the signed and dated prescription to the CalOptima Utilization Management (UM) Department, or a **Health Network**.

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1. For a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, the **Practitioner** shall submit a CalOptima Authorization Request Form (ARF), in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

2. For a **Health Network Member**, the **Practitioner** shall follow the **Health Network's** authorization procedures.

3. A **Practitioner** shall include the following information, at a minimum, in the authorization request for **DME** submitted to CalOptima, or a **Health Network**:

    a. Date of request;

    b. **Member's** name, appropriate health care identification, or, and address;

    c. Medical justification for the requested **DME**;

    d. Description of the **DME**, including:

        i. Manufacturer name, model type or serial number, and purchase price;

        ii. Product description;

        iii. Monthly rental charge, if applicable, and whether it may be applied toward the purchase of the **DME**;

        iv. Billing and procedure codes; and

        v. Estimated length of need, whether rental or purchase is requested, and associated charges.

    e. **DME Provider's** name, address, telephone number, contact name and telephone number, and National Provider Identification (NPI) number; and

    f. Copy of prescription containing the information required as set forth in Section III.A. of this Policy.

4. For unlisted **DME** requests, a **Provider** shall provide the documentation as set forth in Section III.B.3. of this Policy and copies of catalog pages and medical justification to substantiate the reason(s) a listed item is insufficient to meet the **Member's** medical needs.

C. CalOptima or a **Health Network** shall review the authorization request submitted by a **Member's Provider**. If the authorization request is incomplete, CalOptima, or a **Health Network**, shall require the **PCP**, or **Provider**, to provide additional information.

D. A **Member** may appeal a CalOptima or **Health Network** decision to a requested service in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services, MA.9003: Standard Service Appeal, and CMC.9003: Standard Appeal.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) **Members**:

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1. Effective no sooner than July 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for **Specialized or Customized DME** and **Specialized or Customized DME** repairs with a total cost of over five hundred dollars ($500) to CalOptima. The request will include:

    a. Completed Custom DME Authorization Referral Form;

    b. Signed prescription/provider order for the requested **Specialized or Customized DME**;

        i. The provider order must be prescribed by a CCS-paneled physician who is approved to treat the child's **CCS eligible medical condition**, and who has examined the child within six (6) months.

        ii. If the recommending or prescribing physician is not a CCS-paneled physician approved to treat the child's **CCS eligible medical condition**, the request shall be reviewed by the CCS-approved paneled physician for concurrence prior to submission for authorization; and

    c. Vendor specifications that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima Utilization Management/Prior Authorization Department or the **Health Network** staff via secure communication for review and processing.

3. If a referral for **Specialized or Customized DME** or **Specialized or Customized DME** repair for a CCS-eligible Member is received by CalOptima or a **Health Network** directly from a vendor and not from the MTU, the request will be denied, and the **Member** referred to the MTU for evaluation.

4. If the **Member** requests **Specialized or Customized DME** or **Specialized or Customized DME** repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the **Health Network** to issue the appropriate Notice of Action letter.

5. For **Specialized or Customized DME** or **Specialized or Customized DME** repairs that are covered and recommended by the MTU and are in accordance with the current and applicable CCS numbered letter, CalOptima or a **Health Network** will approve the request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Specialized or Customized DME Provider within standard prior authorization turn around-time requirements for Specialized or Customized DME requests.

F. Effective July 1, 2019, for CCS-eligible Members who are not eligible with Orange County CCS MTP, **Specialized or Customized DME**-related requests will be processed by the **Member's Health Network** consistent with evidence-based medical necessity guidelines and current, applicable CCS numbered letters that define **medical necessity** criteria, except with regard to **Continuity of Care** as described in Section III.F. of this Policy

G. CalOptima or a **Health Network** shall provide **Continuity of Care** for a **Member** eligible with the CCS Program and transitioned into the WCM program with a **Specialized or Customized DME** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For **Specialized or Customized DME** under warranty, the **Continuity of Care** period may be extended to the duration of the warranty when deemed **Medically Necessary** by the treating provider.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF)
B. ~~Medicare Physician Certification~~Certificate of Medical Necessity for All Durable Medical Equipment, Except Wheelchairs and Scooters

V. REFERENCES

A. CalOptima Contract for DME Services
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 Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.9003: Standard Appeal
~~F.~~G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~G.~~H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices
~~H.~~K. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
L. CalOptima Policy MA.9003: Standard Appeal
M. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
~~I.~~O. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
P. CCS Numbered Letter 01-0111: Authorization of Insulin Infusion Pumps
Q. CCS Numbered Letter 02-0102: Pulse Oximeters
R. CCS Numbered Letter 02-0107: Authorization of Rental of Portable Home Ventilators Purpose
S. CCS Numbered Letter 02-0197: Authorization of Flutter Valves and ThAIRapy Vests
T. CCS Numbered Letter 09-0514: Powered Mobility Devices
U. CCS Numbered Letter 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
V. CCS Numbered Letter 10-0707: Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies
W. CCS Numbered Letter 14-0801: Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly Known as Augmentative/Alternative Communication (AAC) Devices
X. CCS Numbered Letter 18-0605: Nationwide Recall of Vail Enclosed Bed Systems
Y. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model Program
~~J.~~Z. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
~~K.~~AA. Title 22, California Code of Regulations (C.C.R), §§51303, 51104, 51160, and 51321

~~L.~~BB. Title 42, Code of Federal Regulations (C.F.R), §414.202

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	01/01/2000	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	03/01/2012	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	11/01/2015	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	05/02/2019	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Augmentation and Alternative Communication Device (AAC)	A set of tools and strategies that a Member uses to solve everyday communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech-generating devices.
Automobile Orthopedic Positioning Device (AOPD)	A non-standard positioning device (car seat 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 pads that assist in head and trunk 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 means CalOptima Direct and CalOptima Community Network (CCN).
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 pre-existing provider relationship.

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Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for 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 and Centers for Medicare & Medicaid Services (CMS).
Disability	A physical or mental condition that limits a person's movements, senses, or activities.
Durable Medical Equipment	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 a Member in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the Member's home.
Health Network	For purposes of this policy, a Health Network is a Physician Medical Group (PMG), 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.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee/beneficiary of a CalOptima program.
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.

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	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.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

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Policy #:	GG.1502
Title:	**Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/2000
Revised Date:	05/02/2019
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of **Durable Medical Equipment (DME)** for a **Member**, excluding wheelchair rental, purchase, and repairs.

II. POLICY

A. CalOptima or a **Health Network** shall provide **DME** for a **Member** when **Medically Necessary**.

B. CalOptima or a **Health Network** shall define **Medically Necessary** as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, **DME** prescribed for a **Member** may be a **Covered Service** when it is **Medically Necessary** to:

1. Preserve bodily functions essential to **Activities of Daily Living (ADL)** or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a **Member** through the stabilization of the **Member's** condition or the prevention of additional deterioration of the **Member's** medical status, or functional ability.

C. The following items are not **Covered Services**:

1. Modification of automobiles or other highway motor vehicles, with the exception of **Automobile Orthopedic Positioning Devices (AOPDs)**, in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Alterations or improvements to real property, except when authorized for home dialysis services;

3. Books or other items of a primarily educational nature;

4. Air conditioners, air filters or heaters;

5. Food blenders;

6. Reading lamps or other lighting devices;

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7. Bicycles, tricycles, or exercise equipment, except as otherwise permitted in this Policy;

8. Television sets;

9. Orthopedic mattresses, recliners, rockers, seat lift chairs (for Medi-Cal only), or other furniture items;

10. Waterbeds;

11. Household items;

12. Items required solely for, educational, or vocational needs; and

13. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

D. CalOptima or a **Health Network** shall not grant an authorization for **DME**, if a household or furniture item will adequately serve the **Member's** medical needs.

E. CalOptima or a **Health Network** shall limit authorization for **DME** to the lowest cost item that meets a **Member's** medical needs.

F. If a **Member** has a speech, language or hearing disorder, CalOptima, or a **Health Network**, shall authorize an Augmentation and Alternative Communication Device (AAC) for the **Member** when the following conditions are met:

1. A licensed speech and language pathologist conducts an assessment of the **Member's** medical need for AAC.

2. A physical or occupational therapist conducts an assessment of the **Member's** medical need for AAC if the **Member** has physical limitations which may impact his or her ability to use the AAC.

G. CalOptima or a **Health Network** will provide **Continuity of Care** with a **Specialized or Customized Durable Medical Equipment (DME)** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

H. CalOptima or a **Health Network** may authorize the following **DME** for a **Member** who is an inpatient in a **Skilled Nursing Facility (SNF)** or **Intermediate Care Facility (ICF)**:

1. Equipment that is necessary for the continuous care and unusual medical needs of the **Member**. A **Member** may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics, as such, shall not constitute an unusual medical condition.

2. Canes, crutches, wheelchair cushions, and walkers that are custom made or modified to meet the unusual medical needs of the **Member** and the need is expected to be permanent.

3. Suction and position pressure apparatuses that a **Member** will continuously use or must be immediately available to the **Member** for one (1) month or more.

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I. CalOptima or a **Health Network** shall authorize **DME** for a **Member**, in accordance with the following provisions:

1. A **Practitioner** shall obtain prior authorization for the following:

   a. Purchase of **DME** when the total cost of items purchased within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month;

   b. Repair or maintenance of **DME** when the total cost of the repair and maintenance of items within a **DME** category group exceeds five hundred dollars ($500) within one (1) calendar month. The cost of repairs shall not exceed the replacement value of the item being repaired;

   c. Rental of **DME** when the total cost of renting items within a **DME** category group exceeds five hundred dollars ($500) within a fifteen (15) month period. This includes any daily amount that an individual item, or combination of a similar group of items, exceeds the five hundred dollar ($500) threshold. The fifteen (15) month period begins on the date the first item is rented;

   d. Rental or purchase of an oxygen delivery system;

   e. Purchase, rental, repair, or maintenance of any unlisted devices or equipment, regardless of the dollar amount for any individual item or the total cost.

2. CalOptima or a **Health Network** may audit **DME** authorization requests for appropriateness and accuracy, as necessary.

J. A **Member** is responsible for the appropriate use and care of **DME** purchased for the **Member's** benefit.

K. A **DME** provider shall ensure that the **DME** provided to a **Member** is appropriate for the **Member's** medical needs. A **DME** provider shall, at no cost to CalOptima, or a **Health Network**, adjust, modify, or replace the **DME**, as necessary, when the **DME** provided does not:

1. Meet the **Member's** medical needs and the **Member's** medical condition has not changed since the date the **DME** was originally provided; or

2. Meet the **Member's** functional needs when in actual use.

K. CalOptima or a **Health Network** shall consider **DME** to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented **DME**. CalOptima, or the **Health Network**, shall provide no further reimbursement to the **DME** provider for the use of such **DME**, unless payment is for the subsequent repair and maintenance of the **DME**, as authorized by CalOptima, or the **Health Network**.

L. Effective no sooner than July 1, 2019, CalOptima or a **Health Network** shall be responsible for authorization and claims processing for the rental, purchase and repair of **Specialized or Customized DME** for Whole Child Model (WCM) **Members** whose custom **DME** is **Medically Necessary** to treat or ameliorate the effects of their **California Children's Services (CCS)-eligible Condition**. **Specialized or Customized DME** may include, but is not limited, to devices to assist in standing, ambulating, or positioning parts of the body to improve or maintain function, or to prevent the development of conditions that may result from inadequate support or positioning of the individual's anatomy.

M. With respect to the WCM program, CalOptima and the **Health Networks** shall ensure compliance with all current and applicable:

1. State and federal laws and regulations, as well as contractual requirements;

2. California Department of Health Care Services (DHCS) guidance, including All Plan Letter 18-023: California Children's Services Whole Child Model;

3. CCS programs guidelines, including CCS program regulations, regulations related to WCM program. CCS Numbered Letters, and CCS program information notices, in developing criteria for use by their respective chief medical officer or the equivalent and any other care management staff.

    a. When applicable CCS clinical guidelines to not exist, CalOptima and the **Health Networks** shall use evidence-based guidelines or treatment protocols that are medically appropriate given the **Member's CCS-eligible condition**.

    b. Any CCS Numbered Letters that fall within the Index Category of Authorizations/Benefits, as identified by DHCS, are applicable to CalOptima and the **Health Networks**. For these applicable CCS Numbered Letters, including those referenced in Section V. of this Policy, CalOptima and the **Health Network** shall assume the role of the county or state CCS program as described in the CCS Numbered Letters.

III. PROCEDURE

A. A **Practitioner** shall identify a **Member** who has a **Medical Necessity** for **DME** and issue a written prescription to the **Member** for the purchase, rental, repair, or maintenance of the **DME**. Such prescription shall include:

1. Full name, address, telephone number, and signature of the prescribing **PCP**, or **Provider**;

2. Date of prescription;

3. Specific item(s) prescribed;

4. Estimated length of time the **DME** is determined to be **Medically Necessary**; and

5. **Member's** medical condition or diagnosis necessitating the **DME**, including:

    a. **Member's** medical status and functional limitation(s); and

    b. Description of how the requested **DME** is expected to improve the medical status or functional ability of the **Member**, stabilize the **Member's** medical condition, or prevent additional deterioration of the **Member's** medical status or functional ability.

B. A **Practitioner** shall obtain authorization to provide **DME** to a **Member** by submitting a request form with a copy of the signed and dated prescription to the CalOptima Utilization Management (UM) Department, or a **Health Network**.

1. For a **CalOptima Direct** or **CalOptima Community Network (CCN) Member**, the **Practitioner** shall submit a CalOptima Authorization Request Form (ARF), in accordance with

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CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

2. For a **Health Network Member**, the **Practitioner** shall follow the **Health Network's** authorization procedures.

3. A **Practitioner** shall include the following information, at a minimum, in the authorization request for **DME** submitted to CalOptima, or a **Health Network**:

   a. Date of request;

   b. **Member's** name, appropriate health care identification, or, and address;

   c. Medical justification for the requested **DME**;

   d. Description of the **DME**, including:

      i. Manufacturer name, model type or serial number, and purchase price;

      ii. Product description;

      iii. Monthly rental charge, if applicable, and whether it may be applied toward the purchase of the **DME**;

      iv. Billing and procedure codes; and

      v. Estimated length of need, whether rental or purchase is requested, and associated charges.

   e. **DME Provider's** name, address, telephone number, contact name and telephone number, and National Provider Identification (NPI) number; and

   f. Copy of prescription containing the information required as set forth in Section III.A. of this Policy.

4. For unlisted **DME** requests, a **Provider** shall provide the documentation as set forth in Section III.B.3. of this Policy and copies of catalog pages and medical justification to substantiate the reason(s) a listed item is insufficient to meet the **Member's** medical needs.

C. CalOptima or a **Health Network** shall review the authorization request submitted by a **Member's Provider**. If the authorization request is incomplete, CalOptima, or a **Health Network**, shall require the **PCP**, or **Provider**, to provide additional information.

D. A **Member** may appeal a CalOptima or **Health Network** decision to a requested service in accordance with CalOptima Policies GG.1510: Appeal Process for Decisions Regarding Care and Services, MA.9003: Standard Service Appeal, and CMC.9003: Standard Appeal.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) **Members**:

1. Effective no sooner than July 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for **Specialized or Customized DME** and **Specialized or Customized DME**

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repairs with a total cost of over five hundred dollars ($500) to CalOptima. The request will include:

a. Completed Custom DME Authorization Referral Form;

b. Signed prescription/provider order for the requested **Specialized or Customized DME**;

i. The provider order must be prescribed by a CCS-paneled physician who is approved to treat the child's **CCS eligible medical condition**, and who has examined the child within six (6) months.

ii. If the recommending or prescribing physician is not a CCS-paneled physician approved to treat the child's **CCS eligible medical condition**, the request shall be reviewed by the CCS-approved paneled physician for concurrence prior to submission for authorization; and

c. Vendor specifications that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima Utilization Management/Prior Authorization Department or the **Health Network** staff via secure communication for review and processing.

3. If a referral for **Specialized or Customized DME** or **Specialized or Customized DME** repair for a CCS-eligible Member is received by CalOptima or a **Health Network** directly from a vendor and not from the MTU, the request will be denied, and the **Member** referred to the MTU for evaluation.

4. If the **Member** requests **Specialized or Customized DME** or **Specialized or Customized DME** repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the **Health Network** to issue the appropriate Notice of Action letter.

5. For **Specialized or Customized DME** or **Specialized or Customized DME** repairs that are covered and recommended by the MTU and are in accordance with the current and applicable CCS numbered letter, CalOptima or a **Health Network** will approve the request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Specialized or Customized DME Provider within standard prior authorization turn around-time requirements for Specialized or Customized DME requests.

F. Effective July 1, 2019, for CCS-eligible Members who are not eligible with Orange County CCS MTP, **Specialized or Customized DME**-related requests will be processed by the **Member's Health Network** consistent with evidence-based medical necessity guidelines and current, applicable CCS numbered letters that define **medical necessity** criteria, except with regard to **Continuity of Care** as described in Section III.F. of this Policy

G. CalOptima or a **Health Network** shall provide **Continuity of Care** for a **Member** eligible with the CCS Program and transitioned into the WCM program with a **Specialized or Customized DME** provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For **Specialized or Customized DME**

under warranty, the **Continuity of Care** period may be extended to the duration of the warranty when deemed **Medically Necessary** by the treating provider.

IV. ATTACHMENT(S)

A. CalOptima Authorization Request Form (ARF)
B. Certificate of Medical Necessity for All Durable Medical Equipment, Except Wheelchairs and Scooters

V. REFERENCES

A. CalOptima Contract for DME Services
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 Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.9003: Standard Appeal
G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
J. CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices
K. CalOptima Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
L. CalOptima Policy MA.9003: Standard Appeal
M. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
P. CCS Numbered Letter 01-0111: Authorization of Insulin Infusion Pumps
Q. CCS Numbered Letter 02-0102: Pulse Oximeters
R. CCS Numbered Letter 02-0107: Authorization of Rental of Portable Home Ventilators Purpose
S. CCS Numbered Letter 02-0197: Authorization of Flutter Valves and ThAIRapy Vests
T. CCS Numbered Letter 09-0514: Powered Mobility Devices
U. CCS Numbered Letter 09-0703: Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R)
V. CCS Numbered Letter 10-0707: Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies
W. CCS Numbered Letter 14-0801: Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly Known as Augmentative/Alternative Communication (AAC) Devices
X. CCS Numbered Letter 18-0605: Nationwide Recall of Vail Enclosed Bed Systems
Y. Department of Health Care Services All Plan Letter 18-023: California Children's Services Whole Child Model Program
Z. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
AA. Title 22, California Code of Regulations (C.C.R), §§51303, 51104, 51160, and 51321
BB. Title 42, Code of Federal Regulations (C.F.R), §414.202

VI. REGULATORY AGENCY APPROVAL(S)

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None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2000	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	03/01/2012	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal
Revised	11/01/2015	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect
Revised	05/02/2019	GG.1502	Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Augmentation and Alternative Communication Device (AAC)	A set of tools and strategies that a Member uses to solve everyday communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech-generating devices.
Automobile Orthopedic Positioning Device (AOPD)	A non-standard positioning device (car seat 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 pads that assist in head and trunk 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 means CalOptima Direct and CalOptima Community Network (CCN).
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 pre-existing provider relationship.

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers for 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 and Centers for Medicare & Medicaid Services (CMS).
Disability	A physical or mental condition that limits a person's movements, senses, or activities.
Durable Medical Equipment	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 a Member in the absence of an illness, injury functional impairment, or congenital anomaly; and (d) is appropriate for use in or out of the Member's home.
Health Network	For purposes of this policy, a Health Network is a Physician Medical Group (PMG), 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.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee/beneficiary of a CalOptima program.
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.

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	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.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

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

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

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CERTIFICATE OF MEDICAL NECESSITY
FOR ALL DURABLE MEDICAL EQUIPMENT (DME)
(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)*	Last	First	Phone Number	License Number
			( )	

Address	Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx ***(For Rx Renewal, please also complete 2A below)***

Patient Name *(Print)*	Last	First	Phone Number	Date of Birth	Medi-Cal Number
			( )	mm / dd / yy	

Address	Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ❒ ❒No Explain ''Yes'' answer: _____

Equipment required for:

❒ Less than 10 months *(code the TAR for a rental)*

❒ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

c) Replacing existing equiment? Yes ❒ ❒No If yes, explain why: _____

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why: _____

h) Custom features requested and why: _____

i) Other equipment currently in the home: Cane ❒ Walker ❒ Crutches ❒ Prosthesis ❒ Manual Wheelchair ❒

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Patient currently using the following equipment: _____

k) When/How often: _____

State specific reason for accessories requested: _____

_____

Power Wheelchair ❒ Hospital Bed ❒ Oxygen ❒ POV (scooter) ❒ Other: j)

l)

DHCS 6181 (08/09)

SECTION 4—Diagnosis Information

Diagnoses: Date of onset:

Prognosis: _____ _____

_____

SECTION 5—Pertinent History:

_____

_____

SECTION 6—Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted❒ Unable ❒ Bed confined ❒

Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒

Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):

Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒

Other:

_____

Living Assistance: Lives alone ❒ With other person(s) ❒ Alone most of the day ❒ Alone at night ❒ Attendant care:

Live in attendant ❒ or _____ Hours/day Homemaker ❒ Hours _____

Transportation:

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed:

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Is frequent repositioning required throughout the night? Yes ❒ ❒No
Can the beneficiary or caretaker use a ‘‘manual’’ bed? Yes ❒ ❒No
If no, explain why:

Is frequent repositioning required throughout the day? Yes ❒ ❒No
Explain:

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: _____ Title: _____ DME Provider Name: _____

(Please print) *(OT, PT, RESNA, etc.)*

Date:

(Please print)

(Use Ink - A signature stamp is not acceptable) *(Use Ink - A signature stamp is not acceptable)*

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician’s Signature:

_____ Date: _____

(Use Ink - A signature stamp is not acceptable)

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Policy #:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/15
Review Date:	10/04/18
Revised Date:	10/04/18

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following. There is an existing relationship with:

   a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

   b. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

   b. An out-of-network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; and

   c. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer

qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;

3. The Existing Out-of-Network Provider meets applicable professional standards and has no disqualifying quality of care issues;

4. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS;

5. The Existing Out-of-Network Provider is a California State Plan-approved provider;

6. The Existing Out-of-Network Provider supplies CalOptima with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan as allowed under federal and state privacy laws and regulations; and

7. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal beneficiary a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008 (Revised).: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the

Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population –Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, or Specialty Care Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the qualifying period stated in Section II.C.1., and include the last date upon which services were provided .

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a Provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP, Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming

appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section II.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS provider for up to twelve (12) months in accordance with Section II.C.1. of this Policy.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

iv. Appealing Continuity of Care Limitations

a) CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

1) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

2) A eligible Member, the Member's family or designated caregiver of the eligible Member may appeal the Continuity of Care limitation to the Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1401: Pharmacy Authorization Process
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy GG.1301: Comprehensive Case Management
F. CalOptima Policy GG.1209: Population- Based Care: Disease Management
G. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
H. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
I. CalOptima Policy GG.1401: Pharmacy Authorization Process
J. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
K. California Health and Safety Code, §1374.73
L. California Health and Safety Code, §1373.96
M. California Welfare and Institutions Code §§ 14094.13(a)-(d), 14094.13(d)
N. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
O. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care (Revised)
P. Department of Health Care Services, All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 10/18/18: Department of Health Care Services
B. 09/20/18: Department of Health Care Services
C. 06/26/18: Department of Health Care Services
D. 01/31/18: Department of Health Care Services
E. 07/11/17: Department of Health Care Services
F. 08/23/16: Department of Health Care Services
G. 05/15/15: Department of Health Care Services

VII. BOARD ACTION

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
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.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) Service Provider	There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
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 (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 Sections 41515.2 through 41518.9.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.[I]

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.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
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).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: 1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. 2. Psychiatric inpatient hospital services. 3. Targeted Case Management. 4. Psychiatrist services. 5. Psychologist services. 6. EPSDT supplemental Specialty Mental Health Services.

Term	Definition
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

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

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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

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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.

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[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).

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.

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[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;

- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

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[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: 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

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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

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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.

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[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).

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.

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[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;

- Health history. This includes both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs are required to establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

[12] See footnote 4. WIC Section 14094.11(b)(4).

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The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may understand the goals, treatment plan, and course of care the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;
- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams; and
- Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess members' risk levels and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

<u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination or upon a significant change to a member's condition.

[13] See footnote 4. WIC Section 14094.11(c).

WCM Transitioning Members

For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess members' risk levels and needs annually at CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless a member's risk level, all communications, whether by phone or mail, must inform the members and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and identify the method by which the providers will arrange for in-person assessments.[14]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination[15]

MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs that delegate the provision of CCS services to subcontractors must ensure that all subcontractors provide case management and care coordination for members and allow members to access CCS-paneled providers within all of the MCP's subcontracted provider networks for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- Medical therapy units;

[14] See Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population APL 99-005. APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[15] See footnote 4. WIC Section 14094.11(b)(1)-(6).

- EPSDT services, including palliative care;[16]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-Up Program**
   The High Risk Infant Follow-Up (HRIF) program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[17] MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide C.O.C. information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[18]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

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[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 APL 18-007, or any superseding APL.
[17] HRIF Eligibility Criteria is available at:
https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[18] See footnote 4. WIC Section 14094.12(j).

C. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive C.O.C. with existing CCS provider(s) for up to 12 months.[19] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding C.O.C.[20] The C.O.C. requirements extend to MCP's subcontractors. The sections below include additional C.O.C. requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized DME provider, MCPs must provide access to that provider for up to 12 months.[21] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the C.O.C. period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[22]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[23]

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing CCS-eligible members, their families, or designated caregivers, to request C.O.C. case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS

[19] See footnote 4. WIC Section 14094.13.
[20] See footnote 3. HSC Section 1373.96.
[21] See footnote 4. WIC Section 14094.12(f).
[22] See footnote 4. WIC Section 14094.13(b)(3).
[23] See footnote 4. WIC Section 14094.13(e), (f) and (g).

program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. Authorized Prescription Drugs

CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[24]

4. Extension of Continuity of Care Period[25]

MCPs, at their discretion, may extend the C.O.C. period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the C.O.C. period informing members of their right to request a C.O.C. extension and the WCM appeal process for C.O.C. limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the C.O.C. period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section D below).

Including the WCM C.O.C. protections set forth above, MCP members also have C.O.C. rights under current state law as required in the Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care APL 18-008, including any superseding APL.[26]

[24] See footnote 4. WIC Section 14094.13(d)(2).
[25] See footnote 3. HSC Section 1373.96.
[26] See footnote 14. APL 18-008.

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D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. This will not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a C.O.C. period.[27] MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to Section 1557 of the Affordable Care Act.[28]

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended C.O.C. with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments APL 17-006, including any superseding APL.

If MCPs deny requests for extended C.O.C., they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, including any superseding APL, when denying extended C.O.C. requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

E. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[29]

MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary

[27] See footnote 4. WIC Section 14094.13(j).
[28] See footnote 14. For Section 1557 requirements, see Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act APL 17-011, including any superseding APL.
[29] See Non-Emergency Medical and Non-Medical Transportation Services APL 17-010, including any superseding APL.

costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810.[30] These services include, but are not limited to, M&T for out-of-county and out-of-state services.

MCPs must also comply with all requirements listed in the Non-Emergency Medical and Non-Medical Transportation Services APL 17-010 for CCS-eligible members to obtain NEMT and NMT for services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.[31]

F. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontractor's provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition. If CCS-eligible members require services or treatments for a CCS condition that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

G. Advisory Committees

MCPs must establish a quarterly Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

[30] See footnote 1. CCS N.L. 03-0810.
[31] See footnote 14. APL 17-010.

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centers.[32] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[33] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also establish a quarterly Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions.[34]

III. WCM Payment Structure

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[35] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

The MCP will review authorizations and determine whether or not services meet CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo	MCP	MCP	MCP

[32] See footnote 4. WIC Section 14094.7(d)(3).
[33] See footnote 4. WIC Section 14094.17(b)(2).
[34] See footnote 4. WIC Section 14094.17(a).
[35] See footnote 4. WIC Section 14094.16(b).

IV. MCP Responsibilities to DHCS

A. Network Certification[36]

MCPs and their subcontractors are required to meet specific network certification requirements in order to participate in WCM, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals, SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[37]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontractors' provider networks to ensure network certification requirements for WCM are met.

In accordance with Network Certification Requirements APL 18-005, or any other superseding APL, WCM MCPs may request to add a subcontractor to their WCM network 105 days prior to the start of each contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[38] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[39] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[40]

MCPs are required to verify the credentials of all contracted CCS-paneled

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[36] See footnote 14. These requirements are further outlined in the Network Certification Requirements APL.
[37] See footnote 14. The WCM Provider Network Reporting Template is an attachment of APL 18-005.
[38] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[39] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[40] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and recredentialing guidelines contained in the Provider Credentialing/Recredentialing and Screening Enrollment APL 17-019, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[41]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and
- Procedures to detect both under- and over-utilization of health care services.

MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.

2. Reporting and Monitoring

DHCS has developed specific monitoring and oversight standards for MCPs participating in the WCM. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required

[41] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

data in a form and manner specified by DHCS and must comply with all contractual requirements.

D. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in the Subcontractual Relationships and Delegation APL 17-004, or any superseding APL. If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 10, 2018

ALL PLAN LETTER 18-008 *(REVISED)*
SUPERSEDES All PLAN LETTER 15-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL MEMBERS WHO TRANSITION INTO MEDI-CAL MANAGED CARE

PURPOSE:
The Department of Health Care Services (DHCS) is issuing this All Plan Letter (APL) to clarify continuity of care requirements for Medi-Cal members who transition into Medi-Cal managed care.[1] *This APL supersedes APL 15-019*.[2] *Revised text is found in italics.*

POLICY:
Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law, and the MCP contract, with some exceptions. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.

MCPs must provide continuity of care with an out-of-network provider when:

1. The MCP is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).

    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the MCP for a non-emergency visit, unless otherwise specified in this APL.

[1] *Continuity of care provisions for dual-eligible members (members eligible for both Medi-Cal and Medicare) in the Cal MediConnect program can be found at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx
[2] *APLs can be accessed at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

2. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates.

3. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means *the* MCP can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MCP members).

4. The provider is a California State Plan approved provider.

5. The provider supplies the MCP with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

MCPs are not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the *following:* durable medical equipment, transportation, other ancillary *service*, and carved-out service *providers*.

If a member changes MCPs, the 12-month continuity of care period may start over one time. If the member changes MCPs a second time (or more), the continuity of care period does not start over*;* the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls in an MCP, the continuity of care period does not start over. If a member changes MCPs, this continuity of care policy does not extend to providers that the member accessed through their previous MCP.

MCP Processes

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days following the receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when the MCP starts the process to determine if the member has a pre-existing relationship with the provider.

MCPs must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To

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complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

MCPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets all continuity of care requirements described above and the services that are the subject of the request meet the following requirements:

- *Occurred after the member's enrollment into the MCP*
- *Have dates of service after December 29, 2014* [3]
- *Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive continuity of care reimbursement*

Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

Validating Pre-existing Relationship
The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the MCP *that d*emonstrates a pre-existing relationship with *the* provider. A *member's self-attestation of* a pre-existing relationship *is not sufficient proof* (instead, actual documentation must be provided), unless the MCP makes this option available to *the member*.

Following identification of a pre-existing relationship, the MCP must determine if the provider is an in-network provider. If the provider is not an in-network provider, the MCP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

Request Completion Timeline
Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

[3] The first APL that addressed retroactive requests for continuity of care was APL 14-021, which was dated December 29, 2014.

A continuity of care request is considered completed when:

- The MCP notifies the member, in the manner outlined above, that the request has been approved;
- The MCP and the out-of-network Medi-Cal FFS provider are unable to agree to a rate;
- The MCP has documented quality of care issues with the Medi-Cal FFS provider;
- or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Requirements after the Request Process is Completed

If *the* MCP and the out-of-network *Medi-Cal* FFS provider are unable to reach an agreement because they cannot agree to a rate, or the MCP has documented quality of care issues with the provider, the MCP will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to *file a grievance*.

If a provider meets all of the necessary requirements, including *entering into a* letter of agreement or contract with the MCP, the MCP must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the MCP for a shorter timeframe. In this case, the MCP must allow the member to have access to that provider for the shorter period of time.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the MCP must work with the provider to establish a care plan for the member.

Upon approval of a continuity of care request, the MCP must notify the member of the following within seven calendar days:

- The request approval.
- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period.
- The member's right to choose a different provider from the MCP's provider network.

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The MCP must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition *the member's* care *to an in-network provider* at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

MCP Extended Continuity of Care Option
MCPs may choose to work with *a member's* out-of-network provider past the 12-month continuity of care period*; however, MCPs are* not required to do so to fulfill *the* obligations under this APL *or the MCP contract*.

Member and Provider Outreach and Education
MCPs must inform members of their continuity of care protections and must include information about these protections in member information packets and handbooks. This information must include how the member and provider initiate a continuity of care request with the MCP. The MCP must translate these documents into threshold languages and make them available in alternative formats, upon request. MCPs must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

Provider Referral Outside of the MCP Network
An approved out-of-network provider must work with the MCP and its contracted network and must not refer the member to another out-of-network provider without authorization from the MCP. In such cases, the MCP will make the referral, if medically necessary, if the MCP does not have an appropriate provider within its network.

NON-SPECIALTY MENTAL HEALTH SERVICES – CONTINUITY OF CARE FOR APPROVED PROVIDER TYPES:

MCPs are required to cover outpatient mental health services, as outlined in APL 17-018, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual.[4] County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for members under 21 years of age

[4] *APL 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," can be accessed at the following link: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx*

is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.[5]

MCPs must provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from the MCP. In this situation, the continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as "Psychology").[6]

The MCP must allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in the MCP's network for non-specialty mental health services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the MCP for non-specialty mental health services, the 12-month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to the MCP or changes MCPs (i.e., the member does not have the right to a new 12 months of continuity of care).

COVERED CALIFORNIA TO MEDI-CAL TRANSITION:
This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, the MCP must ask these members if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member

[5] *SMHS medical necessity criteria are outlined in Title 9 of the California Code of Regulations (CCR), Sections 1830.205 and 1830.210. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index*
[6] *State Plan Amendment (SPA) 14-012, Attachment 3.1-A is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CASPA14-012ApprovedPackageOriginalADA.pdf*

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enrolls in Medi-Cal, the MCP must contact the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. The MCP must make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

The MCP must honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

The MCP must, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with *the requirements in this APL.*

HEALTH HOMES PROGRAM – MEDI-CAL FFS TO MANAGED CARE TRANSITION:
MCPs must provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP).[7] *Because HHP services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.*

SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON MCP ENROLLMENT:
For a newly enrolled Seniors and Persons with Disabilities (SPDs), the MCP must honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the member or the provider.

[7] *More information on the Health Home Program services can be found here:* http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.

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BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON MCP TRANSITION:

MCPs are responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, MCPs must offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this APL are met. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the MCP must assign the member to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into an MCP, or the date of the member's enrollment into the MCP, if the enrollment date occurred after the transition.

MCPs must continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

<u>Transition of BHT Services from RCs to MCPs</u>

At least 45 days prior to the transition date, DHCS will provide MCPs with a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member-specific utilization data. MCPs must consider every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide MCPs with member utilization and assessment data from the RC prior to the service transition date. MCPs are required to use DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the MCP should attempt to contact the member's parent or guardian to determine *their* preference. If the MCP does not have access to member data that identifies an existing BHT provider, the MCP must contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the MCP in offering

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continuity of care. If the RC is unwilling to release specific provider rate information to the MCP, then the MCP may negotiate rates with the continuity of care provider without being bound by the usual requirement that the MCP offer at least a minimum FFS-equivalent rate. If the MCP is unable to complete a continuity of care agreement, the MCP must ensure that all ongoing services continue at the same level with an MCP in-network provider until the MCP has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

MCPs may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW:

In addition to the protections set forth above, MCP members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), MCPs must allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the MCP-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code *(HSC)* §1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under *HSC* §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the MCP as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member. This APL does not alter *the* MCP's obligation to fully comply with the requirements of *HSC* §1373.96. In addition to the requirements set forth in this APL, each MCP must allow for completion of covered services as required by *HSC* §1373.96, to the extent that doing so would allow a member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. MCPs must allow for the completion of these services for certain timeframes which are specific to each condition and defined under *HSC* §1373.96.

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PREGNANT AND POST-PARTUM BENEFICIARIES:
As noted above, *HSC* §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to *HSC* §1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into an MCP have the right to request out-of-network provider continuity of care for up to 12 months in accordance with *the* MCP contract and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care).

MEDICAL EXEMPTION REQUESTS:
A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to an MCP. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. MCPs are required to consider MERs that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with *APL 17-007.*[8]

REPORTING:
MCPs may be required to report on metrics related to any continuity of care provisions outlined in this APL, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

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

[8] *APLs can be accessed at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 4, 2003
Regular Meeting of the Cal Optima Board of Directors

Report Item
VIII. B. Approve CalOptima Continuity of Care Guidelines for Health Network Medi-Cal Members Required to Involuntarily Change Health Networks

Contact
Joyce Munsell, RN, CCM, MPA, Executive Officer, Medical Management
(714) 246-8400

Recommended Action
Approve CalOptima continuity of care guidelines for health network Medi-Cal members required to involuntarily change health networks.

Background
On December 2, 2002, Blue Cross of California notified CalOptima of its decision not to renew its contract with CalOptima for the Medi-Cal program effective March 31, 2003. Blue Cross' non-renewal of their CalOptima contract affects approximately 30,000 CalOptima members. These members will be required to change health networks and are likely to experience changes in their receipt of health services as well. To date, this is the largest health network membership that has been required to involuntarily change health networks. Because of the large volume of affected members, CalOptima staff believe it is necessary to take steps to assure the smooth transition of members to other contracted health networks in a manner that will not interrupt care of the members.

One of CalOptima's primary goals in planning for the transition of Blue Cross members to other health networks is to assure that affected members are provided continued and appropriate access to medical care, items and/or services without any disruption or delay. This includes members who are in active treatment plans, have medical supply or other ongoing medical care needs, or are in the process of being evaluated for essential medical care services.

CalOptima has undertaken steps to protect members from delays or disruptions in medical care, items and/or services during this transition and to prepare the health networks to which these members will be assigned. Strategies include working with Blue Cross to secure member-specific clinical data, analyzing data to target outreach efforts, and to provide detailed information to receiving health networks, conducting meetings and communicating with health network medical directors and care management staff, developing strategies to maintain physician-member relationships to the greatest extent possible, conducting intensive and targeted outreach to affected members, sending reminder letters to members, and developing a policy establishing continuity of care

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guidelines. The development of this policy is a critical step to support a smooth membership transition and to mitigate the potential for the disruption or delay in providing necessary medical care, items and/or services to members.

Discussion

This policy establishes continuity of care guidelines that will provide CalOptima and the health networks with standardized policies and procedures for handling a variety of circumstances where members will require uninterrupted medical care services during the involuntary transition from one health network to another health network.

The purpose of these guidelines is to ensure that members requiring uninterrupted medical care, items and/or services are not prohibited from accessing care, items and/or services due to potential administrative delays in re-evaluating a member's treatment plan, processing authorizations, or transferring care to new providers by the member's new health network. While, it is important that the member's new health network become involved in evaluating the member's current health status and medical care needs in order to transfer the member's care within its provider network, it is equally important that the re-evaluation process does not create a barrier for a member to have timely access to continuing medical items and/or services, that if not received, will be harmful to the member's health.

The key policy guideline components are:

- Requires that the receiving health network assume full responsibility for a member's care upon transition and assume financial risk for all medical items and/or services including payments to non-contracted providers and hospitals at the CalOptima Direct rates.

- Lays out the circumstances under which a receiving health network is required to continue existing medical care services while it assesses and determines the appropriateness of transferring care to new providers, new facilities or new vendors. Included are specific guidelines that address the continuity of care requirements for oncology services, transplant services, acute care services, post-surgical care services, prenatal and obstetrical care services, and durable medical equipment services. Guidelines also outline requirements for the receiving health network to honor a member's existing provider relationships in specified circumstances.

- Provides that if disputes arise regarding care to members, CalOptima's Chief Medical Officer (CMO) is the final arbiter and can authorize services for which the health network shall pay.

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Fiscal Impact

None to CalOptima; may require higher payments by health networks for some services if provider of services or hospital are not under contract.

Rationale for Recommendation

The policy will protect our member's access to timely medically necessary care during involuntary transitions by ensuring continuous and uninterrupted medical care, supplies and services.

Concurrence

Foley & Lardner

Attachments

None

Authorized Signature **Date** 1/29/03

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Modifications and Development of CalOptima Policies and Procedures Related to Whole-Child Model and Annual Policy Review

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

Authorize the Chief Executive Officer (CEO) to modify existing and develop new Policies and Procedures in connection with Whole Child Model initiative as follows:

1. FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group [Medi-Cal]
2. GG.1101: California Children's Services [Medi-Cal]
3. GG.1112: Standing Referral to Specialist Provider or Specialty Care Center [Medi-Cal, OneCare, OneCare Connect]
4. GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima [Medi-Cal]
5. GG.1330: Case Management – California Children's Services Program/Whole Child Model [Medi-Cal]
6. GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair [Medi-Cal, OneCare, OneCare Connect]
7. GG.1535: Utilization Review Criteria and Guidelines [Medi-Cal, OneCare, OneCare Connect]
8. GG. 1547: Maintenance and Transportation [Medi-Cal]

Background/Discussion

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified, laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated 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

CalOptima expects to integrate California Children's Services (CCS) into its Medi-Cal managed care plan through the Whole-Child Model (WCM) effective January 1, 2019. On June 7, 2018, the CalOptima Board of Directors authorized execution of an Amendment to the Primary Agreement between DHCS and CalOptima with respect to implementation of the WCM program. On September 6, 2018, the CalOptima Board of Directors authorized the Chief Executive Officer to modify existing and develop new Policies and Procedures in connection with WCM. Principle guidance is outlined in Senate Bill 586, signed by Governor Brown on September 25, 2016, and the DHCS's All Plan Letter

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(APL) 18-011 released on June 28, 2018. In addition, DHCS has provided additional reporting requirements and implementation deliverables.

Below is additional information regarding the new and modified policies:

1. ***FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group*** outlines CalOptima's payment methodologies for a provider or practitioner that provides covered services to a member of CalOptima Direct or a member enrolled in a shared risk group. For those members enrolled in a shared risk group, this policy shall only apply to covered services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR). CalOptima revised policy pursuant to the CalOptima annual review process to incorporate relevant language pertaining to the American Indian Health Service Program and ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 17-020: American Indian Health Programs, including APL attachment 1 (revised 08/07/18) and attachment 2 (revised 01/12/18).

2. ***GG.1101: California Children's Services***, which includes attachment A, defines the guidelines for coordination of care between CalOptima or a health network and the local California Children's Services (CCS) program for members eligible with the California Children's Services (CCS) program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible members, or new CCS members enrolling in CalOptima, including the identification and referral of members with CCS-eligible conditions. CalOptima revised policy pursuant to the CalOptima annual review process to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-011: California Children's Services Whole Child Model. Policy outlines CalOptima's responsibility for authorizations, claims and case management beginning January 1, 2019.

3. ***GG.1112: Standing Referral to Specialist Provider or Specialty Care Center*** defines the conditions under which CalOptima and its health networks shall authorize a standing referral to a specialty care provider or a specialty care center. CalOptima revised policy pursuant to the CalOptima annual review process to incorporate standing referrals for members with California Children's Services (CCS)-eligible conditions under the Whole Child Model (WCM) effective 01/01/19 and update references to include CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

4. ***GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima*** establishes the continuity of care guidelines and the process to identify members who have expedited care needs for newly enrolled Medi-Cal members who transition into CalOptima or existing members whose covered services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima. CalOptima revised policy pursuant to the CalOptima annual review process to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-008 *(revised)*: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care *(supersedes APL 15-019)* and APL 18-011 California Children's Services Whole Child Model Program.

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5. ***GG.1330: Case Management – California Children's Services Program/Whole Child Model*** defines the guidelines for the provision of case management by CalOptima or a health network to CalOptima members eligible with the California Children's Services (CCS) program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible members or new CCS members enrolling in CalOptima. CalOptima developed this policy to ensure compliance with the Department of Health Care Services (DHCS), All Plan Letter (APL) 18-011: California Children's Service Whole Child Model Program, as well as the Welfare and Institutions Code §§ 14094.7(d)(4)(C), 14094.11(b)(1)-(6), 14094.11(c), 14094.12(j), 14094.13(e)-(g).

6. ***GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair*** defines the criteria and process for coverage of a wheelchair, seating and positioning components (SPC), and accessories for a member. CalOptima revised policy pursuant to the CalOptima annual review process to align policy with current operational processes, clarify that a health network will provide continuity of care for CCS eligible members transitioning into the Whole Child Model (WCM) program with a specialized or customized durable medical equipment provider, and ensure compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program.

7. ***GG.1535: Utilization Review Criteria and Guidelines*** describes the process by which CalOptima establishes utilization criteria and guidelines to ensure that decisions related to utilization management and coverage or denial of organization determinations are made in a consistent manner and comport with program requirements and local and national care standards. CalOptima revised policy pursuant to the CalOptima review process to align policy with current operational processes and ensure compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program.

8. ***GG. 1547: Maintenance and Transportation*** defines the criteria and process for administration of the maintenance and transportation benefit for CalOptima members eligible with the California Children's Services (CCS) program. CalOptima revised policy pursuant to the CalOptima review process to align policy with current operational processes and ensure compliance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program.

Fiscal Impact

The recommended action to modify existing and develop new policies and procedures related to the WCM program and the annual policy review is a budgeted item, with no anticipated additional fiscal impact. Management has included projected medical and administrative expenses associated with the WCM program and the annual policy review in the CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018. Staff expects the budgeted expenses will be sufficient to cover the costs resulting from the revised or new policies and procedures.

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. FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group [Medi-Cal]
2. GG.1101: California Children's Services [Medi-Cal]
3. GG.1112: Standing Referral to Specialist Provider or Specialty Care Center [Medi-Cal, OneCare, OneCare Connect]
4. GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transfer into CalOptima [Medi-Cal]
5. GG.1330PP: Case Management – California Children's Services Program/Whole Child Model [Medi-Cal]
6. GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair [Medi-Cal, OneCare, OneCare Connect]
7. GG.1535: Utilization Review Criteria and Guidelines [Medi-Cal, OneCare, OneCare Connect]
8. GG. 1547PP: Maintenance and Transportation [Medi-Cal]
9. DHCS All Plan Letter 17-020: 17-020: American Indian Health Programs, including attachment 1 *(revised 08/07/18)* and attachment 2 *(revised 01/12/18)*.
10. DHCS All Plan Letter APL 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care
11. DHCS All Plan Letter 18-011 California Children's Services Whole Child Model Program

/s/ Michael Schrader — *9/26/2018*
Authorized Signature — **Date**

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Policy #:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	10/04/18~~06/01/17~~
Last Revised Date:	10/04/18~~06/01/17~~

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a Non-Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, shall be in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's prior authorization policies, shall be based on the following:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

   b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All

Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior authorization is required for non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: For dates of service after July 1, 2015, CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

B. Practitioner Payment: For purposes of this policy a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-Contracted Practitioner: CalOptima's reimbursement to a Non-Contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

a. Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner that provides Emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. .

ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program -paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse up thirteen cycles of oral contraceptives, a twelve (12) month supply of patches (36 patches), and a twelve (12) month supply of vaginal rings (12 rings), if such quantity is dispensed in an onsite clinic and billed by a Qualified Family Planning Provider, including a non-contracted Qualified Family Planning Provider, or dispensed by a pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife or Certified Nurse Practitioner services, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

   a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   b. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   c. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service ~~Facility~~ Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service ~~Facility~~Program:

   a. If the American Indian Health Service ~~Facility~~Program is a rural health clinic or qualifies as an FQHC, CalOptima shall reimburse the ~~facility~~program at the ~~facility's~~program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

   b. If the American Indian Health Service ~~Facility~~Program is a rural health clinic or FQHC, and CalOptima and the ~~facility~~program have agreed to an at-risk rate and the ~~facility~~program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the ~~facility~~program at the negotiated rate.

   c. If the American Indian Health Service ~~Facility~~Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the ~~facility~~program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service ~~Facility~~Program: CalOptima shall reimburse a non-contracted American Indian Health Service ~~Facility~~Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register . These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Program provider must be identified by DHCS;

   b. Service must be a Covered Service included in CalOptima's contract with DHCS;

   c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit;

      ~~i.~~iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of

CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Services Provider based on the terms and conditions of the contract between such Contracted Ancillary Service Provider and CalOptima.

2. CalOptima shall reimburse a Non-Contracted Ancillary Services Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Non-Contracted Hospitals, Non-Contracted Practitioners, and Non-Contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

H. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

I. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy HH.~~2022~~2022Δ: Record Retention and Access

I. CalOptima Policy HH.~~5000~~5000Δ: Provider Overpayment Investigation and Determination
J. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
K. Section 1932(b)(2)(D) of the Social Security Act
L. California Welfare and Institutions Code,§§, 14105.28 and 14166.245
M. California Health and Safety Code, §1797.1
N. This policy supersedes:
   a. CalOptima Financial Letter dated August 25, 1995: Fee-for-service rates
   b. CalOptima Financial Bulletin #3: Inpatient hospital reimbursement rates under "CalOptima Direct"
   c. CalOptima Financial Bulletin #5: Revised "CalOptima Direct" inpatient hospital rates
   d. CalOptima Financial Bulletin #10: Family planning services
   e. CalOptima Financial Bulletin #17: Additions to CalOptima Direct inpatient hospital rates
   f. CalOptima Financial Bulletin #19: CalOptima Direct rates effective October 1, 1999
   g. CalOptima Financial Bulletin #24: CalOptima Direct rates effective July 1, 2002
   h. CalOptima Financial Bulletin #29: CalOptima Direct rates effective March 1, 2004
O. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
~~P.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
~~Q.~~R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
~~R.~~S. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
~~S.~~T. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates For Emergency and Post-Stabilization Acute Inpatient Services Provided By Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
~~T.~~U. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-003(*revised*): Family Planning Services Policy for Contraceptive Supplies
~~U.~~V. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-017: Provision of Certified Nurse Midwife and Alternative Birth Center Facility Services (Revised)
~~V.~~W. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-016: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network "Border" Hospitals Under the Diagnostic Related Group Payment Methodology

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 07/06/16: Department of Health Care Services
C. 03/10/14: Department of Health Care Services
D. 12/10/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/06/13: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 11/05/09: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 11/06/08: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 10/02/08: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 06/03/08: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 12/04/07: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 06/05/07: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 06/04/02: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) 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, 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.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Services	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 not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
American Indian Health Services ~~Facility~~Program	~~Facilities~~Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.

Term	Definition
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

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Policy #: FF.1003
Title: **Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department: Claims Administration
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/07
Last Review Date: 10/04/18
Last Revised Date: 10/04/18

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a Non-Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, shall be in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's prior authorization policies, shall be based on the following:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

   b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All

Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior authorization is required for non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: For dates of service after July 1, 2015, CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

B. Practitioner Payment: For purposes of this policy a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-Contracted Practitioner: CalOptima's reimbursement to a Non-Contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

a. Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner that provides Emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: CalOptima shall reimburse a Non-Contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. .

ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program -paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case no less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse up thirteen cycles of oral contraceptives, a twelve (12) month supply of patches (36 patches), and a twelve (12) month supply of vaginal rings (12 rings), if such quantity is dispensed in an onsite clinic and billed by a Qualified Family Planning Provider, including a non-contracted Qualified Family Planning Provider, or dispensed by a pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife or Certified Nurse Practitioner services, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

c. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a rural health clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a rural health clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register . These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

i. Medical health visit;

ii. Mental health visit;

iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Services Provider based on the terms and conditions of the contract between such Contracted Ancillary Service Provider and CalOptima.

2. CalOptima shall reimburse a Non-Contracted Ancillary Services Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Non-Contracted Hospitals, Non-Contracted Practitioners, and Non-Contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

H. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

I. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy HH.2022Δ: Record Retention and Access
I. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
J. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
K. Section 1932(b)(2)(D) of the Social Security Act
L. California Welfare and Institutions Code,§§, 14105.28 and 14166.245

M. California Health and Safety Code, §1797.1
N. This policy supersedes:
   a. CalOptima Financial Letter dated August 25, 1995: Fee-for-service rates
   b. CalOptima Financial Bulletin #3: Inpatient hospital reimbursement rates under "CalOptima Direct"
   c. CalOptima Financial Bulletin #5: Revised "CalOptima Direct" inpatient hospital rates
   d. CalOptima Financial Bulletin #10: Family planning services
   e. CalOptima Financial Bulletin #17: Additions to CalOptima Direct inpatient hospital rates
   f. CalOptima Financial Bulletin #19: CalOptima Direct rates effective October 1, 1999
   g. CalOptima Financial Bulletin #24: CalOptima Direct rates effective July 1, 2002
   h. CalOptima Financial Bulletin #29: CalOptima Direct rates effective March 1, 2004
O. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
S. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
T. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates For Emergency and Post-Stabilization Acute Inpatient Services Provided By Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-003(*revised*): Family Planning Services Policy for Contraceptive Supplies
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-017: Provision of Certified Nurse Midwife and Alternative Birth Center Facility Services (Revised)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-016: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network "Border" Hospitals Under the Diagnostic Related Group Payment Methodology

VI. REGULATORY AGENCY APPROVALS

A. 11/09/17: Department of Health Care Services
B. 07/06/16: Department of Health Care Services
C. 03/10/14: Department of Health Care Services
D. 12/10/09: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 06/06/13: Regular Meeting of the CalOptima Board of Directors
C. 11/05/09: Regular Meeting of the CalOptima Board of Directors
D. 11/06/08: Regular Meeting of the CalOptima Board of Directors
E. 10/02/08: Regular Meeting of the CalOptima Board of Directors
F. 06/03/08: Regular Meeting of the CalOptima Board of Directors
G. 12/04/07: Regular Meeting of the CalOptima Board of Directors
H. 06/05/07: Regular Meeting of the CalOptima Board of Directors
I. 06/04/02: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) 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, 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.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Services	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 not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.

Term	Definition
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

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Policy #: GG.1101
Title: **California Children's Services Whole Child Model**
Department: Medical Affairs
Section: Utilization Management

CEO Approval: Michael Schrader _____

Effective Date: 10/01/95
Last Review Date: ~~11/01/17~~10/04/18
Last Revised Date: ~~11/01/17~~10/04/18

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a Health Network and ~~California Children's Services (CCS) for Children with Special Health Care Needs.~~the local California Children's Services (CCS) Program for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions.

II. POLICY

A. ~~CCS provides medical~~Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for 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 Members eligible with the CCS Program and transitioned into the WCM program, newly CCS-eligible Members or new CCS Members enrolling in CalOptima, with the exception of those services that are the responsibility of the Department of Health Care Services (DHCS).

1. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. The local CCS Program maintains responsibility for the following:

a. CCS Program eligibility determination, including responding to and tracking appeals related to CCS Program medical eligibility determinations and redeterminations; and

~~A.~~b. Medical case management, physical and occupational therapy services, and financial assistance to Members under the age of twenty-one (21) who are eligible for CCS ~~services.~~.

~~B.~~C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the local CCS ~~program~~Program for the coordination of CCS services to Members.

~~C.~~D. CalOptima, a Health Network, or a Practitioner~~,~~ shall identify Members who may have a CCS-Eligible Condition in accordance with this Policy.

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~~D.~~E. CalOptima, a Health Network~~,~~ or a Practitioner~~,~~ shall refer a Member to the local CCS Program within twenty-four (24) hours, or the next working day, after determining that the Member may have a CCS-Eligible Condition.

~~E. A Member's Primary Care~~ CalOptima, a Health Network, or a Practitioner ~~(PCP), Health Network, or Practitioner,~~ shall refer ~~the Member to~~ all Members, including new Members, newly 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~~ eligible Members, and WCM transition Members who may have developed a new CCS-Eligible Condition~~.~~

F. ~~CalOptima or a Health Network is~~, immediately to the local CCS Program for CCS eligibility determination and not ~~responsible for the provision or payment of services authorized by CCS for the treatment of a~~ wait until the annual CCS ~~Eligible Condition, after CCS determines that the Member is eligible for CCS~~ medical eligibility determination period.

~~1. CCS shall only reimburse CCS-paneled Providers and CCS-approved hospitals, for services authorized by CCS, for the treatment of a CCS-Eligible Condition.~~

G. CalOptima or a Health Network shall provide the following:

1. Provision and payment of Covered Services related to the identification, evaluation, and diagnosis of a CCS-Eligible Condition;

2. Medically Necessary Covered Services whether related or 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~~

~~4. Covered Services for a Member if CCS does not approve eligibility, in accordance with Section III.E. of this policy.~~

~~H. CalOptima or a Health Network shall designate a case manager to serve as a liaison to CCS to help coordinate services with CCS.~~

3. CalOptima or a Health Network shall only authorize and reimburse CCS-paneled providers and CCS-approved facilities for the treatment of a CCS-Eligible Condition 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.

H. CalOptima or a Health Network shall proactively ~~collaborate with CCS to~~ coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the local CCS Program for ongoing health care and case management services.

I. CalOptima or a Health Network shall proactively coordinate services for a WCM Member reaching twenty-one (21) years of age ~~from CCS to CalOptima Direct, a Health Network, or~~ , including but not limited to those Members eligible for services with the Genetically Handicapped Persons

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Program (GHPP~~).~~), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

~~J. 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.~~

J. CalOptima or a Health Network shall ensure the development of an Individual Care Plan, Case Management, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

K. 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: Coordination of Care for Members With Expedited Health Care Needs and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

L. 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.

M. CalOptima and its Health Networks 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.

N. 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.

III. PROCEDURE

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 ~~may~~ shall provide training and resources to Practitioners and PCPs to ensure timely identification of Members with potential CCS-Eligible Conditions and notification to the local CCS Program.

~~B.~~C. CalOptima or a Health Network shall identify ~~a Member~~Members for CCS-Eligible Conditions through ~~a referral which may be made through,~~various means, including but ~~is~~ not limited to:

~~1. Utilization Management;~~

1. 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;

~~2.~~ Screening of all Members referred for Case Management~~;~~

~~3. PCP;~~

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~~4. Specialist;~~

~~5. Pharmacy;~~ and

~~6.~~ or Disease Management~~.~~

2. ~~CalOptima,~~ services or who are currently enrolled in a ~~Health Network, or a Practitioner,~~Case or Disease Management program; and

3. Review of pharmacy data.

~~C.~~D. CalOptima shall refer a Member to ~~CCS~~the local CCS Program for a medical eligibility determination after identifying ~~and determining~~ that the Member's medical condition may qualify him or her for CCS.

1. ~~CalOptima, a Health Network, or a~~A Practitioner~~,~~ shall refer a Member ~~to~~for CCS ~~by completing the following steps~~medical eligibility determination as follows:

~~A. Contacting the Member's PCP and requesting the Member's Medical Records;~~

~~b.~~a. ~~Ensuring the completion of~~Completing a Service Authorization Request (SAR) form~~,~~ ~~identifying which services the Member may be eligible for~~ or Health Network Authorization Request Form, and submitting the ~~SAR to the Orange County CCS office~~request to CalOptima; and

~~c.~~b. Ensuring the submission of all supporting medical documentation and information needed ~~by CCS to process the SAR~~to determine CCS medical eligibility and to determine the Medical Necessity of the services required.

~~D. If a Member is approved for CCS:~~

~~1. A~~ CalOptima ~~or Health Network case manager~~ shall ~~help coordinate~~facilitate the ~~Member's~~CCS medical eligibility determination by the local 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~~Program by submitting the SAR/Authorization Request Form and ~~approved by a CalOptima or Health Network Medical Director prior~~supporting medical documentation 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.~~2. ~~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~~local CCS Program.

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~~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.~~

~~H. CalOptima, or a Member's Health Network, shall contact a Member at least one hundred twenty (120) calendar days prior to the Member reaching twenty-one (21) years of age to help transition services from CCS to CalOptima Direct, a Health Network, or GHPP.~~

E. The local 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 Provider or Health Network.

2. Disagreements between CalOptima and the local CCS Program regarding CCS medical eligibility determinations must be resolved by the local CCS program, in consultation with DHCS. The local CCS Program shall communicate all resolved disputes in writing to CalOptima within a timely manner. Disputes between CalOptima and the local CCS Program that are unable to be resolved will be referred by either entity to DHCS.

3. Members appealing a CCS eligibility determination must appeal to the local CCS program.

F. Member Grievances

1. CalOptima shall ensure Members are provided information on and are provided the same grievances, appeals and state fair hearing rights in accordance with CalOptima Policies HH.1102: CalOptima Member Compliant, HH.1108: State Hearing Process, and GG.1510: Appeals Process for Decisions Regarding Care and Services.

G. Provider Grievances

1. A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the CalOptima or Health Network directly to CalOptima 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.

IV. ATTACHMENTS

~~a. Application to Determine CCS Program Eligibility~~
~~B.~~A. New Referral CCS~~/GHPP~~ Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model

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~~C.~~D. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
~~D.~~E. CalOptima Health Network Service Agreement
~~E.~~F. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
G. California Welfare and Institutions Code §§14093.06(b) and 14094.15(d)
H. CalOptima Policy GG.1116: Pediatric Preventive Services
I. CalOptima Policy GG.1325: Coordination of Care for Members With Expedited Health Care Needs
J. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
L. CalOptima Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Policy GG.1547: Maintenance and Transportation
P. CalOptima Policy GG.1600: Access and Availability Standards
Q. CalOptima Policy GG.1619: Delegation Oversight
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy HH.1102: CalOptima Member Complaint
T. CalOptima Policy HH.1108: State Hearing Process
U. CalOptima Policy FF.2003: Coordination of Benefits
V. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

~~None to Date~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(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/Whole Child Model	Medi-Cal

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IX. GLOSSARY

Term	Definition
~~Authorized Representative~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: 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 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 sections41515.2 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.
Children with Special Health Care Needs	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).
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.

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Term	Definition
~~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 to Members assigned to that Health Network.
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.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
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.
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.

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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, 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).~~.

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Policy #:	GG.1101
Title:	**California Children's Services Whole Child Model**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
Last Review Date:	10/04/18
Last Revised Date:	10/04/18

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a Health Network and the local California Children's Services (CCS) Program for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions.

II. POLICY

A. Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for 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 Members eligible with the CCS Program and transitioned into the WCM program, newly CCS-eligible Members or new CCS Members enrolling in CalOptima, with the exception of those services that are the responsibility of the Department of Health Care Services (DHCS).

1. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. The local CCS Program maintains responsibility for the following:

a. CCS Program eligibility determination, including responding to and tracking appeals related to CCS Program medical eligibility determinations and redeterminations; and

b. Medical case management, physical and occupational therapy services, and financial assistance to Members under the age of twenty-one (21) who are eligible for CCS.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the local CCS Program for the coordination of CCS services to Members.

D. CalOptima, a Health Network, or a Practitioner shall identify Members who may have a CCS-Eligible Condition in accordance with this Policy.

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E. CalOptima, a Health Network or a Practitioner shall refer a Member to the local CCS Program within twenty-four (24) hours, or the next working day, after determining that the Member may have a CCS-Eligible Condition.

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 the local CCS Program for CCS eligibility determination and not wait until the annual CCS medical eligibility determination period.

G. CalOptima or a Health Network shall provide the following:

1. Provision and payment of Covered Services related to the identification, evaluation, and diagnosis of a CCS-Eligible Condition;

2. Medically Necessary Covered Services whether related or unrelated to a Member's CCS-Eligible Condition;

3. CalOptima or a Health Network shall only authorize and reimburse CCS-paneled providers and CCS-approved facilities for the treatment of a CCS-Eligible Condition 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.

H. CalOptima or a Health Network shall proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the local CCS Program for ongoing health care and case management services.

I. 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 Program/Whole Child Model.

J. CalOptima or a Health Network shall ensure the development of an Individual Care Plan, Case Management, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model.

K. 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: Coordination of Care for Members With Expedited Health Care Needs and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

L. 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.

M. CalOptima and its Health Networks 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.

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N. 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.

III. PROCEDURE

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 training and resources to Practitioners and PCPs to ensure timely identification of Members with potential CCS-Eligible Conditions and notification to the local CCS Program.

C. CalOptima or a Health Network shall identify Members for CCS-Eligible Conditions through various means, including but not limited to:

1. 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;

2. Screening of all Members referred for Case Management and or Disease Management services or who are currently enrolled in a Case or Disease Management program; and

3. Review of pharmacy data.

D. CalOptima shall refer a Member to the local CCS Program for a medical eligibility determination after identifying that the Member's medical condition may qualify him or her for CCS.

1. A Practitioner shall refer a Member for CCS medical eligibility determination as follows:

a. Completing a Service Authorization Request (SAR) form or Health Network Authorization Request Form, and submitting the request to CalOptima; and

b. 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 required.

2. CalOptima shall facilitate the CCS medical eligibility determination by the local CCS Program by submitting the SAR/Authorization Request Form and supporting medical documentation to the local CCS Program.

E. The local 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 Provider or Health Network.

2. Disagreements between CalOptima and the local CCS Program regarding CCS medical eligibility determinations must be resolved by the local CCS program, in consultation with DHCS. The local CCS Program shall communicate all resolved disputes in writing to

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CalOptima within a timely manner. Disputes between CalOptima and the local CCS Program that are unable to be resolved will be referred by either entity to DHCS.

3. Members appealing a CCS eligibility determination must appeal to the local CCS program.

F. Member Grievances

1. CalOptima shall ensure Members are provided information on and are provided the same grievances, appeals and state fair hearing rights in accordance with CalOptima Policies HH.1102: CalOptima Member Compliant, HH.1108: State Hearing Process, and GG.1510: Appeals Process for Decisions Regarding Care and Services.

G. Provider Grievances

1. A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the CalOptima or Health Network directly to CalOptima 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.

IV. ATTACHMENTS

A. New Referral CCS Client Service Authorization Request (SAR)

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model
D. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
E. CalOptima Health Network Service Agreement
F. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
G. California Welfare and Institutions Code §§14093.06(b) and 14094.15(d)
H. CalOptima Policy GG.1116: Pediatric Preventive Services
I. CalOptima Policy GG.1325: Coordination of Care for Members With Expedited Health Care Needs
J. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
L. CalOptima Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Policy GG.1547: Maintenance and Transportation
P. CalOptima Policy GG.1600: Access and Availability Standards
Q. CalOptima Policy GG.1619: Delegation Oversight
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy HH.1102: CalOptima Member Complaint
T. CalOptima Policy HH.1108: State Hearing Process
U. CalOptima Policy FF.2003: Coordination of Benefits

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V. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(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/Whole Child Model	Medi-Cal

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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 sections41515.2 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.
Children with Special Health Care Needs	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).
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.
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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

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Term	Definition
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.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
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.
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.

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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.1112
Title:	**Standing Referral to Specialty Care Provider or Specialty Care Center**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/99
Last Review Date:	~~03/01/17~~10/04/18
Last Revised Date:	~~03/01/17~~10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the conditions under which CalOptima and its Health Networks shall authorize a Standing Referral to a Specialty Care Provider or a Specialty Care Center.

II. POLICY

A. CalOptima and its Health Networks may authorize a Standing Referral for a Member who requires treatment for a medical condition or disease that is life threatening, degenerative, or disabling, and that requires specialized medical care over a prolonged period, including, but not limited to, a Member diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

B. Subject to the provisions of this policy, CalOptima or a Health Network may authorize a Standing Referral for a Member if the Member's Primary Care Practitioner (PCP), in consultation with the Health Network or CalOptima Medical Director and a Specialty Care Provider or Specialty Care Center, determines that the Member needs continuing care from a Specialty Care Provider or a Specialty Care Center.

C. A Member, Authorized Representative, Primary Care Physician (PCP), or Specialty Care Provider may submit a request for a Standing Referral or Extended Referral to CalOptima.

D. If CalOptima or a Health Network determines that a Standing Referral is necessary, CalOptima or the Health Network shall make the referral according to a treatment plan approved by CalOptima or the Health Network in consultation with the PCP, Specialty Care Provider or Specialty Care Center, and the Member.

E. An authorization for a Standing Referral to a Specialty Care Provider or Specialty Care Center may:

1. Designate the duration of continuing care;

2. Require communication between the Specialty Care Provider or Specialty Care Center and the Member's PCP or the CalOptima Medical Director; and/or

3. Delineate the process by which the Member, Authorized Representative, PCP, or Specialty Care Provider or Specialty Care Center may request additional referrals, as needed.

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F. This policy does not require CalOptima or a Health Network to authorize a referral to a Specialty Care Provider or Specialty Care Center that is not employed or contracted with CalOptima or the Health Network to provide Covered Services to Members, unless there is no Specialty Care Provider or Specialty Care Center within the network that is qualified to provide the specialty care to the Member.

G. ~~CalOptima and a Health Network is not responsible~~When the requirements for ~~authorizing~~ a Standing Referral ~~if~~for the treatment of California Children's Services (CCS) ~~program authorizes the Specialty Care Provider~~Program-Eligible Conditions are meet for CCS-eligible Members n the Whole Child Model program, Standing Referrals shall only be made by CalOptima or a Health Network to CCS paneled providers or Specialty Care Center ~~service, including services for a CCS-eligible Member diagnosed with HIV or AIDS.~~ qualified to treat the CCS-Eligible Condition.

III. PROCEDURE

A. A Member's PCP and Specialty Care Provider or Specialty Care Center shall develop a treatment plan with the Member's participation. The treatment plan may limit the number of visits to the Specialty Care Provider or Specialty Care Center, define the services authorized, or limit the period of time for which the visits are authorized.

B. CalOptima or a Health Network may waive the requirement for a treatment plan if it approves an existing Standing Referral to a Specialty Care Provider or Specialty Care Center.

~~A.~~C. A request for a Standing Referral shall include:

1. Member's diagnosis;

2. Required treatment;

3. Requested frequency and duration of care from the Specialty Care Provider or Specialty Care Center; and

4. Relevant clinical information to support the request.

~~C.~~D. Upon request from a Member's PCP or a Specialty Care Provider for a Standing Referral, the following shall occur:

1. CalOptima or a Health Network shall make a determination on the Standing Referral request within three (3) business days after receipt of the appropriate medical records and other information necessary to evaluate the request;

2. CalOptima or a Health Network shall notify the Member, the Member's PCP, or the Specialty Care Provider or Specialty Care Center of a decision to deny, defer, modify, or terminate a request for a Standing Referral in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization; and

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3. Upon approval of a request for a Standing Referral, CalOptima or a Health Network shall provide the referral to the approved Specialty Care Provider or Specialty Care Center within four (4) business days after the determination.

~~D.~~E. A Specialty Care Provider shall provide a Member's PCP with regular reports on the health care provided to the Member in accordance with CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities, and the conditions outlined in this policy.

F. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in CalOptima Direct (COD)-Administrative or CalOptima Community Network (CCN) in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

G. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in a Health Network in accordance with the Health Network's authorization rules. s.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Policy GG.1113: ~~Referral~~Specialty Practitioner Responsibilities
E. CalOptima Policy GG.1500: Authorization Instructions for COD and CalOptima Community Network Providers
~~E.~~F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~F.~~G. CalOptima Three-way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~G.~~H. Health and Safety Code, Section 1374.16
~~H.~~I. Title 42, Code of Federal Regulations (C.F.R), Section 438.208(c)(4)

VI. REGULATORY AGENCY APPROVALS

A. 03/28/16: Department of Health Care Services

VII. BOARD ACTIONS

~~Not Applicable~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/1999	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal
Revised	06/01/2007	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal
Revised	11/01/2015	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	02/01/2016	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	03/01/2017	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009.
California Children Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible ~~children~~individuals under the age of twenty-one (2l) 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 ~~Conditions~~Condition	~~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 defined in Title 22, California Code of Regulations sections41515.2 through 41518.9. ~~, Sec4187, 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~~ ~~17. Accidents, poisonings, violence, and immunization reactions.~~tion 41800..

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Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: 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 Centers of Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) Three-Way Contract.
Extended Referral	A referral to a specialist for more than one (1) visit, where the Member's condition or disease requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling, and requires a specialist to coordinate the Member's health care (including some or all primary care).
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.
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, "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 or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic ~~in accordance with W & I Code 14182(b)(11).~~
Specialty Care Center	A center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

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Term	Definition
Specialty Care Provider	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Standing Referral	A referral to a specialist for more than one (1) visit, as indicated in an Active Treatment Plan, if any, without the Provider having to provide a specific referral for each visit.

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Policy #:	GG.1112
Title:	**Standing Referral to Specialty Care Provider or Specialty Care Center**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/99
Last Review Date:	10/04/18
Last Revised Date:	10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the conditions under which CalOptima and its Health Networks shall authorize a Standing Referral to a Specialty Care Provider or a Specialty Care Center.

II. POLICY

A. CalOptima and its Health Networks may authorize a Standing Referral for a Member who requires treatment for a medical condition or disease that is life threatening, degenerative, or disabling, and that requires specialized medical care over a prolonged period, including, but not limited to, a Member diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

B. Subject to the provisions of this policy, CalOptima or a Health Network may authorize a Standing Referral for a Member if the Member's Primary Care Practitioner (PCP), in consultation with the Health Network or CalOptima Medical Director and a Specialty Care Provider or Specialty Care Center, determines that the Member needs continuing care from a Specialty Care Provider or a Specialty Care Center.

C. A Member, Authorized Representative, Primary Care Physician (PCP), or Specialty Care Provider may submit a request for a Standing Referral or Extended Referral to CalOptima.

D. If CalOptima or a Health Network determines that a Standing Referral is necessary, CalOptima or the Health Network shall make the referral according to a treatment plan approved by CalOptima or the Health Network in consultation with the PCP, Specialty Care Provider or Specialty Care Center, and the Member.

E. An authorization for a Standing Referral to a Specialty Care Provider or Specialty Care Center may:

1. Designate the duration of continuing care;

2. Require communication between the Specialty Care Provider or Specialty Care Center and the Member's PCP or the CalOptima Medical Director; and/or

3. Delineate the process by which the Member, Authorized Representative, PCP, or Specialty Care Provider or Specialty Care Center may request additional referrals, as needed.

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F. This policy does not require CalOptima or a Health Network to authorize a referral to a Specialty Care Provider or Specialty Care Center that is not employed or contracted with CalOptima or the Health Network to provide Covered Services to Members, unless there is no Specialty Care Provider or Specialty Care Center within the network that is qualified to provide the specialty care to the Member.

G. When the requirements for a Standing Referral for the treatment of California Children's Services (CCS) Program-Eligible Conditions are meet for CCS-eligible Members n the Whole Child Model program, Standing Referrals shall only be made by CalOptima or a Health Network to CCS paneled providers or Specialty Care Center qualified to treat the CCS-Eligible Condition.

III. PROCEDURE

A. A Member's PCP and Specialty Care Provider or Specialty Care Center shall develop a treatment plan with the Member's participation. The treatment plan may limit the number of visits to the Specialty Care Provider or Specialty Care Center, define the services authorized, or limit the period of time for which the visits are authorized.

B. CalOptima or a Health Network may waive the requirement for a treatment plan if it approves an existing Standing Referral to a Specialty Care Provider or Specialty Care Center.

C. A request for a Standing Referral shall include:

1. Member's diagnosis;

2. Required treatment;

3. Requested frequency and duration of care from the Specialty Care Provider or Specialty Care Center; and

4. Relevant clinical information to support the request.

D. Upon request from a Member's PCP or a Specialty Care Provider for a Standing Referral, the following shall occur:

1. CalOptima or a Health Network shall make a determination on the Standing Referral request within three (3) business days after receipt of the appropriate medical records and other information necessary to evaluate the request;

2. CalOptima or a Health Network shall notify the Member, the Member's PCP, or the Specialty Care Provider or Specialty Care Center of a decision to deny, defer, modify, or terminate a request for a Standing Referral in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization; and

3. Upon approval of a request for a Standing Referral, CalOptima or a Health Network shall provide the referral to the approved Specialty Care Provider or Specialty Care Center within four (4) business days after the determination.

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E. A Specialty Care Provider shall provide a Member's PCP with regular reports on the health care provided to the Member in accordance with CalOptima Policy GG.1113: Specialty Practitioner Responsibilities, and the conditions outlined in this policy.

F. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in CalOptima Direct (COD)-Administrative or CalOptima Community Network (CCN) in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

G. A Provider or Practitioner shall obtain authorization for Covered Services for Members enrolled in a Health Network in accordance with the Health Network's authorization rules. s.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Policy GG.1113: Specialty Practitioner Responsibilities
E. CalOptima Policy GG.1500: Authorization Instructions for COD and CalOptima Community Network Providers
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Three-way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
H. Health and Safety Code, Section 1374.16
I. Title 42, Code of Federal Regulations (C.F.R), Section 438.208(c)(4)

VI. REGULATORY AGENCY APPROVALS

A. 03/28/16: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/1999	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal
Revised	06/01/2007	GG.1112	Standing Referral to Specialist Practitioner or Specialty Care Center	Medi-Cal

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2015	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	02/01/2016	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	03/01/2017	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1112	Standing Referral to Specialty Care Provider or Specialty Care Center	Medi-Cal OneCare OneCare Connect

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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.
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 defined in Title 22, California Code of Regulations sections41515.2 through 41518.9. tion 41800..
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) Three-Way Contract.
Extended Referral	A referral to a specialist for more than one (1) visit, where the Member's condition or disease requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling, and requires a specialist to coordinate the Member's health care (including some or all primary care).
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.

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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, or eligible for the Whole Child Model, "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 or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic.
Specialty Care Center	A center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
Specialty Care Provider	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Standing Referral	A referral to a specialist for more than one (1) visit, as indicated in an Active Treatment Plan, if any, without the Provider having to provide a specific referral for each visit.

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Policy #:	GG.1325
Title:	~~Coordination~~**Continuity of Care for ~~Newly Enrolled Medi-Cal~~ Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/15
Review Date:	~~11/01/17~~10/04/18
Revised Date:	~~11/01/17~~10/04/18

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process ~~for identifying~~to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima~~.~~ or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal ~~Fee-For-Service (~~FFS~~), or~~, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her ~~out~~Existing Out-of-~~network nursing facility, Primary Care Practitioner (PCP), or Specialty Care~~Network Provider~~,~~ for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, ~~from the date of the Member's transition into CalOptima,~~ if the following criteria are met:

1. ~~The~~A Member has an existing relationship with one (1) of the ~~nursing facility or Provider. An~~ following. There is an existing relationship ~~requires~~with:

~~1.~~a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member ~~having~~has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima ~~for a PCP, Behavioral Health Treatment (BHT) provider, or all other Specialty Care Providers~~;

~~The~~ b. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

b. An out-of-network nursing facility~~, PCP, or~~ if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; and

c. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty ~~Care~~Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider~~,~~ will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;

3. The ~~nursing facility, PCP, or Specialty Care~~Existing Out-of-Network Provider~~,~~ meets applicable professional standards and has no disqualifying quality of care issues;

4. ~~The nursing facility, PCP or Specialty Care~~The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS;

5. The ~~nursing facility, PCP, or Specialty Care~~Existing Out-of-Network Provider~~,~~ is a California State Plan-approved provider;

6. The ~~nursing facility, PCP or Specialty Care~~Existing Out-of-Network Provider supplies CalOptima with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan as allowed under federal and state privacy laws and regulations; and

7. The Member, Authorized Representative of the Member, or the ~~PCP or Specialty Care~~Existing Out-of-Network Provider~~, request~~ requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member ~~with the Member's out-of-network PCP, or Specialty Care Provider~~as described in this Policy, except for the following types of providers:

~~1. Durable Medical Equipment (DME);~~
1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. ~~Ancillary~~Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal beneficiary a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008~~:~~ (Revised).: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved ~~out-of-network nursing facility, PCP or Specialty Care~~Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population –Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, or Specialty Care Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. ~~Resides~~Residing in an out-of-network nursing facility prior to enrollment ~~to~~in CalOptima, or ~~receives~~prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

   a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

   b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the ~~last twelve (12) months~~qualifying period stated in Section II.C.1., and include the last date ~~of the last visit~~upon which services were provided .

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a Provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP ~~or,~~ Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the ~~PCP or Specialty Care~~Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned ~~to their FFS, or Covered California PCP, Specialty Care Provider, or other health care provider,~~Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

   a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the ~~out~~Existing Out-of-~~network FFS provider~~Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance ~~and/or appeal~~, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the ~~out~~Existing Out-of-~~network PCP and/or Specialty Care Providers~~Network Provider of the transition ~~process~~of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

~~1.~~2. Have dates of service(s) that occur after ~~March 2, 2018~~December 29, 2014;

~~2.~~3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the ~~out~~Existing Out-of-~~network PCP, or Specialty Care~~Network Provider~~,~~ requested Continuity of Care retroactive reimbursement; and

~~3.~~4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

   a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

   b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

   c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

   d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated~~,~~ or out-of-network~~,~~ providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

   a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

      i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with ~~CalOptima Policy GG.1508: Authorization and Processing of Referrals~~the Policy.

   b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

~~3. Children Diagnosed with Autism Spectrum Disorder~~

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT ~~providers~~Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the ~~Regional Center of Orange County (~~RCOC~~)~~

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima ~~or a contracted BHT vendor~~ shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT ~~and shall utilize diagnosis, utilization, and assessment data provided by RCOC, or DHCS, to proactively identify current BHT providers. In the absence of data, CalOptima, or a contracted BHT vendor, shall contact the Member's parent(s), or guardian, to obtain the necessary information~~services.

c. ~~CalOptima or a contracted BHT vendor~~If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

~~c.~~d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima~~, or a contracted BHT vendor,~~ shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the ~~following~~ criteria as described in Section II.C. of the Policy are met~~:~~.

~~a) The Member has an existing relationship with the BHT Provider;~~

~~i. The BHT Provider will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;~~

~~ii. The BHT Provider meets applicable professional standards and has no disqualifying quality of care issues;~~

~~iii. The BHT Provider is a State Plan approved provider, as defined in Health & Safety Code Section 1374.73; and~~

~~iv. Relevant documents, including but not limited to assessments and treatment plans are provided to CalOptima by the BHT Provider to facilitate Continuity of Care.~~

~~d.~~e. If CalOptima ~~or a contracted BHT vendor~~ and the Member's existing BHT ~~provider~~Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima~~, or a contracted BHT vendor,~~ shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima~~, or a contracted BHT vendor,~~ shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

   a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

   a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

   b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

   c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

   a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

   b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS provider for up to twelve (12) months in accordance with Section II.C.1. of this Policy.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility

for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

iv. Appealing Continuity of Care Limitations

a) CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

1) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

2) A eligible Member, the Member's family or designated caregiver of the eligible Member may appeal the Continuity of Care limitation to the Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

~~A. California Health and Safety Code, §1374.73~~
~~B.~~A. ~~California Health and Safety Code, §1373.96~~
~~C.~~A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~B. CalOptima Policy GG.1401: Pharmacy Authorization Process
~~E.~~C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~F.~~D. CalOptima Policy HH.1102: CalOptima Member Complaint
~~G.~~E. CalOptima Policy GG.1301: Comprehensive Case Management
~~H.~~F. CalOptima Policy GG.1209: Population- Based Care: Disease Management
~~I.~~G. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment

H. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
I. CalOptima Policy GG.1401: Pharmacy Authorization Process
J. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
K. California Health and Safety Code, §1374.73
L. California Health and Safety Code, §1373.96
M. California Welfare and Institutions Code §§ 14094.13(a)-(d), 14094.13(d)
~~J.~~N. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
~~K.~~O. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care (Revised)
~~L.~~P. Department of Health Care Services, All Plan Letter (APL) ~~16-001 Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications~~18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 06/26/18: Department of Health Care Services
B. 01/31/18: Department of Health Care Services
C. 07/11/17: Department of Health Care Services
D. 08/23/16: Department of Health Care Services
E. 05/15/15: Department of Health Care Services

VII. BOARD ACTION

~~None to Date~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
Authorized Representative	~~Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) ~~Providers~~Service Provider	~~Providers that are State Plan approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals. For purposes of this policy, BHT providers are considered Specialty Care Providers.~~There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
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 (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 sections41515.2 through 41518.9.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.

Term	Definition
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.[
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.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
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).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. B. Psychiatric inpatient hospital services. C. Targeted Case Management. D. Psychiatrist services. E. Psychologist services. F. EPSDT supplemental Specialty Mental Health Services.

Term	Definition
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

Policy #:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Services**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader
Effective Date:	01/01/15
Review Date:	10/04/18
Revised Date:	10/04/18

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify Members who have expedited care needs for newly enrolled Medi-Cal Members who transition into CalOptima or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima.

II. POLICY

A. Effective July 1, 2017, CalOptima shall screen all new Members for the need for expedited services upon their enrollment into CalOptima as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with this Policy, CalOptima or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following. There is an existing relationship with:

   a. An out-of-network Primary Care Practitioner (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima;

   b. An out-of-network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima or the date of the Member's initial enrollment in CalOptima if the enrollment occurred on or after July 1, 2018;

   b. An out-of-network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima; and

   c. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer

qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima.

2. The Existing Out-of-Network Provider will accept CalOptima, or Medi-Cal FFS rates, whichever is higher;

3. The Existing Out-of-Network Provider meets applicable professional standards and has no disqualifying quality of care issues;

4. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS;

5. The Existing Out-of-Network Provider is a California State Plan-approved provider;

6. The Existing Out-of-Network Provider supplies CalOptima with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan as allowed under federal and state privacy laws and regulations; and

7. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to enrollment in CalOptima or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

D. CalOptima or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program as described in Section III.O.8.b.i. of this Policy;

2. Transportation; and

3. Other ancillary services.

E. CalOptima and Health Networks are also required to comply with existing state law Continuity of Care obligations which may allow a Medi-Cal beneficiary a longer period of treatment by an out-of-network provider than would be required under DHCS All Plan Letter 18-008 (Revised).: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

F. CalOptima or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima's contract with the Department of Health Care Services (DHCS).

G. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the

Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to providers that the beneficiary accessed through their previous MCP. If the Member returns to Medi-Cal FFS and later reenrolls in CalOptima, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima enrollment period.

H. An approved Existing Out-of-Network Provider must work with CalOptima and its contracted network and cannot refer the Member to another out-of-network provider without prior authorization from CalOptima or a Health Network.

I. CalOptima shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima website at www.caloptima.org, and Member newsletter.

J. CalOptima or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care protections.

III. PROCEDURE

A. CalOptima shall include a health information form in each New Member Welcome Packet mailing with a postage paid envelope.

1. If the Member does not respond to the mailed health information form, CalOptima shall make two (2) call attempts within ninety (90) calendar days to remind the Member to complete the form.

B. CalOptima shall conduct an initial screening of all responses received within ninety (90) calendar days of the Members' effective date(s) of enrollment.

1. Additional outreach and care coordination activities may occur in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process and GG.1209: Population –Based Care: Disease Management.

2. Upon disenrollment, CalOptima shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. Upon request from the Member, and in accordance with the requirements of this Policy, CalOptima or a Health Network shall provide the completion of Covered Services by an out-of-network nursing facility, PCP, or Specialty Care Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the out-of-network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima, or prior to receiving long term care benefits from CalOptima: Up to twelve (12) months.

D. CalOptima or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima's Customer Service Department shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested provider.

a. CalOptima shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

b. If CalOptima does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a provider in accordance with the criteria included in Section II.C.1. of this Policy, a provider shall submit a signed attestation to CalOptima that confirms the provider saw the Member for a medical visit within the qualifying period stated in Section II.C.1., and include the last date upon which services were provided .

i. A self-attestation from a Member is insufficient to provide proof of a relationship with a provider.

c. The Continuity of Care process shall begin when CalOptima or the Health Network begin the process to determine if the Member has a pre-existing relationship with the provider.

d. If DHCS has notified CalOptima of a Provider suspension, termination, or decertification, CalOptima, or a Health Network, shall not approve the Continuity of Care request.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima's Case Management Department for access to care issues.

F. For access to care issues, CalOptima's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare provider, in accordance with this Policy.

G. If the PCP, Specialty Care Provider or other provider specified in this Policy is an out-of-network provider, CalOptima or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

H. CalOptima or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request;

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs; or

3. Three (3) calendar days if there is risk of harm to the Member. For purposes of this policy, risk of harm means an imminent and serious threat to the health of the Member.

K. CalOptima or a Health Network shall notify the Member of the following, in writing, and within seven (7) calendar days of the completion of a Continuity of Care request:

1. The outcome of the request (approval or denial) sent to the Member by U.S. Mail;

2. The duration of the Continuity of Care arrangement, if approved;

a. For any Continuity of Care response for which a provider is only willing to continue providing services for less than twelve (12) months, CalOptima or a Health Network shall allow the Member to have access to that provider for the shorter period of time.

3. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved; and

4. The Member's right to choose a different provider from CalOptima's provider network.

5. If CalOptima and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima has documented quality of care issues with the provider, CalOptima will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network provider.

6. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint.

L. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima or a Health Network shall notify, in writing via U.S. Mail, the Member and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network provider to ensure continuity of services through the transition to a new provider, except as provided in Section III.O.8.b.iv. for Members in the WCM program.

M. CalOptima or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. Occurred after the Member's enrollment into CalOptima;

2. Have dates of service(s) that occur after December 29, 2014;

3. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

4. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

N. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima or a Health Network and the provider are unable to agree to a rate;

3. CalOptima or a Health Network has documented quality of care issues with the provider; or

4. CalOptima or a Health Network has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

O. Other Continuity of Care Requirements

1. Former Covered California Enrollees

a. CalOptima shall outreach to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima to inquire if the Member has upcoming

appointments, or scheduled treatments. CalOptima shall assist the Member in making a Continuity of Care request at that time, as appropriate.

b. CalOptima or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to sixty (60) calendar days, or until a new assessment is completed by a CalOptima contracted provider or a Health Network.

c. CalOptima or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section II.C. of this Policy.

d. CalOptima or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

2. Seniors and Persons with Disabilities

a. CalOptima or a Health Network shall honor, without request by the Member or the Member's out-of-network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima contracted provider to the extent FFS TAR data is available from DHCS.

i. CalOptima or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

b. CalOptima shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

3. Members Under Twenty-One Years of Age Receiving BHT Services

a. CalOptima shall provide continued access to an out-of-network BHT Service Provider in accordance with Section II.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima, provided the Member has an existing relationship with the provider as defined in this Policy.

b. Retroactive requests for BHT service continuity of care reimbursement are limited to services provided after a Member's transition date into CalOptima, or the date of the Member's enrollment into CalOptima, if enrollment date occurred after the transition.

4. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima shall contact the Member's parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current provider has been identified, CalOptima shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section II.C. of the Policy are met.

e. If CalOptima and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

5. Pregnant and Post-Partum Members

a. CalOptima or a Health Network shall provide continued access to out-of-network providers in accordance with Section II.C. of this Policy for up to twelve (12) months.

6. Nursing Facility Services

a. CalOptima or a Health Network shall offer a Member residing in an out-of-network skilled nursing facility (SNF) when the Member transitioned into CalOptima the opportunity to return to the out-of-network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima, or a Health Network, is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for Nursing Facility (NF) services that were in effect when a Member enrolled into CalOptima to the extent DHCS provides FFS TAR data to CalOptima. CalOptima or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima.

c. CalOptima or a Health Network shall not require a Member who is a resident of an NF prior to enrollment in CalOptima to change NFs during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima agree to Medi-Cal rates.

7. Non-Specialty Mental Health Services

a. CalOptima shall provide continuity of care with an out-of-network Specialty Mental Health provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima shall allow, at the request of the Member, the Member's Specialty Mental Health provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health provider in CalOptima's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

8. Whole Child Model (WCM) Program

a. Effective January 1, 2019, CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS provider for up to twelve (12) months in accordance with Section II.C.1. of this Policy.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME provider, CalOptima or a Health Network must provide access to that Specialized or Customized DME provider for up to twelve (12) months.

b) CalOptima or a Health Network shall pay the Specialized or Customized DME provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME provider and CalOptima or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating provider.

ii. Case Management

a) An eligible Member shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Program.

iii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process.

iv. Appealing Continuity of Care Limitations

a) CalOptima or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition. The appeals process notice must include the following information:

1) The eligible Member must first appeal a Continuity of Care decision with CalOptima in accordance with CalOptima Policy GG.1510: Appeals Process Regarding Care and Services; and

2) A eligible Member, the Member's family or designated caregiver of the eligible Member may appeal the Continuity of Care limitation to the Department of Health Care Services (DHCS) director or his or her designee after exhausting CalOptima's appeal process.

P. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima's Health Network Relations Department in a format and at a frequency prescribed by CalOptima.

Q. CalOptima's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima.

R. CalOptima's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1401: Pharmacy Authorization Process
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy HH.1102: CalOptima Member Complaint
E. CalOptima Policy GG.1301: Comprehensive Case Management
F. CalOptima Policy GG.1209: Population- Based Care: Disease Management
G. CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
H. CalOptima Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
I. CalOptima Policy GG.1401: Pharmacy Authorization Process
J. CalOptima Policy GG.1510: Appeals Process Regarding Care and Services
K. California Health and Safety Code, §1374.73
L. California Health and Safety Code, §1373.96
M. California Welfare and Institutions Code §§ 14094.13(a)-(d), 14094.13(d)
N. Department of Health Care Services, All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
O. Department of Health Care Services, All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care (Revised)
P. Department of Health Care Services, All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program

VI. REGULATORY AGENCY APPROVALS

A. 06/26/18: Department of Health Care Services
B. 01/31/18: Department of Health Care Services
C. 07/11/17: Department of Health Care Services
D. 08/23/16: Department of Health Care Services
E. 05/15/15: Department of Health Care Services

VII. BOARD ACTION

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
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.
Behavioral Health Treatment (BHT)	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) Service Provider	There are three (3) classifications: 1. Qualified Autism Services (QAS) Provider – A licensed practitioner or Board Certified Behavior Analyst (BCBA) 2. QAS Professional – A Behavior Management Consultant (BMC), BCBA, Behavior Management Assistant (BMA), or Behavior Analyst Associate (Board Certified Assistant Behavior Analyst) 3. QAS Paraprofessional – Minimum high school level with 40 hours of BHT training who is employed and supervised by a QAS provider.
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 (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 sections41515.2 through 41518.9.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Existing Out-of-Network Provider	For purposes of this Policy, an out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health provider.
Health Risk Assessment	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.[I]

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.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
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).
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Specialty Mental Health Services, which are the responsibility of the County Mental Health Plan, include the following: A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. B. Psychiatric inpatient hospital services. C. Targeted Case Management. D. Psychiatrist services. E. Psychologist services. F. EPSDT supplemental Specialty Mental Health Services.

Term	Definition
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.

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Policy #: GG.1330PP
Title: **Case Management - California Children's Services Program/Whole Child Model**
Department: Medical Affairs
Section: Case Management

CEO Approval: Michael Schrader _____

Effective Date: 01/01/19
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

I. PURPOSE

This policy defines the guidelines for the provision of Case Management by CalOptima or a Health Network to CalOptima Members eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members or new CCS Members enrolling in CalOptima.

II. POLICY

A. Effective January 1, 2019, CalOptima or a Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, case management, and quality oversight.

1. CalOptima and its Health Networks shall ensure the provision of case management and care coordination for CCS by staff with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

B. CalOptima or a Health Network shall identify and refer Members with potential CCS-Eligible Conditions to the local CCS Program for CCS medical eligibility determination in accordance with CalOptima Policy GG.1101: California Children's Services.

C. CalOptima shall identify the health risk of each CCS-eligible Member using a Department of Health Care Services (DHCS)-approved proprietary pediatric risk stratification algorithm within forty-five (45) calendar days of the eligibility with the CCS Program or transition into the WCM program.

D. Based on the results of the risk stratification, CalOptima shall assess each CCS-eligible Member's risk level and needs to ensure the appropriate provision of case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider through the administration of a DHCS-approved Health Needs Assessment (HNA), or risk assessment, as follows:

1. High-risk: Within ninety (90) calendar days; and

2. Low-risk: Within one hundred twenty (120) calendar days.

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3. CalOptima shall reassess Members as follows:

    a. Annually, at a Member's CCS eligibility redetermination; or

    b. Upon signification change to a Member's health condition.

4. The HNA shall address, at a minimum, the following:

    a. General health status and recent health care utilization;

    b. Health history;

    c. Specialty provider referral needs;

    d. Prescription medication utilization;

    e. Specialized or customized durable medical equipment (DME) needs;

    f. Need for specialized therapies;

    g. Limitations of activities of daily living (ADLs) or daily functioning;

    h. Demographics and social history; and

    i. Age-specific questions.

E. CalOptima or a Health Network shall use the HNA to develop an Individual Care Plan (ICP) individualized to meet Member's medical (including specialty care and behavioral health needs), functional, psychosocial, social support and access to care needs, for all members assigned a care management level of care coordination or complex care management.

F. CalOptima or a Health Network shall proactively coordinate services for a CCS-eligible Member reaching twenty-one (21) years of age, including:

1. Identification of primary care and specialty care providers appropriate to the Member's CCS-Eligible condition; and

2. Assistance with transition planning to allow for purposeful, planned preparation of Members, families, and caregivers for transfer of a Member from pediatric to adult medical or health care services prior to age twenty-one (21).

G. CalOptima or a Health Network shall provide care coordination to CCS-eligible Members who are in need of an adult provider when a treating CCS-paneled provider determines his or her services are no longer beneficial or appropriate to the treatment of the CCS-eligible Member. 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.

H. Members eligible with CCS Program and transitioned into the WCM program may submit a request to continue receiving case management and care coordination service from his or her

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existing public health nurse. A Member shall submit the request to CalOptima within ninety (90) calendar days of his or her transition date.

I. CalOptima shall convene a quarterly meeting between CalOptima and the local CCS Program to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding and other WCM related matters.

J. CalOptima shall ensure that the HNA is provided in a linguistically and culturally appropriate manner and will offer an in-person assessment.

K. For Members eligible with CCS Program and transitioned into the WCM program, CalOptima and a Health Network shall 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 CalOptima, for at least three (3) years after they age-out of the WCM program.

L. CalOptima, a Health Network, or a practitioner shall identify Members who may have a CCS-Eligible Condition in accordance with CalOptima Policies GG.1101: California Children's Services and GG.1116: Pediatric Preventive Services.

M. CalOptima and its Health Networks 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 GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

N. 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.

III. PROCEDURE

A. Pediatric Risk Stratification

1. The pediatric risk stratification algorithm shall incorporate Member-specific data that signifies each CCS-eligible Member's clinical history and specific utilization data to assess the health risk, high or low, of a Member to include review of:

   a. Medical utilization data;

   b. Medical claims and encounter data;

   c. Existing assessment or survey data;

   d. Pharmacy data;

   e. Data provided by the local CCS Program and DHCS; and

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f. Telephonic or in-person communications, if available at the time of the risk stratification.

2. For Members for which medical utilization data, claims processing data, or other assessments or survey information is not available, CalOptima shall automatically categorize such Member as high-risk until CalOptima is able to gather further assessment data to make an additional risk determination.

B. Health Needs Assessment

1. Upon enrollment in CCS or transition to WCM, CalOptima shall perform outreach to a CCS-eligible Member to complete the HNA telephonically or in-person as follows:

a. High Risk Members

i. CalOptima shall make three (3) attempts to reach the Member/Member's family by telephone within ninety (90) calendar days. CalOptima shall offer to assist the Member with completion of the HNA by telephone or in-person.

ii. If CalOptima is not able to reach the Member after three (3) attempts, CalOptima shall mail a letter to the Member's address, requesting the Member telephone CalOptima to complete the HNA.

iii. CalOptima shall establish an Individual Care Plan (ICP) for high risk Members based on the results of the risk stratification and HNA, within ninety (90) calendar days of the completion of the HNA or other assessment by telephone or in-person communication and as described in Section III.D. of this Policy.

iv. For Members eligible with CCS Program and transitioned into the WCM program, CalOptima shall complete risk stratification and telephonic and/or in person communication within one (1) year, including the ICP.

b. Low Risk Members

i. CalOptima shall make three (3) attempts to reach the Member/Member's family by telephone within one hundred twenty (120) calendar days. CalOptima shall offer to assist the Member with completion of the HNA by telephone or in-person.

ii. If CalOptima is not able to reach the Member after three (3) attempts, CalOptima shall mail a letter to the Member's address, requesting the Member telephone CalOptima to complete the HNA.

iii. For Members eligible with CCS Program and transitioned into the WCM program, CalOptima shall complete risk stratification and telephonic and/or in person communication within one (1) year.

2. CalOptima shall offer an in-person HNA to a CCS-eligible Member administered by a CalOptima Registered Nurse or Personal Care Coordinator (PCC) when a Member's

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health condition precludes the administration of an HNA via telephone during the HNA collection time period (based on risk level), including but not limited to, inpatient hospitalization.

3. If a Member fails to complete the HNA after the third outreach attempt, CalOptima shall close the Member's HNA file in the electronic database.

4. CalOptima shall offer reassessment annually, either telephonically or in-person, to all CCS-eligible Members no later than the anniversary date of their most recent HNA or the month of their eligibility date, if no HNA has been collected.

C. Care Management and Care Coordination

1. A CalOptima Registered Nurse shall review and evaluate the pediatric risk stratification results and the responses to the HNA to assign one (1) of the following care management levels to a CCS-eligible Member:

   a. Complex care management (high risk);

   b. Care coordination care management (high risk); or

   c. Basic care management.

2. Care Management

   a. CalOptima or a Health Network will assign a Personal Care Coordinator (PCC) to each CCS-eligible Member. The PCC shall serve as the Member's assigned point of contact with CalOptima or a Health Network. The PCC shall:

      i. Perform initial and periodic outreach to assist the Member with care coordination;

      ii. Provide information, education and support continuously, as appropriate; and

      iii. Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.

   b. PCCs shall be supported by a CalOptima or Health Network Registered Nurse for clinical considerations.

   c. CalOptima or a Health Network may transition a Member to a higher or lower level of care management as needed, due to a change in the Member's condition or as requested by the Member.

3. For those Members assigned a care management level of care coordination care management or complex care management, CalOptima or a Health Network shall assign a licensed care manager, in addition to the PCC. An ICP shall be developed within ninety (90) calendar days of a completed HNA and in accordance with Section III.D. of this

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Policy. The ICP shall be shared with the Member and/or Member's family, PCP, and Interdisciplinary Care Team (ICT).

4. The Care Management process shall also address:

   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 Care Team (ICT) 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 ICTs; and

   d. Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of CalOptima;

5. CalOptima or a Health Network shall ensure ongoing care coordination in accordance with CalOptima Policy GG.1301: Comprehensive Case Management Process.

D. Individual Care Plan (ICP)

1. CalOptima or a Health Network shall develop an ICP for a high-risk Member within ninety (90) calendar days of the completion of the HNA or other assessment, by telephone or in-person communication. CalOptima shall develop the ICP in collaboration with the Member, as appropriate, the Member's family, or caregiver and ICT.

2. The ICP shall incorporate the CCS-eligible Member's goals and preferences and provide measurable objectives and timeframes for completion to meet the needs for:

   a. Medical services (primary and specialty services);

   b. Mild to moderate or county specialty mental health services;

   c. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);

   d. County substance use disorder (SUD) or Drug Medi-Cal services;

   e. Home health services;

   f. Regional center services; and

   g. Other Medically Necessary services provided by CalOptima or a Health Network, including when necessary, out of network providers.

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3. CalOptima or a Health Network shall reevaluate and update each CCS-eligible Member's ICP at least annually or upon a significant change to the Member's condition.

E. Continuity of Care - Case Management

1. Members eligible with CCS Program and transitioned into the WCM program shall have the opportunity to request, within the first ninety (90) calendar days of the transition, to continue to receive case management from their existing CCS Public Health Nurse (PHN).

2. Upon receipt of a request for continuity of case management services, CalOptima shall communicate this request to the local CCS Program within five (5) business days.

   a. If the Member's PHN is available to continue case management, CalOptima or a Health Network shall coordinate care with the CCS PHN.

   b. If the Member's PHN is not available, CalOptima or a Health Network shall ensure that case management services are provided by a 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.

F. Age-Out Transition and Planning

1. CalOptima or a Health Network shall proactively coordinate services for a CCS-eligible Member reaching twenty-one (21) years of age as follows:

   a. Age 14:

      i. Identify CCS eligible Members who will require long-term health care transition planning; and

      ii. Notify, via mail, the Member, the Member's family, and PCP, of the transition process.

   b. Age 16:

      i. Identify CCS-eligible Members who will require long-term health care transition planning who were not identified or known at age 14;

      ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

      iii. Notify, via mail, the Member and the Member's family of the need to formally institute transition planning;

      iv. Notify the PCP of the need to schedule an adolescent transition health care conference; and

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v. Request information from special care centers, as appropriate, regarding steps the center(s) has taken to institute the transition planning process, including identification or primary and specialty care providers appropriate to the Member's CCS-Eligible Condition who will provide care after the Member's 21st birthday, the need for DME, and the Member's PCP.

c. Age 17:

i. Send Adult Services Declaration and Notice of Privacy Practices with acknowledgement receipt to those CCS-eligible Members identified as needing transition services.

d. Age 18:

i. Identify CCS-eligible Members who will require long term health care transition planning who were not identified or known at age 16;

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify, via mail, the Member and the Member's family of the need to prepare or update transition planning;

iv. If not received, resend Notice of Privacy Practices with acknowledgement of receipt via mail;

v. Request updated information from special care centers regarding steps the center (s) has taken to institute the transition planning process, including identification or primary and specialty care providers appropriate to the Member's CCS-Eligible Condition who will provide care after the Member's 21st birthday, the need for DME, and the Member's PCP.

e. Age 20:

i. Identify CCS-eligible Members who will require long term health care transition planning who were not identified or known to the program at age 18;

ii. Notify, via mail, the PCPs of newly identified Members about the transition planning process;

iii. Notify the Member and the Member's family of the need to prepare or update transition planning, or update Adolescent Transition Health Care Plan to identify any unmet needs and modify, as necessary;

iv. Send a letter to the Member's CCS PCP to determine if he or she will continue to provide care after the Member's 21st birthday and name of the identified adult provider if the pediatric provider will not continue care. If necessary, request a referral to adult provider if one is required and has not been identified;

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v. Send a letter to the Member and the Member's family requesting transition planning meeting or teleconference;

vi. Evaluate the Member for additional care coordination needs; and

vii. Send an exit interview survey to the Member and the Member's family.

f. Age 20 and 8 months:

i. A CCS-eligible 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 CalOptima Policy DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process; and

ii. CalOptima will assist Members who need to change his or her Health Network with selecting a new Health Network and with coordinating care through the transition.

F. Moving Out-of-Area

1. Upon notification that a CCS-eligible Member has moved to another county, CalOptima shall provide the local CCS Program with the following:

a. A copy of the PCP version of the most recent ICP;

b. Clinical and other relevant data;

c. Any open authorizations; and

d. The most recent HNA.

G. Case Management Oversight of Health Network ICPs

1. CalOptima Registered Nurses shall review the data collected from each HNA and shall:

a. Evaluate completion and accuracy of information provided;

b. Evaluate clinical data;

c. Assign a provisional care management level; and

d. Prepare a provisional initial care plan (iCP), as appropriate

2. A CalOptima Registered Nurse shall upload the iCP and HNA via secure FTP site to the CCS-eligible Member's assigned Health Network for completion of the ICP, as appropriate.

3. The Health Network shall retrieve the iCP and HNA.

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4. The licensed care manager at the Health Network shall be responsible for the care management of the Member as described in Section III.C. of this Policy.

5. Upon completion of the ICP, the Health Network shall upload the completed ICP and supporting records to the secure FTP site.

6. On a daily basis, CalOptima shall retrieve the completed ICPs and records from the secure FTP site.

7. CalOptima Registered Nurses shall review the completed ICPs and records for completeness, accuracy and compliance with the requirements of this Policy.

8. CalOptima Registered Nurses shall document their review of each returned record in the CalOptima medical management system.

9. On a daily basis, CalOptima shall communicate any deficiencies to the Health Network.

10. On a monthly basis, CalOptima shall provide feedback regarding the scoring of the ICP bundles to the Health Network.

IV. ATTACHMENTS

A. Health Needs Assessment

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy DD.2008: Health Network and CalOptima Community Network (CCN) Selection Process
D. CalOptima Policy GG.1101: California Children's Services
E. CalOptima Policy GG.1116: Pediatric Preventive Services
F. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
G. CalOptima Policy GG.1301: Comprehensive Case Management Process.
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-011: California Children's Service Whole Child Model Program
J. Welfare and Institutions Code §§ 14094.7(d)(4)(C), 14094.11(b)(1)-(6), 14094.11(c), 14094.12(j), 14094.13(e)-(g)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2019	GG.1330PP	Case Management - California Children's Services Program/Whole Child Model	Medi-Cal

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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.
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.
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 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 Needs Assessment (HNA)	The assessment CalOptima uses as a health risk assessment for CCS-eligible Members.
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.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

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Readability Grade Level: Gunning Fog 6.2, SMOG 4.7, 7/6/2018AS (Eliminated the chart, answer choices for question #s 1, 9-11 and all the answer lines)
Reviewed by VC 7-17-18; Reviewed by MKC 7-17-18; e-ticket# SVC-18-004276; Readability Grade Level: Gunning Fog 6.9, SMOG 5.6 on 7-17-18 by MKC (Eliminated the chart, answer choices for question #s 1, 9-11 and all the answer lines)
7/23/18 Readability Updated to Gunning Fog 6.5 and SMOG 5.0 (Eliminated the chart, answer choices for question #s 1, 9-11 and all the answer lines) by MKC

Medi-Cal CalOptima A Public Agency Better. Together.

CalOptima Children with Special Health Care Needs Assessment Mailing Date: [MM/DD/YYYY]

Dear Parent or Guardian:

We want to provide your child with access to good health care. Your answers to the questions on this survey will help us do that. We will only share your answers with those who are helping your child get better care such as your child's doctor. An older child may complete this survey on his or her own.

Filling out this survey will **not** stop your child from getting health care. If you need help to fill out this survey, please call toll-free at **1-888-587-8088**. We can get help for you over the phone. **Please complete and send us this survey as soon as you can.**

Child's Last Name:	Child's First Name:	Health Network:water
Child's CalOptima ID # (CIN):	Phone (Home):	Phone (Parent or Guardian Cell):
Address:		
Child's Height:	Child's Weight:	Today's Date:
Child's Date of Birth:		Child's Gender:

What to do:

a. Please read each question and mark the box like this: ☒ for your answer.
b. Some questions ask you to write an answer on the line. Please write your answer on the line next to the question. Thank you!

Survey completed by: □ Parent or Guardian □ Child or Member □ Other _____

Name of person completing this survey: _____
Please print

What is the best way for us to contact you? □ Phone □ Mail

What language do you prefer to speak?

□ English □ Spanish □ Vietnamese □ Arabic □ Farsi
□ Korean □ Mandarin □ Cantonese □ Other: _____

Do you have any other health insurance? □ Yes □ No
If yes, what other health insurance do you have? _____

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CalOptima Children with Special Healthcare Needs Assessment

Current Health Care

1. **What health issues does your child have? (Mark an X in the box next to the issue that your child has or write it out)**

□ Asthma	□ Kidney problem with dialysis
□ ADD or ADHD	□ Down Syndrome
□ Autism or Autism Spectrum Disorder	□ Hearing problems
□ Severe behavioral problems	□ Heart problems
□ Blood problems	□ Learning problems
□ Bone/joint problems	□ Muscle problems
□ Cancer, type: _____	□ Prematurity or low birth weight
□ Cerebral Palsy	□ Seizure disorder or epilepsy
□ Cystic Fibrosis	□ Speech problems
□ Developmental delay	□ Vision problems
□ Diabetes	□ Other: _____

2. **Does your child get care from a specialist now? For example a specialist can be a lung doctor, a heart doctor, a mental health expert or any other doctors.**
   □ Yes □ No Name of doctor_____
   Type of doctor _____

3. **Has your child been told to get health care or services that you have not been able to get?**
   □ Yes □ No
   If yes, please list them here _____

4. **Does your child take any medicines daily (other than vitamins, iron, fluoride or things like that)?**
   □ Yes □ No

5. **Do you have any concerns about your child's health right now that are not being taken care of?**
   □ Yes □ No
   If yes, please list them here _____

Past Health History

6. **In the past 12 months, how many times has your child been in the hospital overnight?**
   □ None □ 1–2 times □ 3 times or more

7. **In the past 6 months, how many times did your child go to the emergency room and not spend the night?**
   □ None □ 1 time □ 2 times □ 3 times □ 4 or more times

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8. **In the past 12 months, how many days did your child miss school due to health reasons?**
   □ 0–3 days □ 4–6 days □ 7–10 days □ More than 10 days □ Does not go to school

Daily Activity

9. **Due to his or her health, does your child need more help than other children their age with any of these? (Mark an X in the box next to the task your child needs extra help with.)**
   □ Bathing
   □ Eating
   □ Getting dressed
   □ None
   □ Using the toilet
   □ Walking
   □ Moving in and out of a bed or a chair

Care Received

10. **Does your child use any of these? (Mark an X in the box next to the item your child uses now.)**
    □ Apnea monitor
    □ Diabetes supplies (glucose meter, insulin pump)
    □ Braces or artificial limb(s)
    □ Diapers after age 4
    □ Feeding tube
    □ Hearing aids
    □ Oxygen
    □ Respirator or ventilator (machine that breathes for child)
    □ Speech board or other communication device
    □ Wheelchair, walker or stander
    □ Other: _____

11. **Does your child get any of this help now? (Mark an X in the box next to the help that your child gets now.)**
    □ Assistance from a transportation service
    □ Counseling for an emotional or behavioral problem
    □ Food assistance programs (WIC, CalFresh, food banks)
    □ Home health nurse on a long-term basis (more than 6 weeks)
    □ Physical, occupational or speech therapy
    □ Regional Center of Orange County (RCOC)
    □ Respite care
    □ Other community resource: _____

12. **Does your child need any help that he or she is not getting now?** □ Yes □ No
    If yes, please list the type of help they need _____

Social History

13. **How often do you or your family feel overwhelmed by caring for your child's health?**
    □A few times a week □ About once a month □ Every 6 months □ Never

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14. Who gives you and your family help when you need it?
□ Friends and family □ Support group □ Church or faith-based group
□ No one □ Other _____

15. Where do you live now?
□ House or apartment □ Shelter □ Motel
□ Homeless □ Other: _____

Children ages 12 and older should complete the following section:

16. Over the past 2 weeks, how often have you been bothered by any of the following problems: Little interest or pleasure in doing things.
□ Not at all □ Several days □ More than half the day □ Nearly every day

17. Over the past 2 weeks, how often have you been bothered by any of the following problems: Feeling down, depressed or hopeless.
□ Not at all □ Several days □ More than half the day □ Nearly every day

18. Do you smoke, vape or use any tobacco now? □ Yes □ No

19. In the past 12 months, did you drink alcohol? Do not count sips of alcohol taken during family or religious events.
□ Yes □ No

20. In the past 12 months, did you use anything to get high? This includes illegal drugs, over-the-counter and prescription drugs and things you sniff or "huff."
□ Yes □ No

21. How often does anyone, including family, physically hurt you?
□ Never □ Rarely □ Sometimes □ Often

22. [This question is for girls only.] **Are you pregnant now?** □ Yes □ No

Thank you for taking time to complete this survey. Please fold and return it in the envelope we sent with this survey. We look forward to serving you and your child! If you have any questions about your child's doctor or health care, please call us toll-free at 1-888-587-8088, Monday through Friday, 8 a.m. to 5:30 p.m. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff who speak your language.

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Policy #:	GG.1531
Title:	**Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/09
Last Review Date:	~~08/01/17~~10/04/18
Last Revised Date:	~~08/01/17~~10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member.

II. POLICY

A. CalOptima or a Health Network shall provide a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member when Medically Necessary.

B. CalOptima or a Health Network shall define Medically Necessary as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, a Wheelchair, SPCs, and accessories prescribed for a Member may be a Covered Service and Medically Necessary when it is used in or out of a Member's home to:

1. Preserve bodily functions essential to Activities of Daily Living (ADL), Instrumental Activities of Daily Living (~~iADL~~IADL), or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a Member, when a Member is not ambulatory or functionally ambulatory without static supports such as a cane, crutches, or walker, through the stabilization of the Member's condition, or the prevention of additional deterioration of the Member's medical status, or functional ability.

C. The following items are not Covered Services:

1. Modification of automobiles or other highway motor vehicles, with the exception of Automobile Orthopedic Positioning Devices (AOPDs) for eligible CalOptima Medi-Cal Members in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Orthopedic recliners, rockers, seat lift chairs, or other furniture items;

3. Household items; and

4. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

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D. CalOptima or a Health Network shall determine a Member's eligibility for a Wheelchair, SPCs, and accessories upon receipt of a written prescription for a Wheelchair, SPCs, and accessories by a Member's licensed Practitioner, within the Practitioner's scope of practice, as established by California law.

E. CalOptima or a Health Network shall provide one (1) of the following Wheelchairs, SPCs, and accessories to a Member:

1. Standard manual wheelchair;
2. Custom manual or powered wheelchair;
3. Custom lightweight manual, or powered, wheelchair;
4. Electric-powered wheelchair;
5. Power-assisted vehicle (POV) wheelchair;
6. Push rim activated device;
7. Power Mobility Devices (PMD);
8. Therapeutic seat cushions;
9. SPCs; or
10. Other related wheelchair accessories.

F. CalOptima and a Health Network shall authorize a Wheelchair, SPCs, and accessories for a Member, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The following provisions shall also apply:

1. A licensed Practitioner shall obtain Prior Authorization for the following Covered Services:
   a. Rental of a Wheelchair, SPCs, and accessories;
   b. Purchase of a Wheelchair, SPCs, and accessories; or
   c. Repair or maintenance of a Wheelchair, SPCs, and accessories exceeding a ~~cumulative~~total cost of two hundred fifty dollars ($250).
2. A licensed Practitioner shall utilize Department of Health Care Services (DHCS) clinical guidelines, as provided in DHCS All Plan Letter 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, to determine the appropriate device to meet the medical needs of a CalOptima Member.
3. A licensed Practitioner shall obtain Prior Authorization for the evaluation of a custom wheelchair prior to the purchase of a custom wheelchair and accessories.

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4. A licensed Practitioner shall request Prior Authorization for a CalOptima Direct~~, or CalOptima Community Network (CCN),~~ Member, in accordance with this ~~policy~~Policy and CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers. A licensed Practitioner shall request Prior Authorization for a Health Network Member, in accordance with this policy and the Health Network's Prior Authorization procedures.

5. CalOptima or a Health Network shall refer a Member to a contracted wheelchair Evaluation Services Provider (ESP) for evaluation prior to authorizing a custom Wheelchair, SPCs, and accessories for the Member. In-home evaluation shall be the primary evaluation method for a custom Wheelchair, SPCs, and accessories. Use of a contracted seating clinic is appropriate in cases where an in-home evaluation may be impractical, or if the Member does not wish to have an evaluation conducted in his or her home.

6. If Medicare or Other Health Coverage (OHC) is the primary payer for the Wheelchair, SPCs, and accessories, the Practitioner and Provider are subject to Prior Authorization, as set forth in this policy and CalOptima Policies FF.2003: Coordination of Benefits, MA.3103: Claims Coordination of Benefits, and CMC.3103: Claims Coordination of Benefits.

7. CalOptima or a Health Network shall authorize one (1) Wheelchair per Member. If, at a later time, a Member requires a subsequent Wheelchair, SPCs, and accessories, CalOptima or a Health Network, may authorize a subsequent Wheelchair, SPCs, and accessories, in accordance with the provisions of this policy.

8. CalOptima or a Health Network may authorize the following Wheelchair, SPCs, and accessories for a Member who is an inpatient in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF):

    a. A Wheelchair, SPCs, and accessories are necessary for the continuous care and unusual medical needs of a Member. A Member may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics~~, as such,~~ shall not constitute an unusual medical condition.

    b. A Wheelchair accessory that is custom made~~,~~ or modified~~,~~ to meet the unusual medical needs of a Member and the need is expected to be permanent.

9. CalOptima or a Health Network shall limit authorization for a Wheelchair, SPCs, and accessories to the lowest cost item that meets a Member's medical needs.

10. CalOptima or a Health Network shall not deny an authorization for a Wheelchair or SPCs for a Medi-Cal or OCC Member on the grounds it is for use outside of the home when determined to be Medically Necessary for the Member's medical condition.

11. CalOptima or a Health Network shall not grant an authorization for a Wheelchair, SPCs, and accessories if a household, or furniture, item shall adequately serve the Member's medical needs.

12. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Member is in possession of a Wheelchair that already meets the Member's ADL

or IADL. If the Member's medical, or functional, needs have changed, the Member's Practitioner may submit a functional assessment containing medical justification for the Member's need for a new, adjusted, or modified Wheelchair.

13. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Wheelchair, SPCs, and accessories are not Medically Necessary and needed solely for a social, educational, or vocational purpose. CalOptima shall refer the Member to the California State Department of Rehabilitation for Wheelchair, SPCs, and accessories requests based on vocational needs.

14. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories when:

    a. Not Medically Necessary;

    b. Not used by the Member;

    c. Used as a convenience item;

    d. Used to replace private, or public, transportation such as an automobile, bus, or taxi;

    e. Not used primarily for health care, and not regularly and primarily used by a Member who ~~does not have~~has a specific medical need;

    f. For PMDs, the underlying condition is reversible, and the length of need is less than three (3) months, such as following lower extremity surgery ~~which~~that limits ambulation;

    g. Used in a Facility that is expected to provide such items to a Member, except as specified in Section II.F.8. of this policy; or

    h. Not prescribed by a licensed Practitioner, or for custom Wheelchairs, a licensed Practitioner and an ESP.

15. CalOptima or a Health Network shall consider a Wheelchair, SPCs, and accessories to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented wheelchair and accessories. CalOptima shall provide no further reimbursement for the use of such Wheelchair, SPCs, and accessories, unless payment is for the subsequent repair and maintenance of the Wheelchair, SPCs, and accessories as authorized by CalOptima, or the Health Network. The cost ~~of repairs~~per repair shall not exceed the replacement value of the item being repaired.

16. CalOptima or a Health Network may audit Wheelchair authorization requests, as necessary, for appropriateness and accuracy.

G. A Member is responsible for the appropriate use and care of a Wheelchair, SPCs, and accessories rented or purchased for the Member's benefit.

H. Upon authorization to provide a Wheelchair, SPCs, and accessories for a Member, a Wheelchair Provider shall:

1. Provide a Wheelchair, SPCs, and accessories, in accordance with statutory, regulatory, contractual, CalOptima and Health Network policy, and other requirements related to the CalOptima program;

2. Ensure that the Wheelchair, SPCs, and accessories provided to a Member are appropriate for the Member's medical and functional needs. When necessary, the Wheelchair Provider shall adjust or modify the Wheelchair, SPCs, and accessories during the post-fitting period if the Wheelchair does not:

   a. Meet the Member's medical needs and the Member's medical condition has not changed since the date the Wheelchair was originally provided; or

   b. Meet the Member's functional needs when in actual use.

3. Replace any Wheelchair, SPCs and accessories that cannot be adjusted or modified during the post-fitting period of the Wheelchair at no cost to CalOptima or a Health Network.

III. PROCEDURE

A. Standard Wheelchair

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a standard Wheelchair rental or purchase and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department~~,~~ or the Health Network. Authorization request documentation shall include:

   a. Member's name, date of birth, phone number, address, and identification (ID) number;

   b. Full name, address, telephone number, and signature of the prescribing Practitioner;

   c. Date of request;

   d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for a standard Wheelchair in accordance with DHCS guidelines; and

   e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

2. CalOptima or a Health Network shall approve, modify, or deny an authorization for a standard Wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

B. Manual or Powered Custom Wheelchair~~-~~:

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a custom Wheelchair purchase and shall submit a complete authorization request to CalOptima's UM Department~~,~~ or the Health Network.

   a. For a CalOptima Direct ~~or CCN~~ Member the authorization request shall consist of the

Customized Wheelchair Evaluation Request Form (CWER) and Clinical Questionnaire. Authorization request documentation shall include:

i. Member's name, date of birth, phone number, address, and identification (ID) number;

ii. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

iii. Date of request;

iv. Specific items requested;

v. Supporting documentation that the Member meets the Medical Necessity criteria for a manual or powered custom Wheelchair, in accordance with DHCS guidelines; and

vi. Member's medical condition or diagnosis necessitating the custom Wheelchair, including:

a) Member's medical status and functional limitations; and

b) Description of how the requested custom Wheelchair is expected to improve the medical status or functional ability of the Member, stabilize the Member's medical condition, or prevent additional deterioration of the Member's medical status or functional ability.

b. For a Health Network Member, a Practitioner shall submit authorization request documentation~~,~~ in accordance with the Health Network's authorization procedures.

2. CalOptima's UM Department~~,~~ or the Health Network~~,~~ shall review the authorization request documentation submitted by a Member's Practitioner and, if incomplete, shall require the Practitioner to provide additional information.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for a custom wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

4. If CalOptima or the Health Network approves the request for a customized wheelchair evaluation, CalOptima or the Health Network shall contact a contracted ESP to arrange an assessment in the Member's residence, or at a seating clinic.

5. ~~An~~ ESP staff shall submit a Letter of Recommendation (LOR) to CalOptima or the Health Network following its initial assessment. The LOR shall contain determination of Medical Necessity based on the standards set forth in Section II.B. of this ~~policy~~Policy, and the Member's unique medical needs and living environment.

6. CalOptima or the Health Network shall review the LOR and the licensed Practitioner's original Wheelchair request. If the recommendation on the LOR varies from the Practitioner's original request, CalOptima~~,~~ or the Health Network~~,~~ shall notify the Member and Member's Practitioner of such determination according to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

7. If CalOptima or the Health Network approves a customized Wheelchair:

   a. For a CalOptima Direct ~~or CCN~~ Member, CalOptima shall forward the LOR, Clinical Questionnaire Form, and CWER Form, to a selected Wheelchair Provider.

   b. For a Health Network Member, the Health Network shall forward the LOR~~,~~ and authorization request~~,~~ to a selected Wheelchair Provider.

   c. CalOptima~~,~~ or the Health Network~~,~~ may select a contracted Wheelchair Provider that has a history with a Member to provide continuity of services.

      i. CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program with a Specialized or Customized Durable Medical Equipment (DME) provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For Specialized or Customized DME under warranty, the Continuity of Care period may be extended to the duration of the warranty.

8. The selected Wheelchair Provider shall arrange a fitting appointment with the Member at the Member's residence~~,~~ or at a seating clinic.

9. The Wheelchair Provider shall obtain Prior Authorization to provide a customized Wheelchair to a Member by submitting an authorization request and a Wheelchair Quote that is signed and dated by the Member's Practitioner to CalOptima~~,~~ or the Health Network.

10. The Wheelchair Provider shall include the following information, at a minimum, in the Wheelchair Quote and prescription submitted to CalOptima~~,~~ or the Health Network:

    a. Member's name, date of birth, phone number, address, and identification (ID) number;

    b. Wheelchair Provider's name, address, telephone number, contact name and telephone number, and National Provider Identifier;

    c. Date of request; and

    d. Description of the Wheelchair and related items, including:

       i. Manufacturer name, model type or serial number, and purchase price;

       ii. Product description;

       iii. Billing and procedure codes, as applicable;

       iv. For unlisted or miscellaneous codes, copy of the catalogue page with price.

11. For an unlisted Wheelchair and accessories, the Member's Wheelchair Provider shall submit the following information:

a. Medical documentation justifying that the equipment is Medically Necessary and meets the Member's medical needs; and

b. Explanation of why a listed item does not meet the Member's medical needs and how the unlisted item best accommodates the Member's functional limitations and medical needs.

12. CalOptima or the Health Network shall review the authorization request and the signed Wheelchair Quote submitted by the Wheelchair Provider and, if incomplete, shall require the Member's Practitioner, or Wheelchair Provider to provide additional information.

13. If CalOptima or the Health Network approves the custom Wheelchair, CalOptima or the Health Network shall send a letter of authorization to the contracted custom Wheelchair Provider. Upon receipt, the Wheelchair Provider shall assemble the custom wheelchair in accordance with the authorization.

14. Upon completion of the Wheelchair, the Wheelchair Provider shall provide a post-fitting at the Member's residence~~,~~ or at the seating clinic~~,~~ to ensure that the Member's Wheelchair meets the medical and functional needs of the Member.

15. Upon receipt of the signed delivery ticket from the contracted Wheelchair Provider and confirmation that the Member's Wheelchair meets the medical and functional needs of the Member, CalOptima~~,~~ or the Health Network~~,~~ shall process the claim for payment.

C. Seating and Positioning Component

1. A Member may be eligible to receive SPCs when Medically Necessary, and, for Medi-Cal and OCC Members, pursuant to DHCS guidance.

2. A licensed Practitioner and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department~~,~~ or the Health Network. Authorization request documentation shall include:

a. Member's name, date of birth, phone number, address, and identification (ID) number;

b. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

c. Date of request;

d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for SPCs, in accordance with DHCS guidelines; and

e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for SPCs, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

~~C.~~D. Wheelchair Repair

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1. A Wheelchair repair request with a ~~cumulative~~total cost of less than two hundred fifty dollars ($250), that is a Covered Service, and that does not exceed frequency limitations, shall not require a Prior Authorization.

   ~~1.~~a. For a CalOptima Direct ~~or CCN~~ Member, CalOptima shall reimburse such repair pursuant to all applicable claims requirements, in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group and CMC.3101: Claims Processing.

   b. For a Health Network Member, a Health Network shall reimburse such repair pursuant to all applicable claims requirements.

2. A Member's Practitioner shall complete a Wheelchair repair authorization request for a Wheelchair repair exceeding a ~~cumulative~~total cost of two hundred fifty dollars ($250). Documentation shall include:

   a. Member's name, date of birth, phone number, address, and identification (ID) number;

   b. Full name, address, telephone number, and signature of the prescribing Practitioner;

   c. Date of request; and

   d. Description of the repair, or maintenance, required.

3. Upon submission of the Wheelchair repair authorization request, CalOptima's UM Department~~,~~ or the Health Network~~,~~ shall review the request for benefit coverage, frequency limitations, and Medical Necessity. CalOptima~~,~~ or the Health Network~~,~~ shall approve, modify, or deny a Wheelchair repair authorization, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) Members

1. Effective January 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for Wheelchairs and Wheelchair repairs with a total cost of over $250 to CalOptima. The request will include:

   a. Completed Custom Wheelchair Authorization Referral Form, if applicable;

   b. Signed prescription/provider order for the requested Wheelchair; and

   c. Wheelchair specifications, HCPCS codes and pricing from the Wheelchair vendor that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima or the Health Network Prior Authorization staff via secure communication.

3. If a referral for a Wheelchair or Wheelchair repair for a CCS-eligible Member is received by

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CalOptima or a Health Network directly from a vendor and not from the MTU, the request will be denied, and the Member referred to the MTU for evaluation.

4. If the Member requests a Wheelchair or a Wheelchair repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the Health Network to issue the appropriate Notice of Action letter.

5. For Wheelchairs or Wheelchair repairs that are covered and recommended by the MTU, CalOptima or a Health Network will approve the Wheelchair request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Wheelchair Provider within standard prior authorization turn around-time requirements for Wheelchair requests.

7. Effective January 1, 2019, for all other CCS-eligible Members, Wheelchair-related requests will be processed in the same manner as provided for non-CCS Members in this Policy, except with regard to Continuity of Care as described in Section III.B.7.c.i. of this Policy.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)
B. Customized Wheelchair Evaluation Request (CWER) Form
C. Clinical Questionnaire: Referring Physician Authorization for New Wheelchair
D. Wheelchair Repairs Authorization Referral Form
~~E. CalOptima Customized Wheelchair Authorization Process Flowchart~~
~~F. CalOptima Wheelchair Repair Process Flowchart~~

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
~~C.~~D. CalOptima Contract for Wheelchair Services
~~D.~~E. CalOptima Health Network Service Agreement
~~E.~~F. CalOptima Policy CMC.3103: Claims Coordination of Benefits
~~F.~~G. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
~~G.~~H. CalOptima Policy FF.2003: Coordination of Benefits
I. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~H.~~J. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~I.~~K. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~J.~~L. CalOptima Policy MA.3103: Claims Coordination of Benefits

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~~K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

~~L.~~M. Centers for Medicare & Medicaid Services (CMS) Managed Care Manual (MCM) Chapter 4, Section 10.12: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

~~M.~~N. Department of Health Care Services All Plan Letter (APL) 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, including DHCS Guidance: Durable Medical Equipment: Wheelchair and Wheelchair Accessories

~~N.~~O. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview

P. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program

~~O.~~Q. McKesson Health Solutions InterQual Level of Care Criteria

~~P.~~R. Title 22, California Code of Regulations (CCR.), §§ 51303, 51104, 51160, and 51321

~~Q.~~S. Welfare and Institutions Code, §14105.485

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

B. 07/10/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2009	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	01/01/2010	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	08/01/2015	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	10/04/2018	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Dressing/bathing, eating ambulating (walking), toileting and hygiene.
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 pre-existing provider relationship.
Custom Wheelchair	For the purposes of this policy, refers to those wheelchairs which are specialized, requiring an evaluation be done by a Seating Clinic prior to submitting an Authorization Request Form to a contracted vendor who is able to provide the wheelchair customization needed for the member.
Durable Medical Equipment	Any equipment that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
Evaluation Services Provider (ESP)	A professional who has specific training and/or experience in Wheelchair evaluation and ordering.
Health Network	A Physician Medical Group (PMG), 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.
Instrumental Activities of Daily Living (IADL)	Those activities that allow a Member to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within the Member's community.
Intermediate Care Facility (ICF)	Medi-Cal: A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program. Medicare: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Other Health Coverage (OHC)	Medi-Cal: 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. OneCare/OneCare Connect: Evidence of health coverage other than OneCare/OneCare Connect including, but not necessarily limited to: 1. The CalOptima Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
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.
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.
Seating and Positioning Components (SPC)	Seat, back and positioning equipment mounted to the Wheelchair base.
Seating Clinic	A CalOptima contracted utilization management evaluation by a multidisciplinary team led by a principal therapist to evaluate a Member's needs for a Custom Seating System, recommend the most appropriate Custom Seating System, fit the Custom Seating System, and Report UM activity.

Term	Definition
Skilled Nursing Facility (SNF)	Medi-Cal: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. OneCare/OneCare Connect: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Standard Wheelchair	For the purposes of this policy, refers to those wheelchairs that are available through any contracted vendor that provides wheelchair rentals on a short term basis, or for purchase. These wheelchairs do not require an evaluation by the Seating Clinic and are typically for short term use and are not customizable.
Wheelchair	A wheelchair may be a: 1. Manual wheelchair; 2. Power mobility device (PMD); 3. Power-assisted vehicle (POV); or 4. Push rim activated device.
Wheelchair Provider	A contracted provider, acting within his or her scope of practice, to furnish wheelchairs, SPCs, and related accessories to Members. The Wheelchair Provider ensures the Wheelchair, SPCs, and accessories furnished are appropriate for the Member's medical and functional needs and may adjust or modify the furnished items as appropriate.

Policy #:	GG.1531
Title:	**Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/09
Last Review Date:	10/04/18
Last Revised Date:	10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria and process for coverage of a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member.

II. POLICY

A. CalOptima or a Health Network shall provide a Wheelchair, Seating and Positioning Components (SPCs), and accessories for a Member when Medically Necessary.

B. CalOptima or a Health Network shall define Medically Necessary as reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, a Wheelchair, SPCs, and accessories prescribed for a Member may be a Covered Service and Medically Necessary when it is used in or out of a Member's home to:

1. Preserve bodily functions essential to Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), or to prevent significant physical disability; or

2. Improve the medical status or functional ability of a Member, when a Member is not ambulatory or functionally ambulatory without static supports such as a cane, crutches, or walker, through the stabilization of the Member's condition, or the prevention of additional deterioration of the Member's medical status, or functional ability.

C. The following items are not Covered Services:

1. Modification of automobiles or other highway motor vehicles, with the exception of Automobile Orthopedic Positioning Devices (AOPDs) for eligible CalOptima Medi-Cal Members in accordance with CalOptima Policy GG.1515: Criteria for Medically Necessary Automobile Orthopedic Positioning Devices;

2. Orthopedic recliners, rockers, seat lift chairs, or other furniture items;

3. Household items; and

4. Other items not generally used primarily for health care and which are regularly and primarily used by an individual who does not have a specific medical need for such item.

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D. CalOptima or a Health Network shall determine a Member's eligibility for a Wheelchair, SPCs, and accessories upon receipt of a written prescription for a Wheelchair, SPCs, and accessories by a Member's licensed Practitioner, within the Practitioner's scope of practice, as established by California law.

E. CalOptima or a Health Network shall provide one (1) of the following Wheelchairs, SPCs, and accessories to a Member:

1. Standard manual wheelchair;
2. Custom manual or powered wheelchair;
3. Custom lightweight manual, or powered, wheelchair;
4. Electric-powered wheelchair;
5. Power-assisted vehicle (POV) wheelchair;
6. Push rim activated device;
7. Power Mobility Devices (PMD);
8. Therapeutic seat cushions;
9. SPCs; or
10. Other related wheelchair accessories.

F. CalOptima and a Health Network shall authorize a Wheelchair, SPCs, and accessories for a Member, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals. The following provisions shall also apply:

1. A licensed Practitioner shall obtain Prior Authorization for the following Covered Services:
   a. Rental of a Wheelchair, SPCs, and accessories;
   b. Purchase of a Wheelchair, SPCs, and accessories; or
   c. Repair or maintenance of a Wheelchair, SPCs, and accessories exceeding a total cost of two hundred fifty dollars ($250).
2. A licensed Practitioner shall utilize Department of Health Care Services (DHCS) clinical guidelines, as provided in DHCS All Plan Letter 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, to determine the appropriate device to meet the medical needs of a CalOptima Member.
3. A licensed Practitioner shall obtain Prior Authorization for the evaluation of a custom wheelchair prior to the purchase of a custom wheelchair and accessories.

4. A licensed Practitioner shall request Prior Authorization for a CalOptima Direct Member, in accordance with this Policy and CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers. A licensed Practitioner shall request Prior Authorization for a Health Network Member, in accordance with this policy and the Health Network's Prior Authorization procedures.

5. CalOptima or a Health Network shall refer a Member to a contracted wheelchair Evaluation Services Provider (ESP) for evaluation prior to authorizing a custom Wheelchair, SPCs, and accessories for the Member. In-home evaluation shall be the primary evaluation method for a custom Wheelchair, SPCs, and accessories. Use of a contracted seating clinic is appropriate in cases where an in-home evaluation may be impractical, or if the Member does not wish to have an evaluation conducted in his or her home.

6. If Medicare or Other Health Coverage (OHC) is the primary payer for the Wheelchair, SPCs, and accessories, the Practitioner and Provider are subject to Prior Authorization, as set forth in this policy and CalOptima Policies FF.2003: Coordination of Benefits, MA.3103: Claims Coordination of Benefits, and CMC.3103: Claims Coordination of Benefits.

7. CalOptima or a Health Network shall authorize one (1) Wheelchair per Member. If, at a later time, a Member requires a subsequent Wheelchair, SPCs, and accessories, CalOptima or a Health Network, may authorize a subsequent Wheelchair, SPCs, and accessories, in accordance with the provisions of this policy.

8. CalOptima or a Health Network may authorize the following Wheelchair, SPCs, and accessories for a Member who is an inpatient in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF):

    a. A Wheelchair, SPCs, and accessories are necessary for the continuous care and unusual medical needs of a Member. A Member may be considered to have unusual medical needs if a disease or medical condition is exacerbated by physical characteristics such as height, weight, and build. Physical characteristics shall not constitute an unusual medical condition.

    b. A Wheelchair accessory that is custom made or modified to meet the unusual medical needs of a Member and the need is expected to be permanent.

9. CalOptima or a Health Network shall limit authorization for a Wheelchair, SPCs, and accessories to the lowest cost item that meets a Member's medical needs.

10. CalOptima or a Health Network shall not deny an authorization for a Wheelchair or SPCs for a Medi-Cal or OCC Member on the grounds it is for use outside of the home when determined to be Medically Necessary for the Member's medical condition.

11. CalOptima or a Health Network shall not grant an authorization for a Wheelchair, SPCs, and accessories if a household, or furniture, item shall adequately serve the Member's medical needs.

12. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Member is in possession of a Wheelchair that already meets the Member's ADL or IADL. If the Member's medical, or functional, needs have changed, the Member's

Practitioner may submit a functional assessment containing medical justification for the Member's need for a new, adjusted, or modified Wheelchair.

13. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories for a Member if the Wheelchair, SPCs, and accessories are not Medically Necessary and needed solely for a social, educational, or vocational purpose. CalOptima shall refer the Member to the California State Department of Rehabilitation for Wheelchair, SPCs, and accessories requests based on vocational needs.

14. CalOptima or a Health Network shall not authorize a Wheelchair, SPCs, and accessories when:

    a. Not Medically Necessary;

    b. Not used by the Member;

    c. Used as a convenience item;

    d. Used to replace private, or public, transportation such as an automobile, bus, or taxi;

    e. Not used primarily for health care, and not regularly and primarily used by a Member who has a specific medical need;

    f. For PMDs, the underlying condition is reversible, and the length of need is less than three (3) months, such as following lower extremity surgery that limits ambulation;

    g. Used in a Facility that is expected to provide such items to a Member, except as specified in Section II.F.8. of this policy; or

    h. Not prescribed by a licensed Practitioner, or for custom Wheelchairs, a licensed Practitioner and an ESP.

15. CalOptima or a Health Network shall consider a Wheelchair, SPCs, and accessories to be purchased when previously paid rental charges equal the maximum allowable purchase price of the rented wheelchair and accessories. CalOptima shall provide no further reimbursement for the use of such Wheelchair, SPCs, and accessories, unless payment is for the subsequent repair and maintenance of the Wheelchair, SPCs, and accessories as authorized by CalOptima, or the Health Network. The cost per repair shall not exceed the replacement value of the item being repaired.

16. CalOptima or a Health Network may audit Wheelchair authorization requests, as necessary, for appropriateness and accuracy.

G. A Member is responsible for the appropriate use and care of a Wheelchair, SPCs, and accessories rented or purchased for the Member's benefit.

H. Upon authorization to provide a Wheelchair, SPCs, and accessories for a Member, a Wheelchair Provider shall:

1. Provide a Wheelchair, SPCs, and accessories, in accordance with statutory, regulatory, contractual, CalOptima and Health Network policy, and other requirements related to the CalOptima program;

2. Ensure that the Wheelchair, SPCs, and accessories provided to a Member are appropriate for the Member's medical and functional needs. When necessary, the Wheelchair Provider shall adjust or modify the Wheelchair, SPCs, and accessories during the post-fitting period if the Wheelchair does not:

   a. Meet the Member's medical needs and the Member's medical condition has not changed since the date the Wheelchair was originally provided; or

   b. Meet the Member's functional needs when in actual use.

3. Replace any Wheelchair, SPCs and accessories that cannot be adjusted or modified during the post-fitting period of the Wheelchair at no cost to CalOptima or a Health Network.

III. PROCEDURE

A. Standard Wheelchair

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a standard Wheelchair rental or purchase and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department or the Health Network. Authorization request documentation shall include:

   a. Member's name, date of birth, phone number, address, and identification (ID) number;

   b. Full name, address, telephone number, and signature of the prescribing Practitioner;

   c. Date of request;

   d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for a standard Wheelchair in accordance with DHCS guidelines; and

   e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

2. CalOptima or a Health Network shall approve, modify, or deny an authorization for a standard Wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

B. Manual or Powered Custom Wheelchair:

1. A Member's Practitioner shall identify a Member who has a Medical Necessity for a custom Wheelchair purchase and shall submit a complete authorization request to CalOptima's UM Department or the Health Network.

   a. For a CalOptima Direct Member the authorization request shall consist of the Customized

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Wheelchair Evaluation Request Form (CWER) and Clinical Questionnaire. Authorization request documentation shall include:

i. Member's name, date of birth, phone number, address, and identification (ID) number;

ii. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

iii. Date of request;

iv. Specific items requested;

v. Supporting documentation that the Member meets the Medical Necessity criteria for a manual or powered custom Wheelchair, in accordance with DHCS guidelines; and

vi. Member's medical condition or diagnosis necessitating the custom Wheelchair, including:

a) Member's medical status and functional limitations; and

b) Description of how the requested custom Wheelchair is expected to improve the medical status or functional ability of the Member, stabilize the Member's medical condition, or prevent additional deterioration of the Member's medical status or functional ability.

b. For a Health Network Member, a Practitioner shall submit authorization request documentation in accordance with the Health Network's authorization procedures.

2. CalOptima's UM Department or the Health Network shall review the authorization request documentation submitted by a Member's Practitioner and, if incomplete, shall require the Practitioner to provide additional information.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for a custom wheelchair, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

4. If CalOptima or the Health Network approves the request for a customized wheelchair evaluation, CalOptima or the Health Network shall contact a contracted ESP to arrange an assessment in the Member's residence, or at a seating clinic.

5. ESP staff shall submit a Letter of Recommendation (LOR) to CalOptima or the Health Network following its initial assessment. The LOR shall contain determination of Medical Necessity based on the standards set forth in Section II.B. of this Policy, and the Member's unique medical needs and living environment.

6. CalOptima or the Health Network shall review the LOR and the licensed Practitioner's original Wheelchair request. If the recommendation on the LOR varies from the Practitioner's original request, CalOptima or the Health Network shall notify the Member and Member's Practitioner of such determination according to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

7. If CalOptima or the Health Network approves a customized Wheelchair:

    a. For a CalOptima Direct Member, CalOptima shall forward the LOR, Clinical Questionnaire Form, and CWER Form, to a selected Wheelchair Provider.

    b. For a Health Network Member, the Health Network shall forward the LOR and authorization request to a selected Wheelchair Provider.

    c. CalOptima or the Health Network may select a contracted Wheelchair Provider that has a history with a Member to provide continuity of services.

        i. CalOptima or a Health Network shall provide Continuity of Care for a Member eligible with the California Children's Services (CCS) Program and transitioned into the Whole Child Model (WCM) program with a Specialized or Customized Durable Medical Equipment (DME) provider for up to twelve (12) months, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services. For Specialized or Customized DME under warranty, the Continuity of Care period may be extended to the duration of the warranty.

8. The selected Wheelchair Provider shall arrange a fitting appointment with the Member at the Member's residence or at a seating clinic.

9. The Wheelchair Provider shall obtain Prior Authorization to provide a customized Wheelchair to a Member by submitting an authorization request and a Wheelchair Quote that is signed and dated by the Member's Practitioner to CalOptima or the Health Network.

10. The Wheelchair Provider shall include the following information, at a minimum, in the Wheelchair Quote and prescription submitted to CalOptima or the Health Network:

    a. Member's name, date of birth, phone number, address, and identification (ID) number;

    b. Wheelchair Provider's name, address, telephone number, contact name and telephone number, and National Provider Identifier;

    c. Date of request; and

    d. Description of the Wheelchair and related items, including:

        i. Manufacturer name, model type or serial number, and purchase price;

        ii. Product description;

        iii. Billing and procedure codes, as applicable;

        iv. For unlisted or miscellaneous codes, copy of the catalogue page with price.

11. For an unlisted Wheelchair and accessories, the Member's Wheelchair Provider shall submit the following information:

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a. Medical documentation justifying that the equipment is Medically Necessary and meets the Member's medical needs; and

b. Explanation of why a listed item does not meet the Member's medical needs and how the unlisted item best accommodates the Member's functional limitations and medical needs.

12. CalOptima or the Health Network shall review the authorization request and the signed Wheelchair Quote submitted by the Wheelchair Provider and, if incomplete, shall require the Member's Practitioner, or Wheelchair Provider to provide additional information.

13. If CalOptima or the Health Network approves the custom Wheelchair, CalOptima or the Health Network shall send a letter of authorization to the contracted custom Wheelchair Provider. Upon receipt, the Wheelchair Provider shall assemble the custom wheelchair in accordance with the authorization.

14. Upon completion of the Wheelchair, the Wheelchair Provider shall provide a post-fitting at the Member's residence or at the seating clinic to ensure that the Member's Wheelchair meets the medical and functional needs of the Member.

15. Upon receipt of the signed delivery ticket from the contracted Wheelchair Provider and confirmation that the Member's Wheelchair meets the medical and functional needs of the Member, CalOptima or the Health Network shall process the claim for payment.

C. Seating and Positioning Component

1. A Member may be eligible to receive SPCs when Medically Necessary, and, for Medi-Cal and OCC Members, pursuant to DHCS guidance.

2. A licensed Practitioner and shall submit a complete authorization request with a written prescription to CalOptima's Utilization Management (UM) Department or the Health Network. Authorization request documentation shall include:

a. Member's name, date of birth, phone number, address, and identification (ID) number;

b. Full name, address, telephone number, and signature of the prescribing licensed Practitioner;

c. Date of request;

d. For Medi-Cal and OCC Members, supporting documentation that the Member meets the Medical Necessity criteria for SPCs, in accordance with DHCS guidelines; and

e. Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes.

3. CalOptima or a Health Network shall approve, modify, or deny an authorization for SPCs, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

D. Wheelchair Repair

1. A Wheelchair repair request with a total cost of less than two hundred fifty dollars ($250), that is a Covered Service, and that does not exceed frequency limitations, shall not require a Prior Authorization.

    a. For a CalOptima Direct Member, CalOptima shall reimburse such repair pursuant to all applicable claims requirements, in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group and CMC.3101: Claims Processing.

    b. For a Health Network Member, a Health Network shall reimburse such repair pursuant to all applicable claims requirements.

2. A Member's Practitioner shall complete a Wheelchair repair authorization request for a Wheelchair repair exceeding a total cost of two hundred fifty dollars ($250). Documentation shall include:

    a. Member's name, date of birth, phone number, address, and identification (ID) number;

    b. Full name, address, telephone number, and signature of the prescribing Practitioner;

    c. Date of request; and

    d. Description of the repair, or maintenance, required.

3. Upon submission of the Wheelchair repair authorization request, CalOptima's UM Department or the Health Network shall review the request for benefit coverage, frequency limitations, and Medical Necessity. CalOptima or the Health Network shall approve, modify, or deny a Wheelchair repair authorization, in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

E. Medical Therapy Program - California Children's Services (CCS)/Whole Child Model Program (WCM) Members

1. Effective January 1, 2019, for Members eligible with the CCS Program who participate in the Orange County CCS Medical Therapy Program (MTP), the MTP shall submit all requests for Wheelchairs and Wheelchair repairs with a total cost of over $250 to CalOptima. The request will include:

    a. Completed Custom Wheelchair Authorization Referral Form, if applicable;

    b. Signed prescription/provider order for the requested Wheelchair; and

    c. Wheelchair specifications, HCPCS codes and pricing from the Wheelchair vendor that have been reviewed/confirmed by Medical Therapy Unit (MTU) therapist/supervisor.

2. CalOptima will review and triage these requests to CalOptima or the Health Network Prior Authorization staff via secure communication.

3. If a referral for a Wheelchair or Wheelchair repair for a CCS-eligible Member is received by

CalOptima or a Health Network directly from a vendor and not from the MTU, the request will be denied, and the Member referred to the MTU for evaluation.

4. If the Member requests a Wheelchair or a Wheelchair repair that the MTU does not recommend, the MTU will notify CalOptima who will issue or instruct the Health Network to issue the appropriate Notice of Action letter.

5. For Wheelchairs or Wheelchair repairs that are covered and recommended by the MTU, CalOptima or a Health Network will approve the Wheelchair request in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.

6. Following approval, CalOptima or a Health Network will notify the requesting provider, the Member's MTP and Wheelchair Provider within standard prior authorization turn around-time requirements for Wheelchair requests.

7. Effective January 1, 2019, for all other CCS-eligible Members, Wheelchair-related requests will be processed in the same manner as provided for non-CCS Members in this Policy, except with regard to Continuity of Care as described in Section III.B.7.c.i. of this Policy.

IV. ATTACHMENTS

A. CalOptima Authorization Request Form (ARF)
B. Customized Wheelchair Evaluation Request (CWER) Form
C. Clinical Questionnaire: Referring Physician Authorization for New Wheelchair
D. Wheelchair Repairs Authorization Referral Form

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 Contract for Wheelchair Services
E. CalOptima Health Network Service Agreement
F. CalOptima Policy CMC.3103: Claims Coordination of Benefits
G. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
H. CalOptima Policy FF.2003: Coordination of Benefits
I. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
J. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
K. CalOptima Policy GG.1508: Authorization and Processing of Referrals
L. CalOptima Policy MA.3103: Claims Coordination of Benefits
M. Centers for Medicare & Medicaid Services (CMS) Managed Care Manual (MCM) Chapter 4, Section 10.12: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

N. Department of Health Care Services All Plan Letter (APL) 15-018: Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, including DHCS Guidance: Durable Medical Equipment: Wheelchair and Wheelchair Accessories
O. Department of Health Care Services Medi-Cal Allied Health Provider Manual Durable Medical Equipment (DME): An Overview
P. Department of Health Care Services All Plan Letter (APL) 18-011: California Children's Services Whole Child Model Program
Q. McKesson Health Solutions InterQual Level of Care Criteria
R. Title 22, California Code of Regulations (CCR.), §§ 51303, 51104, 51160, and 51321
S. Welfare and Institutions Code, §14105.485

VI. REGULATORY AGENCY APPROVALS

A. 12/10/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors
B. 07/10/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2009	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	01/01/2010	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal
Revised	08/01/2015	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1531	Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Dressing/bathing, eating ambulating (walking), toileting and hygiene.
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 pre-existing provider relationship.
Custom Wheelchair	For the purposes of this policy, refers to those wheelchairs which are specialized, requiring an evaluation be done by a Seating Clinic prior to submitting an Authorization Request Form to a contracted vendor who is able to provide the wheelchair customization needed for the member.
Durable Medical Equipment	Any equipment that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
Evaluation Services Provider (ESP)	A professional who has specific training and/or experience in Wheelchair evaluation and ordering.
Health Network	A Physician Medical Group (PMG), 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.
Instrumental Activities of Daily Living (IADL)	Those activities that allow a Member to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within the Member's community.
Intermediate Care Facility (ICF)	Medi-Cal: A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program. Medicare: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Other Health Coverage (OHC)	Medi-Cal: 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. OneCare/OneCare Connect: Evidence of health coverage other than OneCare/OneCare Connect including, but not necessarily limited to: 1. The CalOptima Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
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.
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.
Seating and Positioning Components (SPC)	Seat, back and positioning equipment mounted to the Wheelchair base.
Seating Clinic	A CalOptima contracted utilization management evaluation by a multidisciplinary team led by a principal therapist to evaluate a Member's needs for a Custom Seating System, recommend the most appropriate Custom Seating System, fit the Custom Seating System, and Report UM activity.

Term	Definition
Skilled Nursing Facility (SNF)	Medi-Cal: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program. OneCare/OneCare Connect: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Standard Wheelchair	For the purposes of this policy, refers to those wheelchairs that are available through any contracted vendor that provides wheelchair rentals on a short term basis, or for purchase. These wheelchairs do not require an evaluation by the Seating Clinic and are typically for short term use and are not customizable.
Wheelchair	A wheelchair may be a: 1. Manual wheelchair; 2. Power mobility device (PMD); 3. Power-assisted vehicle (POV); or 4. Push rim activated device.
Wheelchair Provider	A contracted provider, acting within his or her scope of practice, to furnish wheelchairs, SPCs, and related accessories to Members. The Wheelchair Provider ensures the Wheelchair, SPCs, and accessories furnished are appropriate for the Member's medical and functional needs and may adjust or modify the furnished items as appropriate.

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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

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Print Form

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Custom Wheelchair Evaluation Request

Information to accompany Clinical Questionnaire

Fax information to CalOptima at 714-481-6516

MEMBER INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
(First) (MI) (Last)

Medi-Cal Number (CIN): _____ Gender: ☐ Female ☐ Male Phone: _____

Patient Address: _____ City: _____ ZIP: _____

☐ Home ☐ Board and Care ☐ ICF-DD SNF ☐ Other: _____

Facility Name: _____ Contact: _____

Language: Patient Speaks: _____ Patient Understands: _____

Caregiver / Family member participating in assessment and fitting ☐ YES ☐ NO ☐ N/A If yes, language spoken: _____

Transportation: ☐ Self / Family / Caregiver ☐ Public **OR** Medically necessary: ☐ Medivan ☐ Littervan ☐ Basic Ambulance

PRESCRIPTION

(Rx must be completed, signed, and dated by attending physician.)

Prescribing Physician _____

Medi-Cal Provider ID # _____

Phone: _____ Fax: _____

Address _____

Primary Care Physician (PCP): _____

Medi-Cal Provider ID # _____

Phone: _____ Fax: _____

Address _____

Primary Dx: _____ ICD-10: _____ Current Functional Status: _____

Current Wheelchair: ☐ YES ☐ NO If "YES": ☐ Manual ☐ Power ☐ Tilt/Recline Year: _____ Serial #: _____

Custom DME Prescribed: ☐ Therapeutic Cushion ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Not Specified

M. D. Signature: _____ Date: _____

Preferred Vendor: _____

(If provider or member does not designate, CalOptima will assign DME vendor)

AUTHORIZATION *(For CalOptima Use Only)*

Eligibility Date: _____ Health Network: _____ Other Health Coverage: Medicare N/A

Utilization Contact: _____ Phone: _____ FAX: _____

Approved Codes:

- ☐ S100C & S200C (Therapeutic Seat Cushion and/or Positioning System & Post Delivery Assessment/Fitting)
- ☐ S101C & S201C (Custom Foam/Molded Cushion & Post Delivery Assessment Fitting)
- ☐ S 102C & S202C (Manual Wheelchair With or Without Therapeutic Cushion & Post Delivery
- ☐ S103C & S203C (Manual Wheelchair With Positioning System, With or Without Therapeutic Cushion & Post Delivery Assessment/Fitting
- ☐ S 104C & S204C (Power Wheelchair With or Without Therapeutic Cushion & Post Delivery
- ☐ AS105C & S205C t/Fitti) (Power Wheelchair With Power Tilt/Recline or Specialized Driving Controls & Post Delivery
- ☐ S300C & S301C (In-home assessment by DME Assessment Provider & Post Delivery Assessment/Fitting)

Approved Provider: _____

Authorization #: _____ Date Approved: _____ Date Sent: _____ By: Fax Mail

Records Attached: Progress Notes H&P Therapy Notes Operative Report Acute/LTC Facility Notes Previous Equipment Repairs

Denied M.D. Signature: _____ Date: _____

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Print Form

CalOptima
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Clinical Questionnaire: Referring Physician Authorization for New Wheelchair and/or Custom Seating Equipment

Patient Name: Medi-Cal Number (CIN):

Thank you for taking the time to answer the following questions about your patient's need for new seating equipment. Your complete answers will ensure that your patient's authorization can be reviewed in a timely manner.

1. Please describe the patient's diagnosis and nature of injury:

2. Give a brief explanation of the patient's prognosis:

3. What is the patient's current functional status?

4. If you are prescribing a custom manual or power wheelchair, please give a brief explanation of why a standard manual wheelchair is not adequate for the patient's use:

5. If a power wheelchair is being requested, what is patient's current cognitive status?
   ☐ Not Alert ☐ Alert *Oriented to:* ☐ *Self* ☐ *Other* ☐ *Place* ☐ *Time*

6. If the patient is being evaluated for a custom seating system or therapeutic cushion, please explain why this is being requested.

7. Does the patient have a history of any skin breakdown? ☐ Yes ☐ No

8. List all the patient's relevant previous or pending surgeries:

9. If a new wheelchair, seating system or therapeutic cushion is being prescribed to replace existing equipment, please explain why the current equipment no longer meets the patient's needs.

10. What medical and functional objectives will be met with the equipment you have prescribed?

Additional relevant information:

Physician's Signature: _____ Date: _____

Please complete and return this form to:
CalOptima Care Coordination · P. O. Box 11033 · Orange, CA 92856 · Phone: (714) 246-8686 · FAX: (714) 481-6516

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Print Form

CalOptima
Better Together.

WHEELCHAIR REPAIRS
Authorization Referral Form

Fax information to CalOptima at 714-481-6516

MEMBER INFORMATION

Patient Name:_____ Date of Birth:_____ Age:_____
(Last) (MI) (First)

Medi-Cal Number (CIN): _____ Gender: ☐ Female ☐ Male

Patient Address: _____ City: _____ Zip: _____ Phone: _____

☐ Home ☐ Board and Care ☐ ICF-DD ☐ SNF ☐ Other:_____

Facility Name: _____ Contact: _____

Language: Patient Speaks: _____ Patient Understands: _____

Caregiver / Family member participating in assessment and fitting ☐YES ☐ NO ☐ N/A If yes, language spoken: _____

PRESCRIPTION

(Rx must be completed, signed, and dated by attending physician.)

Prescribing Physician: _____

Medi-Cal Provider ID # _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Primary Dx: _____ ICD-9: _____ Current Functional Status: _____

Current Wheelchair: ☐ Manual ☐ Power ☐ Tilt/Recline Year: _____ Serial #: _____

Brief description of services needed:

M. D. Signature: _____ License No: _____ Date: _____

PRINT Name: _____

CALOPTIMA TO ASSIGN DME VENDOR

02/01/09

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Policy #:	GG.1535
Title:	**Utilization Review Criteria and Guidelines**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/05
Last Review Date:	~~01/01/18~~10/04/18
Last Revised Date:	~~01/01/18~~10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes the process by which CalOptima ~~shall establish~~establishes Utilization ~~Review~~ criteria and guidelines to ensure that decisions related to Utilization Management and coverage or denial of organization determinations are made in a consistent manner and comport with ~~this policy~~program requirements and local and national care standards.

II. POLICY

A. CalOptima shall ensure that decisions related to Utilization Management (UM) and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines set forth in this policy.

~~B. On an annual basis, CalOptima shall administer Inter-Rater Reliability testing to all personnel who perform Organization Determinations and issue individual Corrective Action Plans (CAPs) to CalOptima staff who score below the acceptable threshold.~~

~~C.~~B. CalOptima shall not ~~specifically~~ reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care.

~~D.~~C. CalOptima shall ensure that criteria and practice guidelines and UM activities and decisions:

1. Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field;

2. Consider the needs of the enrolled population;

3. Are developed in consultation with contracted Providers; and

4. Are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician members for review and approval.

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~~E.~~D. CalOptima shall conduct the Utilization Review using criteria and guidelines that are approved and adopted in the CalOptima UM Program. Such criteria and guidelines may include, but are not limited to:

1. Nationally ~~-~~recognized Evidence Based criteria such as Milliman Care Guidelines (MCG);

~~2.~~ Medicare and Medi-Cal ~~coverage guidelines and criteria;~~

~~3.~~1. ~~National Comprehensive Cancer Network (NCCN) Guidelines;~~

~~4.~~2. ~~CalOptima proprietary Level~~Manual of ~~Care criteria for outpatient services~~Criteria;

~~5. Specialty society guidelines, such as American Academy of Pediatrics (AAP);~~

~~6.~~3. Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines;

4. Medicare Part D: CMS-approved Compendia;

5. National Guideline Clearinghouse;

6. National Comprehensive Cancer Network (NCCN) Guidelines;

7. Transplant Centers of Excellence guidelines;

8. Specialty society guidelines, such as American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines;

~~8.~~9. Preventive health guidelines (~~i.~~*e.g.*, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG~~)~~ Guidelines);

~~9.~~10. CalOptima Criteria for outpatient behavioral health ~~Level of Care guidelines for outpatient~~ services~~; and~~,

~~10.~~11. CalOptima Policies and Medi-Cal Benefits Guidelines~~.~~, and

12. Effective January 1, 2019, active CCS Numbered Letters (N.L.s) and CCS Information Notices applicable to County Organized Health System Plans in the WCM program~~.~~.

D. If CalOptima delegates Utilization Review, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the Delegate shall submit its Utilization Review criteria and guidelines to CalOptima for approval prior to implementation.

E. Upon a treating physician's or Member's request, CalOptima~~,~~ or the Member's Health Network shall provide, in writing, all criteria used in making a UM ~~decisions~~decision including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines.

~~F. On an annual basis, CalOptima and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to verify the consistent and accurate application of Utilization Review criteria in decision-making.~~

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~~G.~~F. CalOptima shall ensure its UM policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

III. PROCEDURE

A. CalOptima shall document Utilization Review criteria and guidelines utilized for ~~Organization Determinations~~decisions related to Utilization Management and coverage or denial of requested services.

B. CalOptima shall automatically incorporate all Medicare and Medi-Cal changes into its Utilization Review criteria and guidelines, no later than the effective date of the ~~changes~~change and will seek UMC approval at the next regularly scheduled UMC meeting.

C. On an annual basis, CalOptima's Director of Utilization Management or Designee shall submit criteria and guidelines, as specified in Section ~~III.E~~II.D. of this policy, to the ~~Utilization Management Committee (~~UMC~~)~~ and Quality Improvement Committee (QIC) for review and approval.

D. Upon the QIC's approval of the criteria and guidelines, the CalOptima's Director of Utilization Management or Designee shall adopt and implement the approved criteria into the UM Program.

E. Upon the UM Committee's and QIC's approval of the criteria and guidelines, CalOptima shall:

1. Distribute the criteria and guidelines to all of CalOptima's professional reviewers;

2. Activate the criteria and guidelines in the UM systems; and

3. Make the criteria and guidelines available to Members and Providers, upon request.

F. Delegated Health Networks shall, pursuant to the CalOptima Health Network Service Agreement, adopt and implement Evidence-Based criteria and guidelines related to utilization Organization Determinations. The CalOptima Audit and Oversight Department shall monitor and ensure this requirement is reviewed annually by the Delegate's Utilization Management Committee for all CalOptima programs.

G. ~~On an annual basis, CalOptima's Director of Utilization Management or Designee shall conduct~~ Inter-~~Rater~~Rate Reliability Audits

1. On an annual basis, CalOptima and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to verify the consistent and accurate application of Utilization Review criteria in decision-making.~~audits on professional reviewers.~~

~~G.~~2. CalOptima's Director of Utilization Management or Designee shall forward results of the CalOptima Inter-Rater Reliability audits to the ~~UM Committee~~UMC for review and action.

3. CalOptima shall issue individual Corrective Action Plans (CAPs) to CalOptima staff who score below the acceptable threshold.

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H. If the CalOptima Medical Director identifies a need to update any criteria or guidelines, CalOptima's Director of Utilization Management or Designee shall submit a request to the ~~QIC~~UMC to implement such update~~.~~; updates approved by the UMC will be presented to the next regularly scheduled QIC for final review and approval

I. CalOptima shall monitor a Delegate's UM activities including the Delegate's use of CalOptima's criteria and guidelines, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation.

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.~~A. ~~CalOptima Health Network Service Agreement~~
~~D.~~A. ~~CalOptima Policy GG.1541: Utilization Management Delegation~~
~~E.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1541: Utilization Management Delegation
F. CalOptima Utilization Management Program
G. Medicare and Medi-Cal Coverage Guidelines
H. Health and Safety Code Sections, 1363.5 and 1367.01
I. Title 42, Code of Federal Regulations, Section 438.910(d)
J. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
K. California Children's Services Numbered Letter Index

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

~~None to Date~~A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	01/01/2007	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	06/01/2013	MA.6001	Utilization Review Criteria and Guidelines	OneCare

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2015	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	10/01/2016	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Corrective Action Plan	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	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).
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.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
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.
Inter-Rater Reliability	An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.
Member	An enrollee-beneficiary of a CalOptima program.

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Term	Definition
Organization Determination	Medi-Cal: Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a Member to pay for an item or service, or a limit on the quality of items or service. OneCare and OneCare Connect: Any determination made by OneCare or OneCare Connect with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare or OneCare Connect that the Member believes: a. Are covered under Medicare; or ~~a.~~ ~~2.~~b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare or OneCare Connect. 3. OneCare or OneCare Connect's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare or OneCare Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare or OneCare Connect's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
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.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Review	Process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.

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Policy #:	GG.1535
Title:	**Utilization Review Criteria and Guidelines**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/05
Last Review Date:	10/04/18
Last Revised Date:	10/04/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes the process by which CalOptima establishes Utilization criteria and guidelines to ensure that decisions related to Utilization Management and coverage or denial of organization determinations are made in a consistent manner and comport with program requirements and local and national care standards.

II. POLICY

A. CalOptima shall ensure that decisions related to Utilization Management (UM) and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines set forth in this policy.

B. CalOptima shall not reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care.

C. CalOptima shall ensure that criteria and practice guidelines and UM activities and decisions:

1. Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field;

2. Consider the needs of the enrolled population;

3. Are developed in consultation with contracted Providers; and

4. Are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician members for review and approval.

D. CalOptima shall conduct the Utilization Review using criteria and guidelines that are approved and adopted in the CalOptima UM Program. Such criteria and guidelines may include, but are not limited to:

1. Nationally-recognized Evidence Based criteria such as Milliman Care Guidelines (MCG);

2. Medicare and Medi-Cal Manual of Criteria;

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3. Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines;

4. Medicare Part D: CMS-approved Compendia;

5. National Guideline Clearinghouse;

6. National Comprehensive Cancer Network (NCCN) Guidelines;

7. Transplant Centers of Excellence guidelines;

8. Specialty society guidelines, such as American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines;

9. Preventive health guidelines (*e.g.*, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines);

10. CalOptima Criteria for outpatient behavioral health services,

11. CalOptima Policies and Medi-Cal Benefits Guidelines, and

12. Effective January 1, 2019, active CCS Numbered Letters (N.L.s) and CCS Information Notices applicable to County Organized Health System Plans in the WCM program.

D. If CalOptima delegates Utilization Review, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation, the Delegate shall submit its Utilization Review criteria and guidelines to CalOptima for approval prior to implementation.

E. Upon a treating physician's or Member's request, CalOptima or the Member's Health Network shall provide, in writing, all criteria used in making a UM decision including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines.

F. CalOptima shall ensure its UM policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

III. PROCEDURE

A. CalOptima shall document Utilization Review criteria and guidelines utilized for decisions related to Utilization Management and coverage or denial of requested services.

B. CalOptima shall automatically incorporate all Medicare and Medi-Cal changes into its Utilization Review criteria and guidelines, no later than the effective date of the change and will seek UMC approval at the next regularly scheduled UMC meeting.

C. On an annual basis, CalOptima's Director of Utilization Management or Designee shall submit criteria and guidelines, as specified in Section II.D. of this policy, to the UMC and Quality Improvement Committee (QIC) for review and approval.

D. Upon the QIC's approval of the criteria and guidelines, the CalOptima's Director of Utilization Management or Designee shall adopt and implement the approved criteria into the UM Program.

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E. Upon the UM Committee's and QIC's approval of the criteria and guidelines, CalOptima shall:

1. Distribute the criteria and guidelines to all of CalOptima's professional reviewers;

2. Activate the criteria and guidelines in the UM systems; and

3. Make the criteria and guidelines available to Members and Providers, upon request.

F. Delegated Health Networks shall, pursuant to the CalOptima Health Network Service Agreement, adopt and implement Evidence-Based criteria and guidelines related to utilization Organization Determinations. The CalOptima Audit and Oversight Department shall monitor and ensure this requirement is reviewed annually by the Delegate's Utilization Management Committee for all CalOptima programs.

G. Inter-Rate Reliability Audits

1. On an annual basis, CalOptima and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to verify the consistent and accurate application of Utilization Review criteria in decision-making.

2. CalOptima's Director of Utilization Management or Designee shall forward results of the CalOptima Inter-Rater Reliability audits to the UMC for review and action.

3. CalOptima shall issue individual Corrective Action Plans (CAPs) to CalOptima staff who score below the acceptable threshold.

H. If the CalOptima Medical Director identifies a need to update any criteria or guidelines, CalOptima's Director of Utilization Management or Designee shall submit a request to the UMC to implement such update; updates approved by the UMC will be presented to the next regularly scheduled QIC for final review and approval

I. CalOptima shall monitor a Delegate's UM activities including the Delegate's use of CalOptima's criteria and guidelines, in accordance with CalOptima Policy GG.1541: Utilization Management Delegation.

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. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy GG.1541: Utilization Management Delegation
F. CalOptima Utilization Management Program
G. Medicare and Medi-Cal Coverage Guidelines
H. Health and Safety Code Sections, 1363.5 and 1367.01

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I. Title 42, Code of Federal Regulations, Section 438.910(d)
J. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
K. California Children's Services Numbered Letter Index

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	01/01/2007	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	06/01/2013	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	11/01/2015	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Retired	12/22/2015	MA.6001	Utilization Review Criteria and Guidelines	OneCare
Revised	10/01/2016	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Corrective Action Plan	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	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).
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.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
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.
Inter-Rater Reliability	An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.
Member	An enrollee-beneficiary of a CalOptima program.

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Term	Definition
Organization Determination	Medi-Cal: Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a Member to pay for an item or service, or a limit on the quality of items or service. OneCare and OneCare Connect: Any determination made by OneCare or OneCare Connect with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare or OneCare Connect that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare or OneCare Connect. 3. OneCare or OneCare Connect's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare or OneCare Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare or OneCare Connect's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
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.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Review	Process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.

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Policy #:	GG.1547PP
Title:	**Maintenance and Transportation**
Department:	Medical Affairs
Section:	Case Management
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/19
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy defines the criteria and process for administration of the Maintenance and Transportation benefit for CalOptima Members eligible with the California Children's Services (CCS) Program.

II. POLICY

A. CalOptima is responsible for authorizing and reimbursing Maintenance and Transportation for CCS-eligible Members enrolled in CalOptima Direct and the Health Networks. The Health Networks shall be responsible for identifying CCS-eligible Members that may be eligible for the Maintenance and Transportation benefit and forward the necessary information to CalOptima to determine benefit eligibility.

B. CalOptima shall provide Maintenance and Transportation benefits to CalOptima CCS-eligible Members or such Member's family seeking transportation to a Covered Service related to their CCS-Eligible Condition when the cost of Maintenance and Transportation presents a barrier to accessing authorized diagnostic or treatment services.

C. CalOptima may authorize Maintenance and Transportation when CalOptima determines:

1. No other available resources exist to assist the CCS-eligible Member/parent(s)/legal guardian(s) to access authorized Medically Necessary medical services related to the Member's CCS-Eligible Condition, including:

   a. The Member, parent(s)/legal guardian(s) have no means of reaching the approved provider/facility without outside help; and

   b. Alternative resources for these services are not available in the community

D. A Health Network shall coordinate with the CalOptima Case Management Department to ensure timely and appropriate delivery of Maintenance and Transportation services in accordance with Section III.B. of this Policy.

E. Transportation

1. CalOptima will arrange the most appropriate and cost-effective mode of transportation to access authorized medical services. If the CCS-eligible Member and/or parent(s)/legal guardian(s) choose to go to a provider/facility that is not the closest CCS approved facility/paneled provider, transportation costs beyond those to reach the closest provider capable of delivering

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the level/type of services required are the responsibility of the Member and/or parent(s)/legal guardian(s).

F. Non-Emergency Medical Transportation (NEMT) is not covered under the Maintenance and Transportation benefit. NEMT is provided in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-emergency and Non-medical.

G. CalOptima may approve Transportation to a Medical Therapy Unit (MTU) for physical or occupational therapy, or to attend a Medical Therapy Conference if a transportation need has been identified jointly by the family and the MTU treating therapist as necessary for the CCS-eligible Member's access to these services in accordance with the provisions of this Policy and when transportation is not included in the Member's Individualized Education Plan (IEP).

H. Maintenance and Transportation may be a benefit for authorized medical care provided outside the state of California for a CCS-eligible condition in accordance with the provisions of this Policy.

I. A Member, family or legal guardian may appeal a denial for Maintenance and Transportation assistance in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services.

III. PROCEDURE

A. A Health Network shall identify a CCS-eligible Member who may be eligible for the Maintenance and Transportation benefit through communication with the Member, family or legal guardian and confirmation of an approved treatment request meeting the criteria in this Policy.

B. The Health Network shall forward the following information to CalOptima via fax or other secure method:

1. Completed WCM Maintenance and Transportation Assistance Worksheet;

2. Approval notification for the Medically Necessary diagnostic and/or treatment services for the CCS-Eligible Condition for which Maintenance and Transportation is requested; and

3. Name and contact number for Health Network case manager.

4. The CalOptima case management transportation coordinator shall review the Maintenance and Transportation request and documentation submitted.

   a. If the request meets the requirements for Maintenance and Transportation assistance, as outlined in this Policy, CalOptima shall send notification of approval to the WCM Member/family or legal guardian and the Member's Health Network.

      i. CalOptima shall coordinate with CalOptima's transportation vendor Special Arrangements Liaison to ensure approved Maintenance and Transportation arrangements are made, either prospectively or for reimbursement of allowable expenses incurred by the CCS-eligible Member, family or legal guardian.

      ii. CalOptima shall be responsible to pay approved Maintenance and Transportation costs to the contracted vendor.

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b. If the request does not meet the requirements for Maintenance and Transportation assistance as outlined in this Policy, CalOptima shall issue a Notice of Action (NOA)/Notice of Adverse Benefit Determination (NABD) to the CCS-eligible Member, family or legal guardian and provide a copy of the notice to the Health Network.

i. The Health Network case manager shall work with the WCM Member, family or legal guardian to provide alternative resources.

C. CalOptima shall identify CCS-eligible Members assigned to CalOptima Direct who may be eligible for the Maintenance and Transportation benefit through communication with the CCS-eligible Member, family or legal guardian and approval for treatment request meeting the criteria in this Policy.

1. The assigned CalOptima case manager shall complete the WCM Maintenance and Transportation Assistance Worksheet, attach the document in the medical management system and send a request for action in the medical management system to the CalOptima case management transportation coordinator.

2. The CalOptima case management transportation coordinator shall review the Maintenance and Transportation request and documentation submitted.

a. If the request meets the requirements for Maintenance and Transportation assistance as outlined in this Policy, notification of approval will be sent to the Member/family or legal guardian and a request for action will be sent to the assigned Case Manager.

i. CalOptima shall coordinate with CalOptima's transportation vendor Special Arrangements Liaison to ensure approved Maintenance and Transportation arrangements are made, either prospectively or for reimbursement of allowable expenses incurred by the CCS-eligible Member, family or legal guardian.

b. If the request does not meet the requirements for Maintenance and Transportation assistance as outlined in this Policy, CalOptima shall issue a NOA/NABD to the Member, family or legal guardian.

i. The assigned case manager shall work with the WCM Member, family or legal guardian to provide alternative resources.

D. CalOptima may authorize Maintenance when:

1. The CCS-eligible Member is obtaining authorized outpatient services and the distance from the CCS-eligible Member's home to the facility/provider authorized for outpatient services is such that the trip cannot be made in one (1) calendar day; or

2. If the parent(s)/legal guardian(s) are staying with and supporting a hospitalized CCS-eligible Member and the distance from the Member's home to the facility is such that the trip cannot be made in one (1) calendar day; and

3. Alternative resources have been explored and are unavailable; and

4. The CCS-eligible Member and/or parent(s)/legal guardian(s) have no means of providing for their Maintenance without the assistance from CalOptima.

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5. CalOptima shall not reimburse a family for meals and lodging if the family could make the trip in one (1) calendar day if they had traveled to the nearest appropriate provider for services.

E. Access to Inpatient Services

1. Maintenance

a. For intensive care settings, when the parent/legal guardian is not permitted to stay at the CCS-eligible Member's bedside, CalOptima may initially authorize up to seven (7) calendar days of lodging and meals per hospitalization for one (1) or two (2) parent(s)/legal guardian(s). CalOptima will evaluate the need for additional lodging and meals based on the Member's circumstances.

b. For non-intensive care settings when parent(s)/legal guardian(s) are able to stay at the CCS-eligible Member's bedside, CalOptima may authorize one (1) calendar day of lodging for one (1) or two (2) parent(s)/legal guardian(s) after every six (6) nights of Member hospitalization.

c. CalOptima may authorize the total maximum Maintenance and Transportation authorization when a CCS-eligible Member is in intensive or non-intensive care setting shall be fifteen (15) calendar days of lodging and associated meals for each thirty (30) calendar days of Member hospitalization, beginning with the day of the Member's admission. Each new Member hospitalization shall be a new thirty (30) calendar day Maintenance and Transportation benefit period.

2. Transportation

a. Two (2) round trips per CCS-eligible Member's hospitalization for stays of less than seven (7) calendar days duration.

b. One (1) round trip for every seven (7) calendar days of a CCS-eligible Member's hospitalization in addition to the initial two (2) trips, if the hospitalization lasts longer than seven (7) calendar days.

3. Post-hospitalization

a. CalOptima may authorize lodging and meals for a Member and the Member's parent or guardian if the Member's discharge plan documents the need for daily medical visits for treatment of the CCS-Eligible Condition, and the distance precludes making the trip to the hospital in one (1) calendar day.

F. Access to Outpatient Services

1. Maintenance

a. If a family's trip to the outpatient provider can be completed in one (1) calendar day (round trip travel and appointment time included), there should not be reimbursement for meals or lodging.

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b. If the total time for the trip will exceed one (1) calendar day, lodging and meals for one (1) or two (2) parents/legal guardian(s) and the CCS-eligible Member may be authorized.

2. Transportation

a. If the distance to the provider is such that the trip may be made in one (1) calendar day, then the family may be assisted with Transportation if lack of transportation is a barrier to the family's compliance with the treatment plan.

b. CalOptima may provide approval for a block of multiple trips when it is known that a CCS-eligible Member must make a specified number of visits to the provider for treatment, such as radiation therapy, chemotherapy, etc.

G. Reimbursement

1. Private Car Mileage: Reimbursement will be at the Internal Revenue Service (IRS) standard mileage rate for medical transportation. The rate paid will be the rate in effect on the date the travel occurred, not the rate in effect at the time the claim is submitted for payment.

2. Lodging costs for Member/parent(s)/ legal guardian(s): Reimbursement shall be based on the usual or actual costs of one (1) room up to the maximum amount per night based on the State of California employee lodging. Reimbursement for the cost of lodging provided by facilities sponsored by charitable organizations should not be greater than the customary charges to families.

3. Meals: Reimbursement shall be at actual costs per person, up to $15/day. Hospital meal voucher(s) will be credited as part of the $15/day meal assistance. Reimbursement will be based on actual costs supported by receipts for meals. Hospital meal vouchers provided to the Member/parent(s)/legal guardian(s) will be paid based upon the invoice submitted by the hospital.

4. Other necessary expenses: Reimbursement may be made for other necessary expenses, including, but not limited to, parking and tolls based upon actual costs supported by receipts.

5. CalOptima shall inform CCS-eligible Members or parent(s)/legal guardian(s), in writing, of the following, upon approval of the Maintenance and Transportation request:

a. How to submit requests for reimbursement;

b. How to submit required receipts and/or other documentation for expenses incurred as Maintenance and Transportation (gasoline, hotel/motel, meals, parking, tolls, etc.); and

c. That failure to comply with these requirements could preclude future authorization of Maintenance and Transportation services for the Member/family

H. CalOptima shall maintain a record of authorizations for Maintenance and Transportation services, which includes:

1. Start and end dates of authorization for Maintenance and/or Transportation services;

2. Member name;

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3. Member Client Index Number (CIN);

4. CCS number;

5. Type and number of authorized services; and

6. Vendor contact information.

IV. ATTACHMENTS

A. WCM Maintenance and Transportation Assistance Worksheet

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Department of Health Care Services (DHCS) All Plan Letter 18-011: California Children's Services Whole Child Model Program
C. CCS Numbered Letter 03-0810: Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services
D. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical
E. CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services
F. California Health and Safety Code, §123840(j)
G. U.S. Code Title 26, Subtitle A, Chapter 1, Subchapter B, Part VII, §213

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 10/04/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2019	GG.1547PP	Maintenance and Transportation	Medi-Cal

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IX. GLOSSARY

Term	Definition
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.
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.
Individualized Education Plan (IEP)	A written document for an individual with exceptional needs that is developed, reviewed, and revised in a meeting in accordance with Sections 300.320 to 300.328, inclusive, of Title 34 of the Code of Federal Regulations and California Education Code, Title 2, Division 4, Part 30. It also means "individualized family service plan" as described in Section 1436 of Title 20 of the United States Code if the individualized education program pertains to an individual with exceptional needs younger than three (3) years of age.
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
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.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
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.

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Medi-Cal CalOptima A Public Agency Better. Together.

WCM Maintenance and Transportation Assistance Worksheet

Member Name _____ CIN: _____

Member/Family current address: _____

CCS-Eligible Dx: _____

M&T requested by: ☐ Member ☐ Parent/guardian ☐ Other

Local CCS Provider: _____

Treating Provider/Facility (for treatment requiring M&T) _____

Contact: _____

Address: _____ Phone: _____

Assistance requested:

☐ Lodging: Date(s): _____ ☐ Meals: Date(s): _____

☐ Transportation(**only** non-NEMT): ☐Bus ☐Train ☐Private car ☐Taxi ☐Other _____

☐ Other Transportation Costs: _____

Notes:(Information about treatment needing M&T support- inpatient ICU/other, anticipated length of stay, outpatient treatment)

_____

_____

_____

Alternative resources reviewed with member/family/legal guardian (HN attestation):

☐ Family, friends, faith institution

☐ Alternative appointment schedule/location to minimize need for M&T

For CalOptima Use Only

Services Approved and coordinated with vendor:

☐ Lodging: Facility: _____
Dates of stay: _____
Total # of lodging nights: _____

☐ Meals: Ttl $_____

☐ Transportation: Details: _____

☐ Other Transportation Costs: Ttl $_____

☐ Approval notification sent: date _____

Services Denied: _____

Reason for denial: _____ ☐ NOA sent: date _____

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: January 19, 2018

ALL PLAN LETTER 17-020 *(REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: AMERICAN INDIAN HEALTH PROGRAMS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding reimbursement for American Indian Health Programs (Exhibit A, Attachment 8 of the MCP's contract). The Department of Health Care Services (DHCS) has developed a change in policy regarding reimbursement of American Indian Health Programs providing services to Medi-Cal managed care beneficiaries. *Revised text is found in italics.*

BACKGROUND:

Under federal law, California must ensure that American Indian Health Programs are paid the applicable encounter *rate* published annually in the Federal Register by the Indian Health Service (the Office of Management and Budget (OMB) encounter *rate*), and if there is any difference between the amount paid by an MCP and the applicable OMB encounter rate, the State is required to make an additional payment pursuant to Title 42 of the United States Code (USC) Section 1396u-2(h)(2)(C)(ii)[1] and Title 42 of the Code of Federal Regulations (CFR) Sections 438.14(c)(2) and (3).[2]

Historically, the State satisfied this requirement by tracking the amounts American Indian Health Programs received from MCPs for eligible services and by making subsequent payments necessary to meet the applicable OMB encounter rate.

[1] 42 USC Section 1396u-2(h)(2)(C)(ii) is available at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1396u-2&num=0&edition=prelim

[2] 42 CFR Sections 438.14(c)(2) and (3) are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=38cdce7f77ce8077ee8d0d1b41735ffa&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_114

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Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

Under the policy change addressed in this APL, the State will now require that MCPs *make the necessary payments* to American Indian Health Programs *so that they receive the applicable OMB encounter rate* for eligible services provided on or after January 1, 2018.

POLICY:

Effective January 1, 2018, MCPs are required to *make the payments described below, so that* American Indian Health Programs for eligible services provided on or after January 1, 2018, at the applicable OMB encounter rate, published in the Federal Register by the Indian Health Service.

MCPs are reminded of their obligations to attempt to contract with American Indian Health Programs, prompt payment requirements, and the allowance for non-contracted American Indian Health Programs access, where applicable.

Office of Management and Budget Encounter Rate and Services:

Where the OMB encounter *rate applies, American Indian Health Programs must be paid as follows:*

1) *For* Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the *required payment is the difference between* the "Outpatient Per Visit Rate (Excluding Medicare)" *listed in the Federal Register and 80 percent of the Medicare Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate, as set forth in 42 USC 1395w-4(e)(6)(A)(ii). See Attachment 2 for the specific Dual rate.*

2) *For* Medi-Cal *beneficiaries that do* not have Medicare *Coverage* or *have* Medicare Part A only*, the required payment is the "Outpatient Per Visit Rate (Excluding Medicare)". See Attachment 2 for the specific Non-Dual rate.*

The service types—medical visits, ambulatory visits, and mental health visits— for which the OMB encounter *rate applies* are set forth in the California Medicaid State Plan Supplement 6, Attachment 4.19-B.[3] The service types reimbursed at the OMB

[3] The *relevant State Plan Amendment* is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement6toAttachment4.19-B-REVISEDMAY.pdf

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encounter rate are further detailed in the Provider Manual.[4] To the extent that the Provider Manual conflicts with this APL, the requirements of this APL shall apply. Exceptions to MCP covered services that shall continue to be reimbursed outside the OMB encounter rate are: Non-Medical Transportation, Non-Emergency Medical Transportation, and Pharmacy.

Additionally, this policy does not extend the responsibility of the MCP to provide for eligible OMB encounter services that are outside the responsibility of the MCP currently. For example, MCPs will not be responsible for reimbursing the clinics for any dental services provided. The American Indian Health Programs will continue to follow their current billing practices for services outside the MCP's responsibility.

The OMB encounter rates are historically published with a retroactive effective date. MCPs are required to pay the most current applicable *payments as described in this APL (see Attachment 2)* during the calendar year for which the rate applies, and as an interim rate in a subsequent calendar year if an updated OMB rate has not been published. Plans shall ensure interim payments are reconciled to the applicable updated OMB rate for that calendar year in accordance with contractual prompt payment requirements.

Reimbursement Requirements:

MCPs shall ensure that the following criteria are met for receipt of *payments as described in this APL*:

- The American Indian Health Program provider must be identified by DHCS (see Attachment).
- Service must be a covered benefit included in the MCP's contract with DHCS.
- As set forth in California Medicaid State Plan Supplement 6, Attachment 4.19-B, only one OMB encounter rate payment per day, per category, shall be allowed within the following three categories. This allows for a maximum of three OMB encounter payments per day, one from each category:

[4] The Provider Manual sections related to IHS are available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/indhealth_o01o03.doc

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- Medical Health Visit (Encounter) – A medical visit is a face-to-face encounter occurring at a clinic or center between a American Indian Health Program recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse in certain circumstances.

- Mental Health Visit (Encounter) – A mental health visit is a face-to-face encounter between an American Indian Health Program recipient and a psychiatrist, clinical psychologist, clinical social worker, or other health professional for therapeutic mental health services.

- Ambulatory Visit (Encounter) – An ambulatory visit is a face-to-face encounter between an American Indian Health Program recipient and a health care professional other than a physician or mid-level practitioner which is included in California's Medi-Cal State Plan.

Monitoring of Subcontractors and Delegated Entities:

MCPs remain ultimately responsible for meeting the American Indian Service Programs reimbursement requirements, and must ensure that their delegated entities and subcontractors comply with all applicable State and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance and All Plan Letters (APLs). MCPs must communicate these requirements to all delegated entities and subcontractors in a timely manner to ensure compliance.

If you have any questions regarding this APL, and/or requests for an approved list of American Indian Service Programs, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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APL 17-020
Attachment #1 : List of American Indian Health Program Providers*
Last Updated: 8-7-18

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1366519431	MACT HEALTH BOARD, INC -JACKSON RANCHERIA HEALTH	12140 NEW YORK RANCH RD	JACKSON	AMADOR	09/01/2002	
1629130240	FEATHER RIVER TRIBAL HEALTH	2145 5TH AVE	OROVILLE	BUTTE	09/01/2002	
1740634286	NORTHERN VALLEY INDIAN HEALTH INC	500 COHASSET RD STE 15	CHICO	BUTTE	05/16/2016	
1770859084	NORTHERN VALLEY INDIAN HEALTH INCORPORATED	1515 SPRINGFIELD DRIVE, STE 175	CHICO	BUTTE	12/11/2012	
1265567127	NORTHERN VALLEY INDIAN HEALTH, INC	845 W. EAST AVENUE	CHICO	BUTTE	09/01/2002	
1346410255	MACT HEALTH BOARD INC	1113 HWY 49	SAN ANDREAS	CALAVARES	03/17/2009	
1366159431	MACT HEALTH BOARD, INC	1113A HWY 49	SAN ANDREAS	CALAVARES	05/05/2017	
1790778660	COLUSA INDIAN COMMUNITY COLUSA INDIAN HEALTH CLN	3710 HIGHWAY 45	COLUSA	COLUSA	08/09/2002	
1821440371	UNITED INDIAN HEALTH SERVICES INC	501 NORTH INDIAN RD	SMITH RIVER	DEL NORTE	06/12/2017	
1043216021	UNITED INDIAN HEALTH SERVICS INC	1675 NORTHCREST DR	CRESCENT CITY	DEL NORTE	09/01/2002	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

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NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1821440371	UNITED INDIAN HEALTH SERVICES INC ‡	241 SALMON AVENUE	KLAMATH	DEL NORTE	6/12/2017	
1245356674	SHINGLE SPRINGS TRIBAL HEALTH PROGRAM	4140 MOTHER LODE DR	SHINGLE SPRINGS	EL DORADO	09/01/2002	
1275751257	CENTRAL VALLEY INDIAN HEALTH INC	2740 HERNDON	CLOVIS	FRESNO	09/01/2002	
1235670787	CENTRAL VALLEY INDIAN HEALTH INC	255 W BULLARD AVENUE STE 109	CLOVIS	FRESNO	08/14/2017	
1902025059	CENTRAL VALLEY INDIAN HEALTH-PRATHER	29369 AUBERRY ROAD SUITE 102	PRATHER	FRESNO	09/01/2002	
1295752384	NORTHERN VALLEY INDIAN HEALTH	207 N. BUTTE STREET	WILLOWS	GLENN	09/01/2002	
1386726032	KARUK TRIBE	325 ASIP ROAD	ORLEANS	HUMBOLDT	09/01/2002	
1306904222	K'IMA: W MEDICAL CENTER	POST OFFICE BOX 1288	HOOPA	HUMBOLDT	09/01/2002	
1497751572	UNITED INDIAN HEALTH SVS EUREKA	1600 WEEOT WAY	ARCATA	HUMBOLDT	09/01/2002	
1497751572	UNITED INDIAN HEALTH SVS	940 MAIN STREET	FORTUNA	HUMBOLDT	09/01/2002	
1497751572	UNITED INDIAN HEALTH SVS	HWY 96	WEITCHPEC	HUMBOLDT	09/01/2002	
1265719918	DHHS PHS IHS PHOENIX AREA	ONE INDIAN HILL RD	WINTERHAVEN	IMPERIAL	11/17/2011	

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‡‡Effective Date Change
*Alphabetical by County

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NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1659433191	TOIYABE INDIAN HLTH PROJ - BISHOP CLINIC	250 N SEE VEE LANE	BISHOP	INYO	11/01/1991	
1205950888	TOIYABE INDIAN HLTH PROJ - LONE PINE CLINIC	1150 GOODWIN RD	LONE PINE	INYO	01/15/2008	
1215157375	CENTRAL VLY INDIAN HLTH TACHI MEDICAL CENTER	16835 ALKALI DR STE M	LEMOORE	KINGS	09/01/2002	
1215327804	LAKE COUNTY TRIBAL HEALTH CONSORTIUM INC	359 LAKEPORT BLVD	LAKEPORT	LAKE	04/23/2015	
1881697381	LAKE COUNTY TRIBAL HLTH	925 BEVINS COURT	LAKEPORT	LAKE	09/01/2002	
1770564049	LASSEN INDIAN HEALTH CTR	795 JOAQUIN ST	SUSANVILLE	LASSEN	09/01/2002	
1932329091	NORTH FORK INDIAN & COMM	32938 ROAD 222, STE 2	NORTH FORK	MADERA	09/01/2002	
1366519431	MACT HEALTH BOARD, INC MARIPOSA INDIAN HLTH CLN	5192 HOSPITAL ROAD	MARIPOSA	MARIPOSA	09/01/2002	
1003826009	CONSOLIDATED TRIBAL HEALTH PROJECT	6991 N. STATE STREET	REDWOOD VALLEY	MENDOCINO	09/01/2002	
1669532750	ROUND VALLEY INDIAN HLTH	CORNER HWY 162 AND BIGGAR LN	COVELO	MENDOCINO	09/01/2002	
1891762985	PIT RIVER HEALTH SVS	150 BIA ROUTE 76	ALTURAS	MODOC	09/01/2002	
1093931107	WARNER MOUNTAIN INDIAN HEALTH CLINIC	FT BIDWELL INDIAN RESERVATION	FORT BIDWELL	MODOC	03/03/2003	

‡ Address Change
‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1225331515	TOIYABE INDIAN HLTH PROJECT	73 CAMP ANTELOPE RD	COLEVILLE	MONO	09/08/2014	
1922138841	CHAPA-DE INDIAN HEALTH PROGRAM INC	1350 E. MAIN ST.	GRASS VALLEY	NEVADA	09/01/2002	
1114057163	CHAPA-DE INDIAN HEALTH PROGRAM	11670 ATWOOD ROAD	AUBURN	PLACER	09/01/2002	
1326031881	GREENVILLE RANCHERIA	410 MAIN STREET	GREENVILLE	PLUMAS	09/01/2002	
1619377942	DHEW IND HTLH SV HLTH SVS & MNTL HLTH ADM	9010 MAGNOLIA AVE	RIVERSIDE	RIVERSIDE	09/11/2014	
1639222144	RIVERSIDE-SAN BERNARDINO	39100 CONTRERAS RD STE F	ANZA	RIVERSIDE	02/01/2017	
1437202124	RIVERSIDE-SAN BERNARDINO	66735 MARTINEZ RD	THERMAL	RIVERSIDE	02/01/2017	
1639222144	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	12784 PECHANGA RD	TEMECULA	RIVERSIDE	02/01/2017	
1639222144	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	607 DONNA WAY	SAN JACINTO	RIVERSIDE	02/01/2017	
1437202124	RIVERSIDE-SAN BERNARDINO-COUNTY INDIAN HEALTH INC	11555 1/2 POTRERO	BANNING	RIVERSIDE	02/01/2017	
1174676670	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	11980 MOUNT VERNON AVE	GRAND TERRACE	San Bernardino	02/01/2017	
1174676670	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC	170 YUCCA AVE	BARSTOW	San Bernardino	02/01/2017	

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‡‡Effective Date Change
*Alphabetical by County

NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1346247947	SOUTHERN INDIAN HEALTH COUNCIL	4058 WILLOWS RD	ALPINE	SAN DIEGO	09/01/2002	
1922090885	SOUTHERN INDIAN HEALTH COUNCIL	36350 CHURCH RD	CAMPO	SAN DIEGO	09/01/2002	
1427197078	SYCUAN TRIBAL GOVERNMENT	5442 SYCAUN RD	EL CAJON	SAN DIEGO	06/24/2015	
1992779417	SANTA YNEZ TRIBAL HEALTH CLINIC	90 VIA JUANA RD	SANTA YNEZ	SANTA BARBARA	01/01/2014	
1891762985	PIT RIVER HEALTH SVS	36977 PARK AVENUE	BURNEY	SHASTA	09/01/2002	
1164807533	REDDING RANCHERIA	3184 CHURN CREEK	REDDING	SHASTA	07/30/2015	
1104859354	REDDING RANCHERIA HEALTH SERVICE	1441 LIBERTY ST	REDDING	SHASTA	09/01/2002	
1730279423	KARUK TRIBE	1519 SOUTH OREGON STREET	YREKA	SISKIYOU	09/01/2002	
1730279423	KARUK TRIBE	1515 S OREGON ST	YREKA	SISKIYOU	02/27/2017	
1952483406	KARUK TRIBE OF CALIF	64236 SECOND AVENUE	HAPPY CAMP	SISKIYOU	09/01/2002	
1306062419	QUARTZ VALLEY INDIAN RSV	9024 SNIKTAW ROAD	FORT JONES	SISKIYOU	02/11/2008	
1306062419	QUARTZ VALLEY INDIAN RSV	237 BUTTE STREET	FORT JONES	SISKIYOU	8/16/2016	

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NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1306062419	QUARTZ VALLEY INDIAN RSV	220 COLLIER WAY	ETNA	SISKIYOU	8/16/2016	
1306062419	QUARTZ VALLEY INDIAN RSV	400 HOWELL AVE	ETNA	SISKIYOU	8/16/2016	
1306062419	QUARTZ VALLEY INDIAN RSV	11501 MATTHEWS ST	FORT JONES	SISKIYOU	3/21/2016	
1265457980	SONOMA CO INDIAN HEALTH PROJECT	144 STONY POINT ROAD	SANTA ROSA	SONOMA	09/01/2002	
1588826374	FEATHER RIVER TRIBAL HEALTH INC	555 W ONSTOTT RD	YUBA CITY	SUTTER	09/01/2002	
1164780573	GREENVILLE RANCHERIA	343 OAK STREET	RED BLUFF	TEHAMA	03/13/2013	
1568455053	GREENVILLE RANCHERIA TRIBAL HEALTH PROGRAM	1425 MONTGOMERY ROAD	RED BLUFF	TEHAMA	09/01/2002	
1588799449	NORTHERN VALLEY INDIAN HEALTH, INC	2500 NORTH MAIN ST	RED BLUFF	TEHAMA	11/04/2004	
1679988950	ROLLING HILLS CLINIC	2540 SISTER MAY COLUMBA DR	RED BLUFF	TEHAMA	03/18/2015	
1992012306	ROLLING HILLS CLINIC	740 SOLANO ST	CORNING	TEHAMA	03/18/2011	
1386164580	REDDING RANCHERIA‡‡	31660 HWY 3	WEAVERVILLE	TRINITY	8/15/2017	
1972586972	TULE RIVER INDIAN HEALTH	MOUNTAIN RD 137	PORTERVILLE	TULARE	09/01/2002	

‡ Address Change
‡‡Effective Date Change
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NPI	LEGAL NAME	ADDRESS	CITY	COUNTY	EFFECTIVE DATE	DEACTIVATION DATE
1366519431	MACT HEALTH BOARD, INC	13975 MONO WAY STE G & I	SONORA	TUOLUMNE	09/01/2002	
1255595484	MATHIESEN MEMORIAL HEALTH CLINIC	18144 SECO ST	JAMESTOWN	TUOLUMNE	10/09/2008	
1124286885	TUOLUMNE ME-WUK INDIAN HEALTH	22044 CEDAR RD RD	SONORA	TUOLUMNE	08/19/2008	
1619952397	TUOLUMNE ME-WUK INDIAN HEALTH CENTER, INC	18800 CHERRY VALLEY BLVD.	TUOLUMNE	TUOLUMNE	12/21/2005	
1881960128	NORTHERN VALLEY INDIAN HEALTH, INC	175 WEST COURT STREET	WOODLAND	YOLO	07/02/2012	
1851678585	DHHS IHS PHOENIX AREA	12033 AGENCY RD	PARKER	OUT OF STATE AZ	02/26/2013	
1306897962	FORT MOJAVE INDIAN TRIBE	1607 PLANTATION RD	MOHAVE VALLEY	OUT OF STATE AZ	08/23/2010	
1396778379	WASHOE TRIBE OF NV & CA	1559 WATASHEAMU RD	GARDNERVILLE	OUT OF STATE NV	09/01/2002	
1750338646	YERINGTON PAIUTE TRIBAL COUNCIL	171 CAMPBELL LANE	YERINGTON	OUT OF STATE NV	10/29/2012	

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American Indian Health Program Rates	CY 2018 Rates
Dual Rate (Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only)[1]	$287.72
Non-Dual Rate (Medi-Cal beneficiaries that do not have Medicare Coverage or has Medicare Part A only)	$427.00

[1] To illustrate using the amounts applicable in 2018: The "Outpatient Per Visit Rate (Excluding Medicare)" is $427.00. The 42 USC 1395w-4 Medicare PPS rate calculated using the Geographic Adjustment Factor (GAF) for Locality #75 (Rest of California) is equal to $174.10, which is the product of base PPS rate of $166.60 multiplied by the GAF of 1.045. The 80 percent multiplier reduces this PPS rate to $139.28 (the 20 percent reduction accounts for any coinsurance requirements that would be covered by Medi-Cal for dual eligible beneficiaries.). Thus the required payment is $287.72.

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 10, 2018

ALL PLAN LETTER 18-008 *(REVISED)*
SUPERSEDES All PLAN LETTER 15-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL MEMBERS WHO TRANSITION INTO MEDI-CAL MANAGED CARE

PURPOSE:
The Department of Health Care Services (DHCS) is issuing this All Plan Letter (APL) to clarify continuity of care requirements for Medi-Cal members who transition into Medi-Cal managed care.[1] *This APL supersedes APL 15-019*.[2] *Revised text is found in italics.*

POLICY:
Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law, and the MCP contract, with some exceptions. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.

MCPs must provide continuity of care with an out-of-network provider when:

1. The MCP is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).

    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the MCP for a non-emergency visit, unless otherwise specified in this APL.

[1] *Continuity of care provisions for dual-eligible members (members eligible for both Medi-Cal and Medicare) in the Cal MediConnect program can be found at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx
[2] *APLs can be accessed at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

2. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates.

3. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means *the* MCP can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MCP members).

4. The provider is a California State Plan approved provider.

5. The provider supplies the MCP with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

MCPs are not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the *following:* durable medical equipment, transportation, other ancillary *service*, and carved-out service *providers*.

If a member changes MCPs, the 12-month continuity of care period may start over one time. If the member changes MCPs a second time (or more), the continuity of care period does not start over*;* the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls in an MCP, the continuity of care period does not start over. If a member changes MCPs, this continuity of care policy does not extend to providers that the member accessed through their previous MCP.

MCP Processes

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days following the receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when the MCP starts the process to determine if the member has a pre-existing relationship with the provider.

MCPs must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To

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complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

MCPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets all continuity of care requirements described above and the services that are the subject of the request meet the following requirements:

- *Occurred after the member's enrollment into the MCP*
- *Have dates of service after December 29, 2014* [3]
- *Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive continuity of care reimbursement*

Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

Validating Pre-existing Relationship
The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the MCP *that d*emonstrates a pre-existing relationship with *the* provider. A *member's self-attestation of* a pre-existing relationship *is not sufficient proof* (instead, actual documentation must be provided), unless the MCP makes this option available to *the member*.

Following identification of a pre-existing relationship, the MCP must determine if the provider is an in-network provider. If the provider is not an in-network provider, the MCP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

Request Completion Timeline
Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

[3] The first APL that addressed retroactive requests for continuity of care was APL 14-021, which was dated December 29, 2014.

A continuity of care request is considered completed when:

- The MCP notifies the member, in the manner outlined above, that the request has been approved;
- The MCP and the out-of-network Medi-Cal FFS provider are unable to agree to a rate;
- The MCP has documented quality of care issues with the Medi-Cal FFS provider;
- or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Requirements after the Request Process is Completed

If *the* MCP and the out-of-network *Medi-Cal* FFS provider are unable to reach an agreement because they cannot agree to a rate, or the MCP has documented quality of care issues with the provider, the MCP will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to *file a grievance*.

If a provider meets all of the necessary requirements, including *entering into a* letter of agreement or contract with the MCP, the MCP must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the MCP for a shorter timeframe. In this case, the MCP must allow the member to have access to that provider for the shorter period of time.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the MCP must work with the provider to establish a care plan for the member.

Upon approval of a continuity of care request, the MCP must notify the member of the following within seven calendar days:

- The request approval.
- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period.
- The member's right to choose a different provider from the MCP's provider network.

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The MCP must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition *the member's* care *to an in-network provider* at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

MCP Extended Continuity of Care Option
MCPs may choose to work with *a member's* out-of-network provider past the 12-month continuity of care period*; however, MCPs are* not required to do so to fulfill *the* obligations under this APL *or the MCP contract*.

Member and Provider Outreach and Education
MCPs must inform members of their continuity of care protections and must include information about these protections in member information packets and handbooks. This information must include how the member and provider initiate a continuity of care request with the MCP. The MCP must translate these documents into threshold languages and make them available in alternative formats, upon request. MCPs must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

Provider Referral Outside of the MCP Network
An approved out-of-network provider must work with the MCP and its contracted network and must not refer the member to another out-of-network provider without authorization from the MCP. In such cases, the MCP will make the referral, if medically necessary, if the MCP does not have an appropriate provider within its network.

NON-SPECIALTY MENTAL HEALTH SERVICES – CONTINUITY OF CARE FOR APPROVED PROVIDER TYPES:

MCPs are required to cover outpatient mental health services, as outlined in APL 17-018, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual.[4] County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for members under 21 years of age

[4] *APL 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," can be accessed at the following link: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx*

is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.[5]

MCPs must provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from the MCP. In this situation, the continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as "Psychology").[6]

The MCP must allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in the MCP's network for non-specialty mental health services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the MCP for non-specialty mental health services, the 12-month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to the MCP or changes MCPs (i.e., the member does not have the right to a new 12 months of continuity of care).

COVERED CALIFORNIA TO MEDI-CAL TRANSITION:
This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, the MCP must ask these members if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member

[5] *SMHS medical necessity criteria are outlined in Title 9 of the California Code of Regulations (CCR), Sections 1830.205 and 1830.210. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index*
[6] *State Plan Amendment (SPA) 14-012, Attachment 3.1-A is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CASPA14-012ApprovedPackageOriginalADA.pdf*

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enrolls in Medi-Cal, the MCP must contact the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. The MCP must make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

The MCP must honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

The MCP must, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with *the requirements in this APL.*

HEALTH HOMES PROGRAM – MEDI-CAL FFS TO MANAGED CARE TRANSITION:
MCPs must provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP).[7] *Because HHP services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.*

SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON MCP ENROLLMENT:
For a newly enrolled Seniors and Persons with Disabilities (SPDs), the MCP must honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the member or the provider.

[7] *More information on the Health Home Program services can be found here:* http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.

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BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON MCP TRANSITION:

MCPs are responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, MCPs must offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this APL are met. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the MCP must assign the member to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into an MCP, or the date of the member's enrollment into the MCP, if the enrollment date occurred after the transition.

MCPs must continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

<u>Transition of BHT Services from RCs to MCPs</u>

At least 45 days prior to the transition date, DHCS will provide MCPs with a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member-specific utilization data. MCPs must consider every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide MCPs with member utilization and assessment data from the RC prior to the service transition date. MCPs are required to use DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the MCP should attempt to contact the member's parent or guardian to determine *their* preference. If the MCP does not have access to member data that identifies an existing BHT provider, the MCP must contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the MCP in offering

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continuity of care. If the RC is unwilling to release specific provider rate information to the MCP, then the MCP may negotiate rates with the continuity of care provider without being bound by the usual requirement that the MCP offer at least a minimum FFS-equivalent rate. If the MCP is unable to complete a continuity of care agreement, the MCP must ensure that all ongoing services continue at the same level with an MCP in-network provider until the MCP has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

MCPs may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW:

In addition to the protections set forth above, MCP members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), MCPs must allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the MCP-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code *(HSC)* §1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under *HSC* §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the MCP as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member. This APL does not alter *the* MCP's obligation to fully comply with the requirements of *HSC* §1373.96. In addition to the requirements set forth in this APL, each MCP must allow for completion of covered services as required by *HSC* §1373.96, to the extent that doing so would allow a member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. MCPs must allow for the completion of these services for certain timeframes which are specific to each condition and defined under *HSC* §1373.96.

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PREGNANT AND POST-PARTUM BENEFICIARIES:
As noted above, *HSC* §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to *HSC* §1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into an MCP have the right to request out-of-network provider continuity of care for up to 12 months in accordance with *the* MCP contract and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care).

MEDICAL EXEMPTION REQUESTS:
A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to an MCP. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. MCPs are required to consider MERs that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with *APL 17-007.*[8]

REPORTING:
MCPs may be required to report on metrics related to any continuity of care provisions outlined in this APL, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

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

[8] *APLs can be accessed at the following link:* http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 7, 2018

ALL PLAN LETTER 18-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 04-0618,[1] which provides direction and guidance to county CCS programs on requirements pertaining to the implementation of the WCM program.

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[2] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties will integrate Medi-Cal managed care and county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[3, 4]

MCPs will authorize care that is consistent with CCS Program standards and provided by CCS-paneled providers, approved special care centers, and approved pediatric acute care hospitals. The WCM program will support active participation by parents and families of CCS-eligible members and ensure that members receive protections such as

[1] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[2] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[3] See Health and Safety Code (HSC) Section 123850(b)(1), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=123850.
[4] See Welfare and Institutions Code (WIC) Section 14094.11, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

continuity of care (COC), oversight of network adequacy standards, and quality performance of providers.

WCM will be implemented in 21 specified counties, beginning no sooner than July 1, 2018. Upon determination by DHCS of the MCPs' readiness to address the needs of the CCS-eligible members, MCPs must transition CCS-eligible members into their MCP network of providers by their scheduled implementation date as follows:

MCP	COHS Counties
Phase 1 – No sooner than July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – No sooner than January 1, 2019	
CalOptima	Orange
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

POLICY:
Starting no sooner than July 1, 2018, MCPs in designated counties shall assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including service authorization activities, claims processing and payment, case management, and quality oversight.

Under the WCM, the MCP, county CCS program, and DHCS will each bear responsibility for various administrative functions to support the CCS Program. Responsibilities for the CCS Program's eligibility functions under the WCM are determined by whether the county CCS program operates as an independent or dependent county.[5] Independent CCS counties will maintain responsibility for CCS Program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS Program medical eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS will continue to maintain responsibility for CCS Program medical eligibility determinations and redeterminations, while the county CCS programs will maintain responsibility for financial and residential eligibility determinations and re-determinations. The MCP is responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical

[5] A link to the Division of Responsibility chart can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

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redetermination and other medical determinations, as needed, for the CCS-eligible member.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS Program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage (OHC), with full scope Medi-Cal as payor of last resort.

The implementation of WCM does not impact the activities and functions of the Medical Therapy Program (MTP) and Pediatric Palliative Care Waiver (PPCW). WCM counties participating with the MTP and PPCW will continue to receive a separate allocation for these programs. The MCP is responsible for care coordination of services that remain carved-out of the MCP's contractual responsibilities.

MCPs are required to use all current and applicable CCS Program guidelines, including CCS Program regulations, additional forthcoming regulations related to the WCM program, CCS Numbered Letters (N.L.s),[6] and county CCS program information notices, in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. In addition to the requirements included in this APL, MCPs must comply with all applicable state and federal laws and regulations and contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members. A quarterly meeting between the MCP and the county CCS program must be established to assist with overall coordination by updating policies, procedures, and protocols, as appropriate, and to discuss activities related to the Memorandum of Understanding (MOU) and other WCM related matters.

A. Memorandum of Understanding

MCPs and county CCS programs must execute a MOU outlining their respective responsibilities and obligations under the WCM using the MOU template posted on the CCS WCM page of the DHCS website.[7] The purpose of the MOU is to explain how the MCPs and county CCS programs will coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP will serve as the primary vehicle for ensuring

[6] The CCS Numbered Letter index is available at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx
[7] A link to the MOU template can be found on the CCS WCM website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

collaboration between the MCP and county CCS program. The MOU can be customized based on the needs of the individual county CCS program and the MCP, consistent with the requirements of SB 586 and dependent upon DHCS approval. The MOU must include, at a minimum, all of the provisions specified in the MOU template. Phase 1 MCPs must have submitted an executed MOU, or proved intent and/or progress made towards an executed MOU, by March 31, 2018. Phase 2 MCPs must submit an executed MOU, or prove intent and/or progress made toward an executed MOU, by September 28, 2018. All WCM MOUs are subject to DHCS approval.

B. Transition Plan

Each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into managed care for treatment of their CCS-eligible conditions. The transition plan must describe collaboration between the MCP and the county CCS program on the transfer of case management, care coordination, provider referrals, and service authorization administrative functions from the county CCS program to the MCPs.[8] The transition plan must also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Inter-County Transfer

County CCS programs use CMSNet to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. Through their respective MOUs, the MCPs and county CCS programs will develop protocols for the exchange of ICT data, as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of the CCS member and allow for COC of already approved service authorization requests, as required by this APL and applicable state and federal laws.

When a CCS-eligible member moves from a WCM county to a non-WCM county, the county CCS program and MCP, through their respective MOUs, will exchange ICT data. County CCS programs will continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS eligible member moves out of a WCM county, the county CCS program will notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data

[8] See WIC Section 14094.7(d)(4)(C), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.7.

for members to the county CCS program office. The county CCS program will then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the county CCS program will provide transfer data to the MCP as applicable.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[9] The county CCS program shall communicate all resolved disputes in writing to the MCP within a timely manner. Disputes between the MCP and the county CCS program that are unable to be resolved will be referred by either entity to DHCS, via email to CCSWCM@dhcs.ca.gov, for review and final determination.[10]

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[11] A CCS provider may submit a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP directly to the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Risk Level and Needs Assessment Process

The MCP will assess each CCS child's or youth's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM transition members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include the development of a pediatric risk stratification process (PRSP) and an Individual Care Plan (ICP) for high risk members. All requirements are dependent on the member's risk level that is determined through the PRSP. Furthermore, nothing in this APL shall remove or limit existing survey or assessment requirements that the MCPs are responsible for outside WCM.

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[9] See WIC Section 14093.06(b), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14093.06.
[10] Unresolved disputes must be referred to: CCSWCM@dhcs.ca.gov
[11] See WIC Section 14094.15(d), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.15.

1. **Pediatric Risk Stratification Process**
   MCPs must develop a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the MCP to identify members who have more complex health care needs.

   MCPs are required to complete a risk stratification within 45 days of enrollment for all members including new members, newly CCS-eligible members, or WCM transition members. The risk stratification will assess the member's risk level by:

   - Review of medical utilization and claims processing data, including data received from the county and DHCS;
   - Utilization of existing member assessment or survey data; and
   - Telephonic or in-person communications, if available at time of PRSP.

   Members that do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available will automatically be categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
   MCPs must develop a process to assess a member's current health, including the CCS condition, to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider; this will be dependent upon the member's designation as high or low risk.

   New Members and Newly CCS-eligible Members Determined High Risk
   Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by the MCP for the purposes of WCM is subject to review and approval by DHCS.

   Risk Assessment
   The risk assessment process must address:

   a) General Health Status and Recent Health Care Utilization. This may include, but is not limited to, caretaker self-report of child's health;

outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time.

b) Health History. This includes both CCS and non-CCS diagnoses and past surgeries.

c) Specialty Provider Referral Needs.

d) Prescription Medication Utilization.

e) Specialized or Customized Durable Medical Equipment (DME) Needs (if applicable).

f) Need for Specialized Therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies (PT/OT /ST), mental or behavioral health services, and educational or developmental services.

g) Limitations of Activities of Daily Living or Daily Functioning (if applicable).

h) Demographics and Social History. This may include, but is not limited to, member demographics, assessment of home and school environments, and cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. These may include, but are not limited to, questions related to childhood developmental milestones; pediatric depression, anxiety or attention deficit screening; adolescent substance use; or adolescent sexual behaviors.

Individual Care Plan
MCPs are required to establish an ICP for all members determined high risk based on the results of the risk assessment process, with particular focus on specialty care, within 90 days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication.[12] The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- County substance use disorder (SUD) or Drug Medi-Cal services;

[12] See WIC Section 14094.11(b)(4), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP will be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver. The ICP should indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[13]

a) Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are.

b) A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

c) Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

d) Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

Further, the MCP must reassess the member's risk level and needs annually at their CCS eligibility redetermination or upon significant change to the member's condition.

[13] See WIC Section 14094.11(c), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.11.&lawCode=WIC

New Members and Newly CCS-eligible Members Determined Low Risk
For new members and newly CCS-eligible members identified as lower risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of their enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

The MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination or upon significant change to the member's condition.

WCM Transitioning Members
For WCM transition members, the MCP must complete the PRSP within 45 days of transition, to determine each member's risk level, and complete all required telephonic and/or in-person communication and ICPs for high risk members and all required telephonic and/or in-person communication for low risk members within one year. Additionally, the MCP must reassess the member's risk level and need annually at their CCS eligibility redetermination, or upon significant change to the member's condition.

MCPs must submit to DHCS for review and approval a phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year for WCM transition members.

Regardless of the risk level of a member, all communications, whether by phone or mail, must inform the member and/or his or her designated caregiver that the assessment will be provided in a linguistically and culturally appropriate manner and identify the method by which the provider will arrange for an in-person assessment.[14]

MCPs must refer all members, including new members, newly CCS-eligible members and WCM transition members who may have developed a new CCS-eligible condition, immediately to the county for CCS eligibility determination and not wait until the annual CCS medical eligibility redetermination period.

B. Case Management and Care Coordination
MCPs must provide case management and care coordination for CCS-eligible members and their families. MCPs must ensure that information, education and support is continuously provided to the CCS-eligible member and their family to

[14] See APL 99-005, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL1999/MMCDAPL99005.pdf

assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:[15]

- Primary and preventive care services with specialty care services
- Medical therapy units (MTU)
- EPSDT[16]
- Regional center services
- Home and community-based services

1. **High Risk Infant Follow-Up Program**
   High Risk Infant Follow-Up (HRIF) is a program that helps identify infants who might develop CCS-eligible conditions after they are discharged from a Neonatal Intensive Care Unit (NICU). The MCP is responsible for coordinating and authorizing HRIF services for members and ensuring HRIF case management services. MCPs must notify the counties in writing, within 15 calendar days, of CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services, and provide COC information to the members.

2. **Age-Out Planning Responsibility**
   MCPs must establish and maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the members' CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program.[17]

3. **Pediatric Provider Phase-Out Plan**
   A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment to the child or youth. The MCPs must provide care coordination to

[15] See WIC Section14094.11(b)(1)-(6), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.11.
[16] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 18-007, which is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf
[17] See WIC Section 14094.12(j), which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.12.

CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the service of a pediatric provider. The timing of the transition should be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

C. Continuity of Care

MCPs must establish and maintain a process to allow for members to receive COC with existing CCS provider(s) for up to 12 months, in accordance with WIC Section 14094.13.[18] This APL does not alter the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all other applicable APLs regarding COC. The sections below include additional COC requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If the MCP member has an established relationship with a specialized or customized durable medical equipment (DME) provider, MCPs must provide access to that provider for up to 12 months.[19] MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service rates, unless the DME provider and the MCP enter into an agreement on an alternative payment methodology that is mutually agreed upon. The MCP may extend the COC period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[20]

Specialized or Customized DME must meet all of the following criteria:

- Is uniquely constructed or substantially modified solely for the use of the member.
- Is made to order or adapted to meet the specific needs of the member.
- Is uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. COC Case Management[21]

MCPs must ensure CCS-eligible members receive expert case management,

[18] See WIC Section 14094.13, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.13.
[19] See WIC Section 14094.12(f), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.12.&lawCode=WIC
[20] See WIC Section 14094.13(b)(3) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[21] See WIC Section 14094.13(e), (f) and (g), which are available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

care coordination, service authorization, and provider referral services. MCPs can meet this requirement by allowing the CCS-eligible member, member's family, or designated caregiver to request COC case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with a MCP case manager who has received adequate training on the county CCS Program and who has clinical experience with the CCS population or pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services The MCP must send a follow-up notice 30 days prior to the start of the transition.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.[22]

4. **Appealing COC Limitations**
   MCPs must provide CCS-eligible members with information regarding the WCM appeal process for COC limitations, in writing, 60 days prior to the end of their authorized COC period. The notice must explain the member's right to petition the MCP for an extension of the COC period, the criteria used to evaluate the petition, and the appeals process if the MCP denies the petition.[23] The appeals process notice must include the following information:

   - The CCS-eligible member must first appeal a COC decision with the MCP.
   - A CCS-eligible member, member's family or designated caregiver of the CCS-eligible member may appeal the COC limitation to the DHCS director or his or her designee after exhausting the MCP's appeal process.

[22] See WIC Section 14094.13(d)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC
[23] See WIC Section 14094.13(k), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.13.&lawCode=WIC

- The DHCS director or designee will have five (5) days from the date of appeal to inform the family or caregiver of receipt of the request and must provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS director or designee will inform the member of the decision within 72 hours.[24]

In addition to the protections set forth above, MCP members also have COC rights under current state law.

D. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure members are provided information on grievances, appeals and state fair hearing processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal and state fair hearing rights as provided under state and federal law.[25] MCPs must provide timely processes for accepting and acting upon member complaints and grievances. Members appealing a CCS eligibility determination must appeal to the county CCS program.

E. Transportation

MCPs must provide the CCS Maintenance and Transportation (M&T) benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.), in addition to transportation expenses, and must comply with all requirements listed in N.L. 03-0810.[26] These services include, but are not limited to, M&T for out of county and out of state services.

MCPs must also comply with all requirements listed in APL 17-010[27] for CCS-eligible members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) for all other services not related to their CCS-eligible condition or if the member requires standard transportation that does not require M&T.

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[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

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[28] See WIC Section 14094.7(d)(3), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.7.&lawCode=WIC
[29] See WIC Section 14094.17(b)(2), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC
[30] See WIC Section 14094.17(a), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.17.&lawCode=WIC

an agreement on an alternative payment methodology that is mutually agreed upon.[31]

The payor for NICU services is as follows: an MCP shall pay for NICU services in counties where NICU is carved into the MCP's rate, and DHCS shall pay in counties where NICU is carved out of the MCP's rate.[32]

For WCM counties, all NICU authorizations will be sent to the MCP in which the child is enrolled. The MCP will review authorizations and determine whether or not the services meet CCS NICU requirements. However, claims may be processed and paid by either DHCS or the MCP.

In counties where CCS NICU is carved into the MCP's rate, the MCP will pay all NICU and CCS NICU claims. For counties where CCS is currently carved-out, the MCP will process and pay non-CCS NICU claims, and the State's Fiscal Intermediary will pay CCS NICU claims. Payments made by State's Fiscal Intermediary will be based on the MCP's approval of meeting CCS NICU requirements.

The chart below identifies the entity responsible for NICU acuity assessment, authorization, and payment function activities for WCM:

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-In Counties: Marin, Merced, Monterey, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo	MCP	MCP	MCP

[31] See WIC Section 14094.16(b), which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14094.16.
[32] See the Division of Responsibility chart

CCS NICU	NICU Acuity Assessment	Authorization	Payor (Facility/ Physician)
Carved-Out: Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Orange, Shasta, Siskiyou, Sonoma, and Trinity	MCP	MCP	DHCS

IV. MCP Responsibilities to DHCS

A. Network Certification

MCPs are required to have an adequate network of providers to serve the CCS-eligible population including physicians, specialists, allied professionals, Special Care Centers, hospitals, home health agencies, and specialized and customizable DME providers. Each network of providers will be reviewed by DHCS and certified annually.

The certification requires the MCP and their delegated entities to submit updated policies and procedures and an updated provider network template to ensure the MCP's network of providers meets network adequacy requirements as described in the Network Certification APL Attachments.[33]

MCPs must demonstrate that the provider network contains an adequate provider overlap with CCS-paneled providers. MCPs must submit provider network documentation to DHCS, as described in APL 18-005. Members cannot be limited to a single delegated entity's provider network. The MCP must ensure members have access to all medically necessary CCS-paneled providers within the MCP's entire provider network. MCPs must submit policies and procedures to DHCS no later than 105 days before the start of the contract year.

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional

[33] APL 18-005 and its attachments are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

approval status.[34] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs should direct providers who need to be paneled to the CCS Provider Paneling website.[35] The MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[36]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. The MCP's written policies and procedures must follow the credentialing and recredentialing guidelines of APL 17-019.[37] MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, recredentialing, recertification, and reappointment of providers within their network.

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[38]

- Procedures for pre-authorization, concurrent review, and retrospective review.
- A list of services requiring prior authorization and the utilization review criteria.
- Procedures for the utilization review appeals process for providers and members.
- Procedures that specify timeframes for medical authorization.
- Procedures to detect both under- and over-utilization of health care services.

In addition to the UM processes above, MCPs are responsible for conducting NICU acuity assessments and authorizations in all WCM counties.[39]

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[34] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildpanel_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc
[35] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[36] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf
[37] APL 17-019 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-019.pdf
[38] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[39] See WIC 14094.65, which is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14094.65.&lawCode=WIC

D. MCP Reporting Requirements

1. Quality Performance Measures

DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a form and manner specified by DHCS.

2. Reporting and Monitoring

DHCS will develop specific monitoring and oversight standards for MCPs. MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companions guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

E. Delegation of Authority

In addition to the requirements of this APL, MCPs are responsible for complying with, and ensuring that their delegates also comply with, all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including other APLs, Policy Letters, and Dual Plan Letters. Each MCP must communicate these requirements to all delegated entities and subcontractors. In addition, MCPs must comply with all requirements listed in APL 17-004.[40] If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[40] APL 17-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-004.pdf

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Actions Related to Memorandums of Understanding for Department of Health Care Services Behavioral Health Integration Incentive Program

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Edwin Poon, PhD, Director, Behavioral Health Services (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute Memorandums of Understanding (MOUs) with Behavioral Health Integration (BHI) Incentive Program grantee(s) upon selection and approval by the Department of Health Care Services (DHCS).

Background

Proposition 56 (2016) increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for health care programs administered by DHCS. Proposition 56 initiatives implemented by DHCS have included adjustments to the Medi-Cal fee schedule and other specific provider payment requirements. DHCS is now utilizing Proposition 56 funding, through Medi-Cal Managed Care Health Plans (MCPs) including CalOptima to provide incentive payments to network providers who meet specific measures aimed at promoting BHI.

The BHI Incentive Program aims to improve physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care into provider networks. Providers types eligible to submit applications for grant funding include primary care, specialty care, perinatal care, hospital-based, and behavioral health. Provider types can include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Services (IHS), and public and county-based providers.

The goal of the program is to increase network integration for providers at all levels, focus on new target populations or health disparities, and improve their level of integration or impact. Under the BHI Incentive Program, there are six types of BHI projects, and providers can apply for grant funding more than one of the six projects listed below:

1. Basic Behavioral Health Integration
2. Maternal Access to Mental Health and Substance Use Disorder (SUD) Screening and Treatment
3. Medication Management for Beneficiaries with Co-Occurring Chronic Medical and Behavioral Diagnoses
4. Diabetes Screening and Treatment for People with Serious Mental Illness (SMI)
5. Improving Follow-Up after Hospitalization for Mental Illness
6. Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

DHCS has established the application review and approval timeline listed below for all California MCPs to follow. MCPs are required to review applications according to the DHCS scoring criteria, advance

qualifying applications to DHCS, and operationalize the incentive programs from April 1, 2020 through December 31, 2022.

BHI Incentive Program applications due to the MCP	January 21, 2020
MCPs complete their review of applications and submit qualifying applicants to DHCS	February 18, 2020
DHCS participation decisions issued by MCPs to applicants	March 18, 2020
BHI Incentive Program start date for approved applicants	April 1, 2020

To be considered complete, each application must:

- Identify which BHI project(s) is/are selected, and the specific target population for each based on the population(s) served by the applicant.
- If the entity chooses to target disparities, the applicant must identify the specific disparity target population and report selected measures stratified by the relevant target disparity population.
- Describe the practice redesign component or tasks that are planned for implementation to achieve the objectives of the BHI project(s).
- Identify the performance measures the applicant will report, in addition to the required measures for each BHI project, as specified by DHCS.
- Have all mandatory attachments including a detailed budget, letters of support, and a Memorandum of Understanding (MOU) with the MCP that the applicant has signed.

Information regarding the BHI Incentive Program was initially shared with the CalOptima Board of Directors (Board) on October 25, 2019. It was also included in the October 30, 2019 CEO report to the Board, and in the November 7, 2019 Board agenda. DHCS released the BHI Incentive Program Request for Applications on November 12, 2019 and hosted an overview webinar on November 22, 2019. CalOptima subsequently sent communications to external stakeholders with information regarding how to link to BHI Incentive Program references on the DHCS website and the application process. Information was also made available on the CalOptima website.

Discussion

For the BHI Incentive Program, DHCS has established a timeline that all MCPs should follow.

BHI Incentive Program applications due to the MCP	January 21, 2020
MCPs complete their review of applications and submit qualifying applicants to DHCS	February 18, 2020
DHCS participation decisions issued by MCPs to applicants	March 18, 2020
BHI Incentive Program start date for approved applicants	April 1, 2020

Providers eligible to submit applications in Orange County must be contracted either directly with CalOptima, or through one of CalOptima's delegated Health Networks. Provider types eligible to submit applications include primary care, specialty care, perinatal care, hospital-based, and behavioral health. The provider types can include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Services (IHS), and public and county-based providers.

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Application submissions must include responses to the DHCS application questions and include the following four attachments:

1. Detailed budget for the applicant's defined milestones and associated proposed incentive funding;
2. Letter of support from the county mental managed care plan, if the selected BHI project addresses SMI or requires coordination with county mental health;
3. Letter of support from county SUD managed care plan or SUD fee-for-service program (only required if the selected BHI project addresses SUD); and
4. A BHI Incentive Program Memorandum of Understanding as provided by DHCS signed by the applicant.

Each application must clearly identify which BHI project(s) is/are selected and the specific target population for each based on the population(s) served by the applicant. If the applicant chooses to target disparities, the applicant must identify the specific disparity target population and report selected measures stratified by the relevant target disparity population. The application must describe the practice redesign component or tasks that are planned for implementation to achieve the objectives of the BHI project(s). The application must also identify which performance measures the applicant will report, in addition to the required measures for each BHI project, as specified by DHCS.

In addition, per DHCS application requirements, each application package must include an MOU, signed by the applicant at the time of submission. The MOU document is provided by DHCS as a templated attachment to its BHI Incentive Program application. The MOU outlines parameters, including terms, scope, provider and plan responsibilities, and administration of funds. Per DHCS application guidelines, CalOptima will countersign the MOU only after DHCS has approved a particular grantee's proposal. Once a project is approved, the final MOU for that project will be executed directly with the grantee, regardless of whether the grantee is contracted with CalOptima directly, or through a Health Network.

Once received, CalOptima will evaluate applications based on the project selection criteria and standardized scoring provided by DHCS (see Attachment 4). The DHCS scoring tool will be utilized by an evaluation committee consisting of CalOptima staff, Board advisory committee members, and a representative from the Orange County Health Care Agency Behavioral Health. Once applications have been evaluated, CalOptima is required to advance qualified applicants to DHCS by February 18, 2020. DHCS will only accept applications for the BHI Incentive Program that score 70% or above.

Following review by DHCS, CalOptima will provide award letters to the selected applicants and fully execute the MOU(s), confirming terms that include the final award amount, project term, project purpose, milestones and outcomes, payment schedule, allowable use of funds, and any other conditions as required by DHCS. Once approved and implemented, CalOptima will provide oversight, monitoring, and funding of the approved BHI Incentive Program project(s).

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Fiscal Impact

The recommended action to authorize execution of MOUs for BHI Incentive Program projects with selected grantees is budget neutral to CalOptima. DHCS's payment methodology to MCPs for the BHI Incentive Program is pending federal approval. However, Staff anticipates that program expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation

Staff recommends that the Board approve execution of MOUs with providers for the BHI Incentive Program to meet the regulatory timelines and allow CalOptima and the selected grantee(s) to implement the BHI Incentive Program according to DHCS guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Behavioral Health Integration Incentive Program Presentation
2. Behavioral Health Integration Incentive Program Process Guide for Medi-Cal Managed Care Health Plans (MCPs) and Provider Applicants
3. Behavioral Health Integration Incentive Program Application
4. Behavioral Health Integration Incentive Program Project Selection Criteria

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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A Public Agency

CalOptima

Better. Together.

Behavioral Health Integration (BHI) Incentive Program

Board of Directors Meeting

February 6, 2020

Candice Gomez, Executive Director, Program Implementation

Edwin Poon, PhD, Director, Behavioral Health Services

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Background

- DHCS initiated a standard, statewide BHI Incentive Program application to managed care plans (MCP)
- Program objective
  - Incentivize MCPs to improve physical and behavioral health outcomes, care delivery efficiency, and patient experience
  - Establish or expand fully integrated care in their networks
- Program goal
  - Increase MCP network integration for providers at all levels of integration
  - Focus on new target populations or health disparities
  - Improve the overall level of integration or impact

Background (Cont.)

- Eligible providers must submit applications to one Medi-Cal managed care plan even if contracted with multiple

- CalOptima is required to:
  - Review, score, and approve applicants subject to DHCS approval
  - Monitor BHI Incentive Program projects and distribute funding

- Program effective 4/1/2020-12/31/2022
  - Year 1: Structure and process
  - Years 2 and 3: Meeting milestones and outcomes

BHI Incentive Program Project Options

1. Basic behavioral health integration
2. Maternal access to mental health and substance use disorder screening and treatment
3. Medication management for beneficiaries with co-occurring chronic medical and behavioral diagnoses
4. Diabetes screening and treatment for people with serious mental illness
5. Improving follow-up after hospitalization for mental illness
6. Improving follow-up after emergency department for behavioral health diagnosis

Eligible Providers

- Providers must be contracted directly with CalOptima or through a delegated entity and include:
  - Primary care providers
  - Specialty care providers
  - Perinatal care providers
  - Hospital based and behavioral health providers
  - FQHCs and RHCs that provide or plan to provide behavioral health services and indicate the intention to change their scope of service
  - Indian Health Services Facilities
  - Public providers who provide services to Medi-Cal beneficiaries
  - County-based providers

DHCS Timeline

Date	Milestone
11/12/2019	DHCS release of BHI Incentive Program application
11/22/2019	DHCS webinar for potential applicants/entities
12/11/2019	DHCS call for MCP questions
1/21/2020	BHI Incentive Program applications due to CalOptima
2/18/2020	CalOptima to review BHI Incentive Program application
3/18/2020	CalOptima to issue participation decision to BHI Incentive Program applicants
4/1/2020	BHI Incentive Program Go-Live for approved applicants

Application Process

Submission

- CalOptima to utilize grant management software for application submission due 1/21/2020
- Once received, CalOptima will review for completeness

Evaluation

- Establish evaluation committee and scoring guidelines (based on DHCS tool)
- Evaluate applications and submit recommended applicants (those who score 70% or higher) to DHCS on 2/18/2020

Award

- DHCS confirmation of approved applicants and funding amounts
- CalOptima contracts with applicants for 4/1/2020 start date

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Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute Memorandum of Understanding (MOU) with BHI Incentive Program grantee upon selection and approval by DHCS

CalOptima's Mission

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

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Behavioral Health Integration Incentive Program

Process Guide for Medi-Cal Managed Care Health Plans (MCPs) and Provider Applicants

Trailer Bill implementing the 2019 Budget Act authorized DHCS to develop the Behavioral Health Integration (BHI) Incentive Program as part of its Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care.[1] Interested providers and their MCPs should utilize this process guide to understand the requirements and timeline for participation in the BHI Incentive Program. This document is a companion to the DHCS BHI Incentive Program application and the template memorandum of understanding (MOU).

Application Review Timing

1. DHCS releases BHI Incentive Program Request for Application
   Date: November 12, 2019

2. DHCS conducts webinar for potential applicants/interested entities
   Date: November 22, 2019, at 1 p.m.

3. BHI Incentive Program applications due to the MCP
   Date: January 21, 2020

4. MCPs review applications based on the standardized scoring tool
   Date: February 18, 2020

5. Participation decisions issued by MCPs to applicants
   Date: March 18, 2020

6. BHI Incentive Program start date for approved applicants
   Date: April 1, 2020

7. BHI Incentive Program operations duration
   Date: April 1, 2020, to December 31, 2022

Process Requirements & Responsibilities

Eligible Providers

Primary care, specialty care, perinatal care, hospital based and behavioral health

[1] *See* Welf. & Inst. Code, § 14188 et seq.

providers, federally qualified health centers (FQHCs)/rural health clinics (RHCs)[2], Indian health services (IHS) and public providers who provide services to Medi-Cal beneficiaries are eligible to submit BHI Incentive Program applications. County-based providers are eligible to apply.

All applicants must have a signed MCP network provider agreement.

Applications

BHI Incentive Program application: Interested providers must complete the BHI Incentive Program application. Providers are encouraged, but not required, to do this jointly with a MCP.

Plan and provider MOU: A signed MOU between the provider applicant and their respective MCP will be a prerequisite to issuance of BHI project award. The MOU must include the following domains: goals and objectives, target population, provider responsibilities, and plan responsibilities. The MOU template is attached the BHI Incentive Program application.

Provider submission of application: Providers applying for BHI Incentive Program funds must submit their application to their MCP. If the provider is contracted with more than one MCP, the provider shall choose one MCP to receive their application. The selected MCP will be responsible for oversight and payment to the provider for the BHI project if the provider is awarded BHI funding.

MCPs to review applications: MCPs will review all submitted applications by providers or provider entities and will use a standardized scoring tool to determine which will be accepted. Criteria are outlined in the standardized scoring tool document, which is available at the DHCS BHI Incentive Program web page.

The MCPs will provide award letters to the selected applicants. The award letters will include:

- Final award amount
- Project term
- Project purpose
- Milestones and outcomes
- Payment schedule
- Allowable use of funds
- Any other conditions required by the Department or as outlined in the provider application

Approved applicants must sign the award letter according to the timeline specified by the MCP and return it to the MCP. The signed award letter will serve as the agreement between the MCP and the provider during the course of the project term.

[2] FQHC/RHC providers are eligible to apply if they provide behavioral health services, and/or intend to add such services, and indicate the intention to apply for a scope of service change in the future.

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Oversight and Monitoring

Responsibility for project monitoring: MCPs will be responsible for providing oversight of their contracted providers' BHI Incentive Program projects, including requiring that providers submit regular reports detailing progress made toward milestones and project metrics. The MCPs will report to DHCS based on information received from providers. Additional information regarding reporting requirements is included in the BHI Incentive Program application.

Provider reporting: Providers will be responsible for ensuring implementation of the BHI Incentive Program projects and reporting on progress as outlined in the provider's BHI Incentive Program application and implementation plan. This includes timely reporting to the MCP on milestones achieved, and submission of data for all the BHI project measures.

Funding

Initial infrastructure payment: Providers implementing a BHI project will be provided funding for Incentive Program Year 1 in a single, flat payment upon being selected by the MCP. The amount of funds will be dependent on the provider's infrastructure and implementation needs as described in the BHI Incentive Program application. All payments will be provided through the respective MCP.

Subsequent payments: All payments in Incentive Program Years 2 & 3 will be based upon achievement of milestones and measures, as outlined in the provider's BHI Incentive Program application and agreed upon in the MOU. The MCPs will be responsible for timely BHI Incentive Program payment following receipt of required documentation from providers demonstrating these achievements.

DHCS payment to MCPs: [placeholder; to be described once payment methodology is approved by CMS]

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Behavioral Health Integration Incentive Program Application

Application due January 21, 2020

Background

According to California Department of Health Care Services (DHCS) mental health prevalence estimates, 15.9% of Californian adults suffer from a mental health disorder (MHD). This translates to 4.4 million Californians who are in need of mental health treatment. Nearly two million Californians are suffering from a serious mental illness (SMI), 4.3% of whom are adults and 7.6% children. A common co-occurring condition with MHD is substance use disorder (SUD), which affects 8.8% of Californians. A fragmented health care system is ill equipped to treat people with chronic medical and behavioral health issues.

The prevalence of MHDs varies greatly by economic status. Adult members of households below 200% of the federal poverty level are 150% more likely to have a MHD. Among the SMI population, the disparity is even greater. Adult members of households below 200% of the federal poverty level are almost two times more likely to have a MHD. The prevalence of MHDs also varies greatly by race/ethnicity. Native Americans and Latinos are the most likely to have MHDs (20%), followed by African Americans (19%), Whites (14%), and Asians (10%), who are the least likely to report having MHDs.[1] Within distinct cultures and communities of color, stigma and cultural attitudes about behavioral health have a significant impact on whether individuals seek care and adhere to care plans, and will need to be a factor in designing care teams and treatment plans.

Additionally, drug overdose deaths, including those involving opioids, continue to increase in the United States. Deaths from drug overdose are up among all genders, races, and adults of nearly all ages.[2] Two out of three drug overdose deaths involve an opioid.[3] The current opioid crisis is arguably the most deadly public health epidemic in the U.S. since the 1918 influenza pandemic. However, stimulant use is on the rise in the West and Midwest (and in more rural areas), and methamphetamine is used at an increasing rate among this patient population. In 2018, the overdose rate from methamphetamines in California exceeded that of opioids[4]. While there is no medication to treat stimulant use, there are evidenced-based practices that can be employed to treat this SUD.

MHDs and SUDs reduce a person's life expectancy by 10 to 25 years, which is equivalent to reduced life expectancy from heavy smoking.[5] People with a MHD and/or SUD die from the same causes as the general population, such as heart disease, diabetes, and cancer. However, these diseases are more prevalent among people who

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[1] California Mental Health Prevalence Estimates, Task Team: HSRI, TAC and Expert Consultation From Charles Holzer. http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

[2] Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2017. NCHS Data Brief, no 329. Hyattsville, MD: National Center for Health Statistics. 2018.

[3] Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2018. Available at http://wonder.cdc.gov.

[4] California Opioid Dashboard: https://discovery.cdph.ca.gov/CDIC/ODdash/

[5] University of Oxford, "Many mental illnesses reduce life expectancy more than heavy smoking." ScienceDaily. ScienceDaily, 23 May 2014. www.sciencedaily.com/releases/2014/05/140523082934.htm.

suffer from a MHD or SUD and lead to earlier death.[6] For the entire population, the greatest risk factors for such diseases are smoking, obesity, hypertension, poor diet, and low levels of physical activity. Such health risks have an increased prevalence among those with a MHD and/or SUD, and have an earlier onset. In addition, untreated MHD or SUD often prevents people from adhering to effective medical therapy for these and other diseases, turning what would be a treatable disease into a lethal disease.

Furthermore, MHDs and SUDs in pregnancy and postpartum women affect both the mother and child. Up to one in five women face pregnancy-related or postpartum depression, anxiety, or other maternal MHDs,[7] which affect a child's growth and development as well a mother's ability to function and form healthy bonds. [8] Prenatal substance use continues to be a significant problem, which, if untreated, poses maternal and fetal health risks and can have lasting effects on an exposed child's growth, behavior, cognition, executive functioning, language, achievement, and future drug use.[9]

Only one in three people with a MHD and one in ten people with a SUD access treatment,[10] and individuals who do not access treatment experience serious health burdens and are at risk of premature death.[11] The Substance Abuse and Mental Health Services Administration and Health Resources Services Administration's jointly fund the Center for Integrated Health Solutions (SAMHSA-HRSA CIHS), which advocates for providing better care to those with co-occurring conditions, whether medical or behavioral, by integrating care. Care for individuals with complex medical and social needs is too often fragmented. These individuals seek care from multiple service systems that can each be confusing and difficult to navigate. As a result, persons with co-morbid physical and behavioral health conditions are typically high utilizers of hospital services. When behavioral health (BH) conditions are detected early and treated appropriately, those individuals experience a greater quality of life, better self-care, improved adherence to medical and behavioral health treatments, and better overall health outcomes.[12]

The implementation of validated screening tools along with brief intervention techniques serve as strategies for early detection of MHDs and SUDs, resulting in reduced alcohol and other drug misuse and earlier intervention and treatment opportunities. When preventive efforts are combined with coordinated care efforts (e.g., psych-consultation, team-care approach, peer providers, enhanced linkages to community, and BH settings), the result is a significant improvement in health outcomes. One example of

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[6] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011;49(6):599–604.
[7] https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Maternal-Mental-Health.aspx
[8] https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/
[9] https://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf
[10] Behavioral Health Barometer: California, Volume 4, Substance Abuse and Mental Health Services Administration, 2017, www.samhsa.gov
[11] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011; 49(6):599–604.
[12] SAMHSA-HRSA Center for Integrated health Solutions. http://www.integration.samhsa.gov/

such success is the IMPACT model, also called collaborative care, which led to clinical outcomes that were twice as good as compared to general care.[13] Programs such as collaborative care not only improve care at the individual and population levels, but lead to lower overall health care costs.[14]

Objective

The objective of the DHCS Behavioral Health Integration (BHI) Incentive Program is to incentivize plans to improve physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's (MCP) network, using culturally and linguistically appropriate teams with expertise in primary care, substance use disorder conditions, and mental health conditions who deliver coordinated comprehensive care for the whole patient.

The goal of the BHI Incentive Program is to increase MCP network integration for providers at all levels of integration (those just starting behavioral health integration in their practices as well as those that want to take their integration to the next level), focus on new target populations or health disparities, and improve their level of integration or impact.

General Instructions

Thank you for your interest in the DHCS BHI Incentive Program. DHCS collaborated with MCPs to roll out a standard, statewide BHI Incentive Program application. DHCS will work directly with MCPs across the state to achieve the goals and objectives of the BHI Incentive Program.

In order to apply, providers must complete and sign this application and submit it directly to the local MCP. Prior to completing this application, applicants should carefully review the entire application and other supporting documents that are available on the DHCS website https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx, and consult with the local MCP.

If the provider is contracted with more than one MCP, the provider shall choose one MCP to receive their application. If the provider is awarded BHI funding by the MCP, the selected MCP will be responsible for oversight and payment to the provider for meeting the BHI Incentive Program milestones, based on their approved application.

Please complete the BHI Incentive Program application and return it to the applicable MCP no later than **5 p.m. PST on January 21, 2020**. The MCP may require the application to be submitted to the MCP's online grants management system portal. Incomplete applications will not be considered. In order for this application to be considered complete for the purposes of submission, all components of the application

[13] IMPACT. Evidence-based depression care. http://impact-uw.org/

[14] Jurgen Unützer, Jeffrey Lieberman. Collaborative Care: An Integral Part of Psychiatry's Future. Psychiatry Online, Psychiatric News Article, November 12, 2013.

must be completed, the application must be signed, and the four attachments below must be included:

1. Detailed budget for the applicant's defined milestones and associated proposed incentive funding.
2. Letter of support from their county mental health managed care plan, if the selected BHI project addresses SMI or requires coordination with county mental health.
3. Letter of support from their county substance use disorder managed care plan or substance use disorder fee-for-service program. This attachment is only required if the selected BHI project addresses SUD.
4. An executed *DHCS Behavioral Health Integration Incentive Program Memorandum of Understanding (MOU) (Appendix B).* (If the applicant is selected for the BHI Incentive Program, the applicable MCP will sign the MOU and return a fully executed copy to the awardee.)

The application review process and timing is as follows:

Deliverable/Activity	Date
1. DHCS releases BHI Incentive Program RFA	November 12, 2019
2. DHCS conducts webinar for potential applicants/interested entities	November 22, 2019 at 1:00p.m.
3. BHI Incentive Program Applications due to the MCP(s)	January 21, 2020
4. MCPs review applications based on the standardized scoring tool	February 18, 2020
5. Participation decisions go out from MCPs to applicants	March 18, 2020
6. BHI Incentive Program start date for approved applicants	April 1, 2020
7. BHI Incentive Program operations duration	April 1, 2020 to December 31, 2022

DHCS BHI Incentive Program Application Overview

Through this BHI Incentive Program application, each applicant will select one or more behavioral health integration projects to implement over a 33-month period (April 2020 through December 31, 2022). The applicant will demonstrate how they will meet various behavioral health integration goals, objectives, and milestones. Each BHI project contains a target population, practice redesign components, and corresponding performance measures. Each application will:

- Identify which BHI project(s) they have selected.

- Identify the specific target population for each selected BHI project (pediatric, adolescent, and/or adult) based on the population(s) served by the entity.
    - Optional: Identify if the project will focus on reducing disparities by race, ethnicity, or primary language. If the entity chooses to target disparities, the entity must identify the specific disparity target population (e.g., non-English speaking, Native American, Black, Hispanic) and report selected measures stratified by the relevant target disparity population.
- Describe the practice redesign component/tasks they will implement to achieve the goals and objectives of the selected BHI project(s).
- Identify which performance measures the applicant will report, in addition to the required measures for each BHI project (if applicable). Each BHI project will indicate how many performance measures are required.

In Incentive Program Year 1 (April through December 2020), MCPs will receive a flat incentive payment to reward selected BHI applicants that report baseline data, build infrastructure, hire staff, modify IT systems, and begin implementing practice redesign components as outlined in their application. For Incentive Program Years 2 (calendar year 2021) and 3 (calendar year 2022), MCPs will receive incentive payments from DHCS based on achieving outlined milestones and performance metrics to reward selected BHI applicants for completing Incentive Program redesign component milestones and reporting all performance metrics. The Incentive Program milestones, and the funding amounts for each, will be listed in the application. The total funding amounts that DHCS will award, per selected BHI applicant, will be the same for Incentive Program Years 2 and 3. The funding amount for Incentive Program Year 1 will be two-thirds of the amount that is available for each of the subsequent program years, which the application should reflect.

Section 1: BHI Incentive Program Applicant Information

The purpose of this section is to provide information about the BHI Incentive Program lead applicant. Primary care, specialty care, perinatal care, hospital based and behavioral health providers, federally qualified health centers (FQHCs)/rural health clinics (RHCs)[15], Indian health services (IHS) and public providers who provide services to Medi-Cal beneficiaries are eligible to submit BHI Incentive Program applications. County-based providers are eligible to apply.

All applicants must have a signed MCP network provider agreement.

[15] FQHC/RHC providers are eligible to apply if they provide behavioral health services, and/or intend to add such services, and indicate the intention to apply for a scope of service change in the future.

1.1 BHI Incentive Program Applicant and Contact Person

Organization Name	
Type of Entity (from lead entity description above)	
Service Location Physical Address(es)	
Geographic Service Area(s)	
Number of all Medi-Cal Members Served Per Year	
Percentage of all clients served per year who are Medi-Cal Members at Sites Implementing BHI	
Contact Person	
Contact Person Title	
Telephone Number	
Email Address	
Mailing Address	

Section 2: BHI Incentive Program Project Options

The purpose of this section is to identify the applicant's selected BHI project(s). The first part of this section describes the project options. The applicant will indicate their project selection(s) and additional information in the second part of this section. Applicants can select up to six BHI projects.

BHI Project Options

Below is a list of allowable BHI projects that can be applied in either a pediatric, adolescent, and/or an adult practice:

1. Basic Behavioral Health Integration

2. Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment
3. Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses
4. Diabetes Screening and Treatment for People with Serious Mental Illness
5. Improving Follow-Up after Hospitalization for Mental Illness
6. Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

Below are the target population goals, practice redesign considerations, and performance measures for each BHI project. Please note that the practice redesign considerations are just overall guidance on practice redesign components to consider when putting together the BHI project plan.

See *Appendix A: Core Components and Tasks of Effective Integrated Behavioral Health Care Programs* for examples of integration components/tasks that could be incorporated into the applicant's BHI project across the following categories:

- Patient Identification and Diagnosis
- Engagement in Integrated Care Programs
- Evidence-Based Treatment
- Systematic Follow-up, Treatment Adjustment, and Relapse Prevention
- Communication and Care Coordination
- Systematic Psychiatric Case Review and Consultation
- Program Oversight and Quality Improvement
- Strategies and Practice Redesign Components to Increase Level of Integration

Basic Behavioral Health Integration

Target Population Goal:

Improve evidence-based medical and behavioral health integration practices with a primary care, specialty care, or behavioral health provider's office or clinic. This package is best suited for practices that are new to behavioral health integration.

Practice Redesign:

Ensure culturally appropriate interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder services. Preventive care screenings,[16] including behavioral health screenings (e.g., PHQ-2, PHQ-9, GAD-7, and SBIRT), should be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) to ensure access for

[16] https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

further evaluation and evidence-based treatment, when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Required Measures for the Behavioral Health Integration Package		
NCQA	Screening for Unhealthy Alcohol Use	Pediatric and Adult
CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Pediatric
CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Adult
NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Pediatric and Adult
NCQA	Antidepressant Medication Management (AMM-AD)	Adult
Applicant to select two or more additional measures to report from list below		
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Pediatric
NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Pediatric
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Pediatric
NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Adult
PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Adult
NCQA	Pharmacotherapy for Opioid Use Disorder [17]	Adult
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Adult
NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Adult
NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (MSC-AD)	Adult
NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Pediatric
NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Adult
NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Adult
NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Adult
NCQA	Comprehensive Diabetes Care (CDC)[18]	Adult
NCQA	Controlling High Blood Pressure	Adult

[17] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf

[18] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment

Target Population Goal:
Increase prenatal and postpartum access to mental health and substance use disorder screening and treatment.

Practice Redesign:
Ensure culturally appropriate interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder services. Preventive care screenings,[19] including behavioral health screenings (e.g., PHQ-2, PHQ-9, GAD-7, and SBIRT), would be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and evidence-based treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Required Measures for Maternal Mental Health and Substance Use Package[20]	
CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)
CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)
NCQA	Screening for Unhealthy Alcohol Use
NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)
Applicant to select one or more additional measures to report from list below	
NCQA	Antidepressant Medication Management (AMM-AD)
NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)
NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)
NCQA	Pharmacotherapy for Opioid Use Disorder [21]

Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses

Target Population Goal:
Improve evidence-based behavioral health prescribing and management of psychotropic, opioid use disorder (OUD), and alcohol use disorder medications.

[19] https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
[20] This measure denominator technical specifications will be altered to allow for data collection that captures pregnant or postpartum women.
[21] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf

Practice Redesign:
Ensure culturally appropriate interventions and systems are in place to support improvement in medication adherence, follow-up care, psychosocial care, and metabolic monitoring. Implement appropriate systems to improve patient safety and medication adherence through monitoring per the current evidence-based clinical guidelines. Deploy sustainable interventions to target improvements in medication management and adherence, link to community treatment, and enhance self-management strategies.

Please note that for this BHI project, the entity would identify the specific target population (adults, children, or both) based on the population served by the entity. The entity would report the required measures and additional measures as applicable to the specified target population.

Required Children and Adolescent Measures for Medication Management Package	
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
NCQA	Metabolic Monitoring for Children and Adolescents on Anti-Psychotic Medication
NCQA	Pharmacotherapy for Opioid Use Disorder [22]

Required Adult Measures for Medication Management Package	
NCQA	Antidepressant Medication Management (AMM-AD)
PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)
NCQA	Pharmacotherapy for Opioid Use Disorder [23]

Diabetes Screening and Treatment for People with Serious Mental Illness

Target Population Goal:
Improve health indicators for patients with both diabetes and serious mental illness.

Practice Redesign:
Ensure culturally appropriate interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder services. Preventive care screenings,[24] including medical

[22] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf
[23] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf
[24] https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

and behavioral health screenings (e.g., United States Preventive Services Task Force (USPSTF) diabetes screenings, PHQ-2, PHQ-9, GAD-7, and SBIRT), would be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and evidence-based treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Required Measures for Diabetes Screening and Treatment for People with Serious Mental Illness	
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
NCQA	Comprehensive Diabetes Care (CDC)[25]

Follow Up after Hospitalization for Mental Illness

Target Population Goal:
Improve timely follow up after hospitalization for mental illness.

Practice Redesign:
Culturally appropriate interventions are needed that link individuals in inpatient settings to outpatient mental health treatment following acute treatment.[26] Enhanced access to primary care and/or to mental health specialists could be integrated into discharge planning for these patients. Improved communication mechanisms and data sharing between inpatient and outpatient facilities to support linkages to primary care physicians, mental health specialists, and other community services through the discharge process are critical to successful follow up and ongoing treatment needs. Implementation of outpatient patient navigators, peer navigators, peer support, and/or case management, and developing protocols regarding follow up after hospitalization and/or missed visits.

Please note that for this BHI project, the entity would identify the specific target population (adults, children, or both) based on the population served by the entity. The entity would report the required measures as applicable to the specified target population.

Required Measures for Follow-Up after Hospitalization for Mental Illness Package		
Child Core	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
Adult Core	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

[25] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182296/

Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

Target Population Goal: Improve timely follow-up after emergency department visit for mental illness and substance use disorder.

Practice Redesign: Integrate appropriate screening tools, staff training, and culturally appropriate decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and/or substance use disorders. Enhanced access to primary care and/or to behavioral health specialists could be integrated into discharge planning for these patients. When appropriate, patients should be started on behavioral health medications in the ED. Use of ED care navigators (e.g., community physician liaison program, substance user navigators) may be used to support linkages to primary care physicians and mental health and substance use disorder specialists and other community services through the discharge process.

Required Measures for Follow-Up after Emergency Department Visit Package		
Adult Core	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)
Adult Core	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)

Section 3: BHI Project Selection

The six BHI projects options are listed below, with a specific form for each project. Complete items a-g for each BHI project selected.

3.1 ☐ Basic Behavioral Health Integration

Check the box if this project is selected.

a. Check the box for the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ **Pediatric**

☐ **Adolescent**

☐ **Adult**

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project requires the applicant to select two, or more, performance measures beyond the required measures. Check the boxes for the selected additional measures in the white section below. (See Project measure requirements on pages 6-11 for each Project.)

Applicant to select two, or more, measures to report from list below:		
☐ NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Pediatric
☐ NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Pediatric
☐ NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Pediatric
☐ NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Adult
☐ PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Adult

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☐ NCQA	Pharmacotherapy for Opioid Use Disorder	Adult
☐ NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Adult
☐ NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Adult
☐ NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (MSC-AD)	Adult
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Pediatric
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Adult
☐ NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Adult
☐ NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Adult
☐ NCQA	Comprehensive Diabetes Care (CDC)	Adult
☐ NCQA	Controlling High Blood Pressure	Adult

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:

1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**
3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:

1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1. For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.
e: (500 Words or less.) **Narrative:** **Flat Funding Amount Requested:** **Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):**
f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task. Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the applicant has reported all metric data that is past due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application, through December 2022. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).
f: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**
g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the

component/task will be completed and the funding requested for the component/task.
g: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**

3.2 ☐ Maternal Mental Health and Substance Use

Check the box if this project is selected.

a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ Pediatric

☐ Adolescent

☐ Perinatal

☐ Adult

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project requires the applicant to select one, or more, performance measures beyond the required measures. Check the boxes for the selected additional measure(s) in the white section below. (See Project measure requirements on pages 6-11 for each Project.)

Applicant to select one, or more, measures to report from list below		
☐ NCQA	Antidepressant Medication Management (AMM-AD)	
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	
☐ NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	
☐ NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	
☐ NCQA	Pharmacotherapy for Opioid Use Disorder	

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed

information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:

1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**
3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:

1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that

will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task. Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application, through December 2022. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).
f: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**
g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.
g: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**

3.3 ☐ <u>Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnosis</u> **Check the box if this project is selected.**
a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity): **☐ Pediatric** **☐ Adolescent** **☐ Adult** **In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.**
a:
b. <u>Optional</u>: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population. **If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.**
b:
c. This BHI project this project only requires the standard performance measures. (See Project measure requirements on pages 6-11 for each Project.)
d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)
d: (500 Words or less.) **Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:** **1. You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:** **2. Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:

1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

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e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application, through December 2022. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).
f: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**
g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.
g: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**

3.4 ☐ Diabetes Screening and Treatment for People with Serious Mental Illness **Check the box if this project is selected.**
a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity): **☐ Pediatric** **☐ Adolescent** **☐ Adult** **In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.**
a:
b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population. **If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.**
b:
c. This BHI project only requires the standard performance measures (See Project measure requirements on pages 6-11 for each Project.)
d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)
d: (500 Words or less.) **Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:** **1. You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:** **2. Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:

1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

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Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).
f: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**
g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.
g: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**

3.5 ☐ Improving Follow-up after Hospitalization for Mental Illness **Check the box if this project is selected.**
a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity): **☐ Pediatric** **☐ Adolescent** **☐ Adult** **In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.**
a:
b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population. **If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.**
b:
c. This BHI project only requires the standard performance measures. (See Project measure requirements on pages 6-11 for each Project.)
d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)
d: (500 Words or less.) **Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:** **1. You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:** **2. Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:

1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).
f: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**
g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.
g: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**

3.6 ☐ Improving Follow-up after emergency Department Visit **Check the box if this project is selected.**
a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity): **☐ Pediatric** **☐ Adolescent** **☐ Adult** **In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.**
a:
b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population. **If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.**
b:
c. This BHI project only requires the standard performance measures. (See Project measure requirements on pages 6-11 for each Project.)
d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)
d: (500 Words or less.) **Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:** **1. You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:** **2. Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:

1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

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e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

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f: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**
g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.
g: (500 words or less.) **Narrative:** **Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):**

Section 4: Attestations and Certification

4.1 Attestation

I certify that as the representative of the BHI Incentive Program applicant, I agree to the following conditions:

- The BHI Incentive Program applicant will comply with the terms of the Memorandum of Understanding (Appendix B) executed with its partner MCP.
- The purpose of the BHI Incentive Program funding is to better integrate physical and behavioral health care for Medi-Cal members. The applicant will use the BHI Incentive Program funding to better integrate physical and behavioral health care for all target population members within the applicant's practice panel.
- BHI Incentive Program funding will not duplicate or supplant other previously identified funding that is specifically dedicated to the deliverables listed in this application. BHI Incentive Program funding may be combined with other funding sources to accomplish the milestones listed in this application, to the extent permissible under federal law.
- BHI Incentive Program funding will not be used to reimburse for services currently reimbursable under Medi-Cal, but must be used to improve the delivery system for Medi-Cal managed care enrollees.
- If the BHI Incentive Program applicant is a FQHC, either behavioral health is currently included in the scope of practice, or the FQHC will apply for a future scope of practice change to include behavioral health services.
- The BHI Incentive Program applicant will report and submit timely and complete data to the partner MCP in a format specified by the MCP.
- The BHI Incentive Program applicant shall submit reports in a manner specified by the partner MCP.
- Implementation of the BHI Incentive Program is contingent upon DHCS obtaining all necessary approvals from the Centers for Medicare & Medicaid Services, and the terms for participation are subject to change based on the availability of federal approvals. In addition, continuation of the BHI Incentive Program is contingent upon state legislative appropriations in future fiscal years.
- Payments for BHI projects will be contingent upon completion of the application milestone deliverables.

☐ **I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of BHI Incentive Program participation requirements.**

Signature of BHI Incentive Program Applicant Representative **Date**

Appendix A: Core Components and Tasks of Effective Integrated Behavioral Health Care Programs[27]

Patient Identification and Diagnosis

- Screen for behavioral health problems using valid instruments
- Diagnose behavioral health problems and related conditions
- Use valid measurement tools to assess and document baseline symptom severity

Engagement in Integrated Care Program

- Introduce collaborative care team and engage patient in integrated care program
- Initiate patient tracking in population-based registry

Evidence-Based Treatment

- Develop and regularly update a biopsychosocial treatment plan
- Provide patient and family education about symptoms, treatments, and self-management skills
- Provide evidence-based counseling (e.g., motivational interviewing and behavioral activation)
- Provide evidence-based psychotherapy (e.g., problem solving treatment, cognitive behavior therapy, and interpersonal therapy)
- Prescribe and manage psychotropic medications as clinically indicated
- Change or adjust treatments if patients do not meet treatment targets
- Train staff and providers in trauma-informed care

Systematic Follow-up, Treatment Adjustment, and Relapse Prevention

- Use population-based registry to systematically follow all patients
- Proactively reach out to patients who do not follow up
- Monitor treatment response at each contact with valid outcome measures
- Monitor treatment side effects and complications
- Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment
- Create and support relapse prevention plan when patients are substantially improved

Communication and Care Coordination

- Coordinate and facilitate effective communication among providers
- Engage and support family and significant others as clinically appropriate
- Facilitate and track referrals to specialty care, social services, and community-based resources

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[27] *e.g.,* AIMS Center Behavioral Integration Checklist, McHAF Site Self-Assessment https://www.integration.samhsa.gov/AIMS_BHI_Checklist.pdf

Systematic Psychiatric Case Review and Consultation

- Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving
- Provide specific recommendations for additional diagnostic work up, treatment changes, or referrals
- Provide psychiatric assessments for challenging patients in person or via telemedicine

Program Oversight and Quality Improvement

- Provide administrative support and supervision for the program
- Provide clinical support and supervision for the program
- Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, and patient satisfaction), and use this information for quality improvement

Strategies and practice redesign components that can increase your level of integration[28]

- The behavioral health specialist (BHS) is integrated into the workflow of the clinic
- The BHS shares access to the electronic medical record (EMR)/patient chart with primary care providers (PCPs)
- Clinic treatment plans reflect an integrated approach to patient behavioral and physical health needs
- The clinic scheduling system allows patients to be scheduled for same day appointments with the BHS
- The clinic systematically triages the behavioral health needs of its patients
- The clinic systematically tracks the progress of behavioral health treatment
- The PCP and BHS do warm hand offs according to patient needs
- The PCP and BHS regularly consult about patient care
- The PCP and BHS collaborate in making decisions about mutual patients
- The clinic has at least one integrated care "champion"

[28] Level of Integration Measure (LIM): Purpose: To rate the degree to which behavioral health providers or behavioral health care is integrated into primary care settings from the perspective of staff and/or providers. Developer: Antioch University
https://integrationacademy.ahrq.gov/sites/default/files/measures/5_Level_of_Integration_Measure.pdf

Appendix B: DHCS Behavioral Health Integration Incentive Program Memorandum of Understanding (MOU)

MEMORANDUM OF UNDERSTANDING
BETWEEN
[PROVIDER]
AND
[PLAN]
FOR PROPOSITION 56 VALUE-BASED PAYMENT BEHAVIORAL HEALTH INTEGRATION INCENTIVE PROGRAM

This Memorandum of Understanding ("MOU") is made and entered into as of this ____ day of _____, 2020, by and between [NAME] ("Provider") and [NAME] ("Plan") in order to facilitate successful implementation of the provider's behavioral health integration project(s) ("BHI Project(s)") set forth in the approved BHI Incentive Program application.

Whereas, Section 14188.1 of the Welfare and Institutions Code authorized the Department of Health Care Services ("DHCS") to develop the Proposition 56 Value-Based Payment ("VBP") Program, including the Behavioral Health Integration ("BHI") program in Medi-Cal managed care, with the goals of improving physical and behavioral health outcomes, efficiency in care delivery, and improved patient experience by integrating and coordinating primary care, mental health, and substance use disorder treatment for Medi-Cal beneficiaries; and,

Whereas, DHCS established an application process in partnership with managed care plans whereby eligible providers submitted BHI Incentive Program applications establishing BHI project(s) to be considered for BHI Incentive Program payments, and incentivized plans to oversee and administer payment for approved BHI project(s); and,

Whereas, the provider's BHI project(s) has been selected by the plan for the BHI Incentive Program according to the terms of the provider's BHI Incentive Program application; and,

Whereas, the plan is responsible for oversight and administration of payments to the provider consistent with the terms of the BHI Incentive Program, any terms imposed as a condition of federal approval of the BHI Incentive Program, and any DHCS guidance related to the BHI Incentive Program.

Therefore, the provider and plan agree as follows:

1. **Term**. The Term of this MOU shall begin on [GRANT AWARD DATE] and shall terminate on [END DATE OF GRANT].

2. **Termination**. The terms of this MOU are contingent upon BHI Incentive Program application approval, the availability of sufficient state and federal Medicaid funding, and all necessary federal approvals to be obtained by DHCS. Should sufficient funds not be allocated, or federal financial participation be unavailable, services may be modified accordingly, or this MOU can be terminated by any party after giving 30 days advance written notice. The plan may terminate this MOU with 30 days advance written notice to the provider and DHCS due to the provider's failure to meet terms of a corrective action plan as set forth in Section 5 (Corrective Action).

3. **Scope.** The provider is responsible for the implementation of and compliance with the project(s), as set forth in their BHI Incentive Program application, which is attached as Exhibit 1 and incorporated here by reference, including reporting to the plan on the achievement of milestones and objectives consistent with the terms of the BHI Incentive Program application. The provider shall promptly notify the plan of any material change in information submitted in support of the project(s) or the BHI Incentive Program application, including changes in organizational leadership, business operations, and financial standing. The plan is responsible for overseeing the project(s), including monitoring and verifying milestone achievement and administering payments consistent with the terms of the project(s) or the BHI Incentive Program application, any terms imposed as a condition of federal approval of the BHI Incentive Program, and any subsequent DHCS guidance related to the BHI Incentive Program.

4. **Confidentiality.** The plan and provider collaboration in support of project(s) may require the exchange of confidential or proprietary information ("Confidential Information") as may be identified by either party. The plan and provider agree to abide by processes and requirements applicable to the exchange of either party's respective confidential information, in accordance with applicable state or federal law.

5. **Corrective Action**. In recognition of the need for project flexibility, the plan may utilize a corrective action plan, or other mutually agreed upon or DHCS-required mechanism, for modifying the project terms to facilitate the provider's compliance with project terms or to adjust project goals and objectives and related payments, as necessary. Such modifications are subject to DHCS review and approval. Provider noncompliance with modified project terms may result in termination of this MOU consistent with Section 2 (Termination). In the event of project termination, the

provider shall return funds as directed by the plan.

6. **Provider Responsibilities**:

A. **Use of Funding**

i. The provider shall expend project award funds for the purposes of carrying out activities and achieving milestones as set forth in the approved project(s).

ii. The provider shall document to the plan, in a form and manner determined by the plan, that project activities have been carried out and milestones have been achieved.

iii. To the extent the provider does not or is unable to carry out project activities and achieve milestones, the provider shall notify the plan and return any funds that the provider may have received related to those project activities or milestones.

B. **Practice Redesign and Infrastructure Development Reporting**

i. The provider will implement the practice redesign and infrastructure development components set forth in the BHI Incentive Program application.

ii. The provider will shall report to the plan on the progress of the project's practice redesign and infrastructure development on a schedule in a format and process specified in the BHI Incentive Program application, or as otherwise mutually agreed upon by the plan and provider.

C. **Milestone Achievement**

i. The provider will perform tasks necessary to meet milestones required by the BHI Incentive Program application. The provider shall provide the plan with information necessary to demonstrate progress in achieving milestones as set forth in the BHI Incentive Program application.

D. **Measure Reporting**

i. The provider will report to the plan on target population measures on a schedule in a format and process required by the BHI Incentive Program application, or as otherwise mutually agreed upon by the plan and provider.

ii. The provider will report measures to the plan consistent with the specifications required by the respective measure author (e.g., National Committee for Quality Assurance).

7. **Plan Responsibilities**

A. **Monitoring Project Milestones and Measures**. The plan will collect and evaluate all information related to implementation of the provider's project(s) for the purposes of ensuring progress toward the provider's goals and objectives, reporting to DHCS and other objectives as set forth in the BHI Incentive Program application.

B. **Reporting to DHCS.** The plan will report to DHCS on the project status as specified in the terms of the BHI Incentive Program application, the terms of federal approval for the BHI Incentive Program, and any applicable DHCS-issued guidance.

C. **Information Exchange**. The plan will provide the provider with the following information to support the provider on reporting project target population(s):

i. [LIST MEASURES OR DATA ELEMENTS, E.G., "EMERGENCY DEPARTMENT UTILIZATION"]

D. Administration of Project Funds

a. **Initial Payment**. Within 30 days of the managed care plan's selection of a BHI Incentive Program applicant, or as otherwise mutually agreed upon by the plan and provider, the plan will provide initial payment to the provider as set forth in the terms of the project and BHI Incentive Program application.

b. **Milestone Payments.** Subsequent to the initial payment, all ongoing payments to the provider will be tied to achieving practice redesign components, milestones, or defined progress toward goals required by terms of the project and BHI Incentive Program application. The plan will remit milestone payments to the provider within [NUMBER OF DAYS] days of the provider's successful demonstration to the plan of each milestone achievement per the terms of the project. The plan may adjust milestone measurement and related payments consistent with the terms of a corrective action plan. The plan will not make any milestone payment until all past due reporting is completed.

8. **Liaison.** The plan and provider will each designate a liaison(s) to serve as a point of contact for activities performed related to this MOU.

9. **MOU Monitoring. The** plan and provider will meet on a mutually agreed upon frequency, or upon request to monitor the performance of parties' responsibilities related to this MOU.

10. **Dispute Resolution.** If there is a dispute that cannot be resolved by the parties through Section 9 "MOU Monitoring," either party can submit a request for resolution to the Department of Health Care Services. A party shall give the other five business days of notice of its intent to submit a request for resolution.

Witness whereof, the parties hereto have executed this MOU as of [DATE].

Attest:

[PROVIDER]

By:

[PLAN]

By:

ATTACHMENTS:

Included in MOU	Exhibit/Attachment
X	Exhibit 1 – Approved Provider VBP BHI Project ("Project")

Behavioral Health Integration Incentive Program
Project Selection Criteria

Selection Criteria

The below table includes point values assigned to various sections or components of the BHI application. **Not every section of the application is scored. However, for the application to be considered in the review process, all sections must be complete. Applications missing information will not be considered.**

Application Section	Number of Points
3.1(d) Narrative overview of project (Total points = 40)	
Description of importance to Medi-Cal beneficiaries to be served by the provider	10
Description of the project design, practice redesign components, organizational capacity, leadership and sustainability	15
Description of the approach for implementing the project, including a plan of action (implementation steps)	15
3.1(e) Project Year 1 narrative, milestones, and funding amount (Total points = 20)	
Narrative description of activities and accomplishments that will occur to achieve the goals of the project, and flat funding amount requested	10
List of milestones with accomplishment and date, including a description of how achievement of the milestones will support implementation and collection of the selected measures	10
3.2(f) Project Year 2 narrative and milestone list with associated funding amounts (Total points = 20)	
Narrative description of specific practice redesign components and tasks	10
List of milestones with accomplishment, date, and funding amount, including a description of how achievement of the milestones will support implementation and collection of the selected measures	10
3.1(g) Project Year 3 narrative and milestone list with associated funding amounts (Total points = 20)	
Narrative description of specific practice redesign components and tasks	10
List of milestones with accomplishment, date, and funding amount, including a description of how achievement of the milestones will support implementation and collection of the selected measures	10
Application Total Points	**100**

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Evaluation

Managed care plans will utilize the following scoring grid to assign points for each section of the application. The score for each provider application will be provided to DHCS along with the plan's recommendations for project awards. Prior to making final selection for BHI project awards, DHCS will review the provider application and the MCP's score of each application to ensure the scoring criteria is applied consistently across all provider applications. **Managed care plans will not recommend approval of BHI project applications that score below 70% (inadequate).**

Interpretation	General Basis for Point Assignment	Percent Range of Points
Inadequate	Applicant does not include a response and/or supporting information for the requirement(s) or does not commit to meeting the BHI program requirement(s).	0–69% of available points for the section
Adequate	Response and/or supporting information meets the basic BHI program requirement(s) and demonstrates an understanding of, and the ability and intent to, meet the requirement(s). There may be omission(s), flaw(s), and/or defect(s), but they are inconsequential and acceptable.	70–85% of available points for the section
More than Adequate	Response and/or supporting information demonstrates a thorough, detailed, and complete understanding of the requirement(s); provides evidence of the current ability to comply; and/or provides detailed plans or methodologies to further assure compliance with the requirement(s).	86-100% of available points for the section

Scoring

The following questions will be considered by managed care plans to determine the adequacy of the respective application section and point value awarded.

3.1(d) Narrative overview of project (40 points)
1. Did the applicant adequately describe the target population and rationale for the BHI project?
2. Did the applicant describe the project design, practice redesign components and organizational capacity, leadership, and sustainability at a level of detail demonstrating applicant's understanding and readiness for the project?
3. Did the applicant describe the implementation approach, including a detailed plan of action?

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3.1(e) Project Year 1 narrative, milestones, and funding amount (20 points)
1. Does the response include a narrative description regarding implementation activities for Project Year 1?
2. Does the response include a funding amount requested, with detailed rationale, for Project Year 1?
3. Does the response include a list of milestones to be accomplished in Project Year 1, including dates of completion, reporting plan, and how reported data will demonstrate milestone achievement?
3.2(f) Project Year 2 narrative and milestone list with associated funding amounts (20 points)
1. Does the response include a narrative description regarding practice redesign components/tasks for Project Year 2?
2. Does the response include a list of milestones and associated completion dates to be accomplished in Project Year 2 including a reporting plan and explanation of how reported data will demonstrate milestone achievement?
3. Does the response include a funding amount requested for each milestone, including a rationale for specific costs related to achieving the milestones?
3.1(g) Project Year 3 narrative and milestone list with associated funding amounts (20 points)
1. Does the response include a narrative description regarding practice redesign components/tasks for Project Year 3?
2. Does the response include a list of milestones and associated completion dates to be accomplished in Project Year, including a reporting plan and explanation of how reported data will demonstrate milestone achievement?
3. Does the response include a funding amount requested for each milestone, including a rationale for specific costs related to achieving the milestones?

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

Contact

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

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10); and,
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 10 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-11 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

The IGT funds received under IGTs 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), beginning with IGT 8 funds must be used in the current rate year for CalOptima covered Medi-Cal services per DHCS direction. IGT 8 funds have been allocated to the Homeless Health Initiative. IGT 9 funds have not yet been received, nor allocated; CalOptima staff anticipates returning with recommendations on an allocation plan in a separate Board action; however, as indicated,

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per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing Member's unmet healthcare needs.

Discussion

On December 20, 2019, CalOptima received notification from DHCS regarding the Rating Period 2019 - 20 Voluntary Rate Range IGT Program (IGT 10). Unlike the prior IGTs, which covered the applicable twelve-month state fiscal year, IGT 10 covers eighteen months including the periods of July 1, 2019 through June 30, 2020 and July 1, 2020. through December 31, 2020. CalOptima's proposal, along with the funding entities' supporting documents are due to DHCS no later than February 19, 2020.

The five eligible funding entities from the previous IGT transactions have been contacted regarding their interest in participation in IGT 10. All five funding entities have informally indicated that they are interested in participation in the IGT program this year. The formal DHCS required Letter of Interest is due to CalOptima by February 14, 2020 for delivery to DHCS by February 19, 2020. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in the 2019-20 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with each of the five proposed funding entities submitting a letter of interest (or their designated providers) for the purpose of securing available IGT funds. Consistent with the nine prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to the Board with additional information regarding the IGT 10 transaction and a proposed expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended actions to submit a proposal to DHCS and pursue IGT funding partnerships with five governmental funding entities for IGT 10 is expected to generate one-time IGT revenue that will be invested in covered Medi-Cal services for CalOptima members. As such, there is no net fiscal impact on CalOptima's current and future operating budgets.

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Rationale for Recommendation

Consistent with the previous nine IGT transactions, submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2019-20 (IGT 10). Also, consistent with the 2020-22 Strategic Plan, it would increase funding to support delivery of covered Medi-Cal services for CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

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Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 15

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Children and Families Commission of Orange County	1505 E. 17th Street, 230	Santa Ana	CA	92705
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOME
GOVERNOR

DEC 2 0 2019

Nancy Huang
Interim Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Rating Period 2019–20 (July 1, 2019 through December 31, 2020) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Nancy Huang:

The Rating Period 2019-20 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020.

DHCS shall not direct the MCP's expenditure of payments received under the Rating Period 2019-20 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from

programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Rating Period 2019-20 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR RATING PERIOD 2019-20:

MCPs should refer to the estimated Rating Period 2019-20 (service periods July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020) county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Rating Period 2019-20 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that for service periods July 1, 2019 through June 30, 2020 and July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Estimated Member Months, and the actual amounts may change based on actual enrollment. Note that for service period July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Projected Contribution PMPMs, and the actual amounts may change based on the risk adjustment process that DHCS uses as part of its rate development methodology.

If an MCP elect to participate in the Rating Period 2019-20 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Rating Period 2019-20 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

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Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
    2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
    3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Rating Period 2019-20. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
    4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Wednesday, February 19, 2020.

- The proposals and letters of interest are due to DHCS ***by 5pm on*** **Wednesday, February 19, 2020**. Please send a PDF copy of the required documents by e-

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mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the Rating Period 2019-20 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Rating Period 2019-20 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

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cc: Michael Schrader
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Rating Period 2019-20 (July 1, 2019 through December 31, 2020) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

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Attachment B

Voluntary Rate Range Program Supplemental Attachment
Rating Period 2019-20 (July 1, 2019 through December 31, 2020)

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than February 19, 2020.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2018 - June 30, 2019.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2018 through June 30, 2019.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. Please provide the following information:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2019 - June 2020)

	Total	50% FFP (Non-MCHIP,SPD and LTC)	88% FFP (MCHIP - 7/2019 to 9/2019)	76.5% FFP (MCHIP - 10/2019 to 6/2020)	BCCTP[3]	WCM[4]	93% FFP Optional Expansion (7/2019 - 12/2019)	90% FFP Optional Expansion (1/2020 - 6/2020)
Total Funds Available	$ 143,831,947	$ 60,609,553	$ 2,248,273	$ 6,744,806	$ 567,560	$ 20,884,320	$ 26,388,727	$ 26,388,708
Federal Match	$ 98,389,329	$ 30,304,777	$ 1,978,480	$ 5,159,777	$ 189,344	$ 12,465,598	$ 24,541,516	$ 23,749,837
Governmental Funding Entity's Portion	$ 45,442,618	$ 30,304,776	$ 269,793	$ 1,585,029	$ 378,216	$ 8,418,722	$ 1,847,211	$ 2,638,871
	31.6%	50.0%	12.0%	23.5%	66.6%	40.3%	7.0%	10.0%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,271,664	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 15,356,449
Child - MCHIP 7/2019 - 9/2019	303,510	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,051,728
Child - MCHIP 10/2019 - 6/2020	910,531	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 6,155,190
Adult - non MCHIP	1,007,518	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 19,948,856
Adult - MCHIP 7/2019 - 9/2019	9,788	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 193,802
Adult - MCHIP 10/2019 - 6/2020	29,363	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 581,387
SPD	448,861	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 20,346,869
SPD/Full-Dual	24,336	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 235,572
BCCTP	7,026	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 567,560
LTC	15,492	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 4,721,807
LTC - MCHIP 7/2019 - 9/2019	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2019 - 6/2020	27	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 8,229
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	146,382	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 20,884,320
Optional Expansion 7/2019 - 12/2019	1,394,753	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,727
Optional Expansion 1/2020 - 6/2020	1,394,752	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,708
	7,964,012	$ 333.59	$ 353.87	$ 20.27	$ 2.21	$ 18.06	$ 143,831,947

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2020 - December 2020)

	Total	50% FFP (Non-MCHIP and SPD)	76.5% FFP (MCHIP - 7/2020 to 9/2020)	65% FFP (MCHIP - 10/2020 to 12/2020)	BCCTP [3]	WCM [4]	90% FFP Optional Expansion
Total Funds Available	$ 71,458,138	$ 30,053,529	$ 2,227,321	$ 2,227,321	$ 282,165	$ 10,402,926	$ 26,264,876
Federal Match	$ 47,878,762	$ 15,026,765	$ 1,703,901	$ 1,447,759	$ 94,133	$ 5,967,816	$ 23,638,388
Governmental Funding Entity's Portion	$ 23,579,376	$ 15,026,764	$ 523,420	$ 779,562	$ 188,032	$ 4,435,110	$ 2,626,488
	33.0%	50.0%	23.5%	35.0%	66.6%	42.6%	10.0%

Rate Categories [1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage [2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	1,126,338	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 7,614,045
Child - MCHIP 7/2020 - 9/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Child - MCHIP 10/2020 - 12/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Adult - non MCHIP	493,892	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 9,779,062
Adult - MCHIP 7/2020 - 9/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
Adult - MCHIP 10/2020 - 12/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
SPD	224,524	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 10,177,673
SPD/Full-Dual	12,241	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 118,493
BCCTP	3,493	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 282,165
LTC	7,757	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,364,256
LTC - MCHIP 7/2020 - 9/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2020 - 12/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	72,916	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 10,402,926
Optional Expansion	1,388,207	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,264,876
	3,950,524	$ 334.30	$ 354.61	$ 20.31	$ 2.22	$ 18.09	$ 71,458,138

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

Continued to the March 5, 2020 Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Receive Report from Grant Thornton on Compensation and Benefits Benchmarking and Analysis; Consider Actions Related to Recommendations from Grant Thornton

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400
Brigette Gibb, Executive Director, Human Resources, (714) 246-8400

Recommended Actions
1. Receive Report from Grant Thornton on compensation and benefits benchmarking and analysis;
2. Adopt Resolution approving CalOptima's updated Human Resources Policies GA.8057: Compensation Program and GA.8058: Salary Schedule, with a proposed effective date for the Salary Schedule of March 1, 2020;
3. Authorize the Chief Executive Officer to administer CalOptima compensation practices in accordance with CalOptima policies and Grant Thornton recommendations; and
4. Direct staff to research deferred compensation plan options and return to the Board with recommendations.

Background/Discussion
On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer (CEO) to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board or a committee appointed by the Board for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

On August 1, 2013, the Board adopted the CalOptima Compensation Philosophy, which established the objectives of the compensation program to include base salary, incentive, and benefit levels competitive with the median range of CalOptima's labor market.

On March 6, 2014, the Board approved revisions to CalOptima's Compensation Administration Guidelines (Guidelines), which is a document that defines the principles upon which CalOptima's compensation practices are managed, the procedural aspects of how compensation is administered, and how the overall compensation administration function responds to changing market conditions and business demands to compete for and retain talent. The approved Guidelines reflect the results of an independent review of CalOptima's total compensation and related administration practices and established pay rates based on the market fiftieth percentile.

According to the Guidelines, CalOptima's salary structure should be reviewed on a regular basis, either annually or every other year, to continue to reflect market competitiveness. As provided in the Guidelines, market adjustments are to be applied to the salary schedule as needed, at least every two years. Following approval of the salary structure and salary schedule in the first half of 2014, on December 3, 2015, the Board approved an adjustment to CalOptima's salary schedule pay ranges up by 4% to keep pace with the then current market rates.

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Continued to the March 5, 2020 Board Meeting

Consistent with the Guidelines, staff requested authorization and appropriation on May 18, 2017 for a compensation study as part of the fiscal year (FY) 2017-18 operating budget to review CalOptima's salary structure. However, the Finance and Audit Committee directed staff to remove the compensation study from the FY 2017-18 budget in order to mitigate the then anticipated reductions from the state in Medi-Cal Classic and Medi-Cal Expansion provider rates.

Since the most recent employee compensation study was completed in 2014, CalOptima has experienced significant change and growth in terms of the number of members served, as well as a more than doubling in terms of revenue and number of employees. CalOptima has also seen significant expansion of its programs, bringing certain functions in-house, along with new programs and initiatives. In addition, the general labor market is experiencing historically low unemployment rates, leading to competition for qualified applicants and employees.

At the Board's May 3, 2018 meeting, staff received direction to look into conducting periodic salary surveys and include implementation funds in the budget.

At its June 7, 2018 meeting, the Board authorized and appropriated funds in the FY 2018-19 Operating Budget, which included $300,000 in professional fees to conduct an independent compensation study, and Grant Thornton was engaged to perform a study of CalOptima's total compensation and related administration practices. The goal of the review by Grant Thornton was to determine CalOptima's competitiveness with other organizations for human capital recruitment and retention, and to make recommendations.

At the Board's May 2, 2019 meeting, Chair Yost appointed Directors DiLuigi and Penrose to review the work of Grant Thornton, the compensation consultant.

At its June 6, 2019 meeting, the Board approved the FY 2019-20 Operating Budget, which includes $1.5 million for compensation market adjustments and an additional $50,000 in professional fees to complete the compensation study-related tasks.

In alignment with CalOptima's Compensation Philosophy, and building on the framework that was established by the Board for the compensation program, Grant Thornton evaluated CalOptima's total compensation and has made recommendations based on current market data to update CalOptima's current pay practices to reflect market competitiveness, including, but not limited to, base pay, incentive pay, benefits, and other supplemental pay practices.

As reflected in the Board-approved Guidelines, periodic review of CalOptima's salary structure is necessary to obtain current market compensation data as a key element in an effective recruitment and retention strategy. Grant Thornton has made recommendations to support both recruitment and retention efforts. As provided in the Guidelines, any adjustment to the salary schedule structure requires that the CEO take the recommendations to the Board for final approval. Based on the Compensation Philosophy, Guidelines, and Grant Thornton's recommendations, the following proposal is presented for Board approval and has been incorporated in the proposed revised policy:

- Adjust CalOptima's salary structure and salary schedule effective March 1, 2020, to keep pace with the current market rates, taking into account internal evaluation of job responsibilities.

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Upon Board authorization, the CEO, will complete the phased in implementation of CalOptima compensation practices in accordance with recommendations by Grant Thornton in FY 2019-20 and FY 2020-21.

Additionally, consistent with Grant Thornton's report, it is recommended that the Board direct staff to explore options for long-term deferred compensation in order to bring total compensation into alignment with CalOptima's compensation philosophy.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists the Human Resources policies that have been updated and are being presented for review and approval:

	Policy No./Name	**Summary of Changes**	**Reason for Change**

1.	GA.8057 Compensation Program
	
	Attachment A – Compensation Guidelines
		• Deleted language to comply with the California Equal Pay Act requirements.
		• Minor language and formatting changes to the Policy.
		• Attachment A – Compensation Guidelines updated with:
		  • Minor language and formatting changes;
		  • Revised merit pay calculation methodology to coincide with fiscal year;
		  • Provide clarifying language and modifications to reflect current operational processes and practices;
		  • Clarify the method for calculating
			• Revised Policy to comply with California Equal Pay Act, Labor Code section 1197.5 and Labor Code section 432.3
			• Clarifying language provided for ease of comprehension and consistent application and to reflect current compensation practices

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	Policy No./Name	Summary of Changes	Reason for Change
		salary for promotions, demotions and transfers.	
2.	GA.8058 – Salary Schedule Attachment A- Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Minor language and formatting changes to the Policy • Attachment A – Salary Schedule has been revised in order to reflect changes to the salary structure based on Grant Thornton's compensation study and internal evaluation of job responsibilities. Changes include the proposed addition of new positions and the deletion of positions that are no longer in use. A summary of the changes to the Salary Schedule is included for reference. • The proposed effective date of the Salary Schedule updates is March 1, 2020.	• Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima must update the salary schedule to reflect current job titles and pay rates for each job position. • Attachment A changes include the addition of new positions and deletion of positions which are no longer being used. Revisions to wage grades and salary ranges are made as a result of the Grant Thornton Compensation Study and internal evaluation of job responsibilities. • New Positions: Creation of new Job Titles are typically due to a change in the scope of a current position or the addition of a new level in a job family. • Implementing changes to the salary schedule effective March 1, 2020, will provide HR sufficient time to ensure administrative actions can be completed prior to implementation.

Continued to the March 5, 2020 Board Meeting

Fiscal Impact

The proposed effective date for the updated Salary Schedule is March 1, 2020. The fiscal impact of the recommended actions to implement the initial phase of salary adjustments pursuant to recommendations by Grant Thornton is $1.7 million through June 30, 2020. Compensation market adjustments and unspent budgeted funds for salaries and benefits included in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, will fund the recommended actions. The estimated annual cost for the recommended actions is approximately $9 million. Upon approval, Management will include updated expenses in future operating budgets.

Rationale for Recommendation

The independent review of CalOptima's compensation structure and program will ensure that CalOptima's compensation practices are clear, consistent, and competitive. The revised policies will also address the need to respond to changing market conditions and business demands for talent in a manner that is consistent with CalOptima's status as a public agency and the Board-approved Compensation Guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Grant Thornton Compensation and Benefits Benchmarking and Analysis Report
2. Resolution No. 20-0206-01, Approve Updated Human Resources Policies
3. Revised CalOptima Policies:
   a. GA. 8057: Compensation Program (redlined and clean copies) with revised Attachment A (redlined and clean copies)
   b. GA. 8058: Salary Schedule (redlined and clean copies) with revised Attachment A (redlined and clean copies.
4. Summary of Changes to Salary Schedule

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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Grant Thornton

CalOptima

Compensation and Benefits Benchmarking and Analysis

February 6, 2020

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Prepared by:

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General Overview

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General Overview – About Grant Thornton

Grant Thornton LLP is the U.S. member firm of Grant Thornton International Ltd., one of the world's leading organizations of independent assurance, tax, and advisory firms. Proactive teams led by approachable partners in these firms use insights, experience and instinct to understand complex issues for not-for-profit, public sector, privately owned and publicly listed clients and help them to find solutions.

Our human capital services professionals are a senior team that possess the right mix of experience, technical skills, industry knowledge, and personal commitment to help you achieve your desired results. Not only do we know competitive benchmarking from the executive to staff level and short and long-term incentive design, but we also have the support and bench strength of national benefits and tax specialists to provide assessments on other compensation topics if needed.

We have extensive experience serving health plans similar to CalOptima. We conduct assessments of competitive compensation levels, deferred compensation and other benefits/perquisite programs using proven methodologies and relevant resources. Our ability to design and implement value-added strategies is grounded in our understanding of your business goals and value drives, as well as risk factors.

General Overview

A successful total compensation program is one that promotes the ability of an organization to recruit, retain and motivate qualified employees to help the organization achieve its mission and goals. The objective for this Compensation and Benefits Study is to assess the competitiveness of CalOptima's total compensation program, measured against similar organizations from which CalOptima competes for labor. Our review includes base salary and incentive compensation, where applicable. As well as, employee benefits that are an essential component of an employee's overall compensation such as retirement, health insurance, life insurance, pension, sick leave, vacation time, etc.

In an effort to have a program that is fair, equitable, and competitive, CalOptima has undertaken an internal review on the following key items:

- **Job descriptions.** Updated and accurate job descriptions that describe what employees are doing within their respective roles
- **Relevant markets**. Revised comparison markets by functional area and classification that more accurately captures the compensation paid at organizations from which CalOptima recruits employees
- **Market-based structure.** Salary structure that is based on a balance between defined, specific comparison markets and internal factors
- **Revised pay guidelines.** Key principles that help Human Resources administer compensation in a disciplined way to ensure that compensation of employees is managed fairly and consistently

Scope of Work
Overview of Project

Grant Thornton was engaged to perform a Compensation Study (Salary and Benefits) to evaluate CalOptima's pay practices for human capital recruitment and retention as compared to other local, regional, and national organizations of similar size and operations i.e., hospitals (public agencies, non-profit and private), health plans (public agencies and private), health networks, and other employers (public agencies and private entities).

We reviewed and made recommendations on the appropriateness and competitiveness of CalOptima's current pay practices (Salary and Benefits) in order to remain competitive in the market, taking into account CalOptima's organization as a public agency and its obligation to remain fiscally prudent. We focused on skilled employees to fill and retain leadership roles and key positions essential to fulfilling the agency's strategic plan and operational goals.

The study included base pay, incentive pay, and other supplemental pay practices, along with all benefits offered to CalOptima employees (i.e. paid time off, employer share of health benefits, retirement benefits (CalPERS and PARS), life insurance, etc.) We benchmarked positions against internal CalOptima positions, where appropriate, to ensure fairness in its pay practices and to avoid pay compression. Some job titles with similar job functions and responsibilities were benchmarked against other CalOptima positions.

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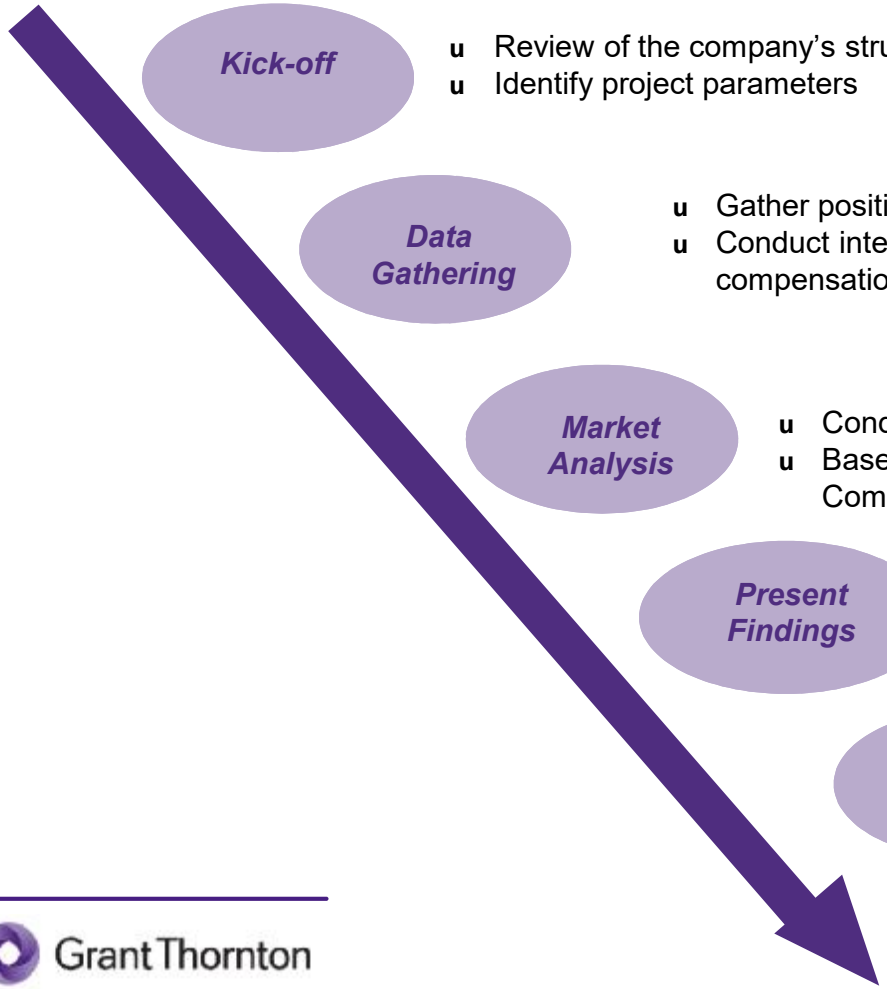
Scope of Work
Grant Thornton's Engagement Approach



Kick-off

- Review of the company's structure, goals, and objectives
- Identify project parameters

Data Gathering

- Gather position information, pay information, and benefit program summaries
- Conduct interviews with key stakeholders regarding issues relevant to compensation philosophy and executive pay

Market Analysis

- Conduct assessment and market comparisons:
- Base Salary, Total Cash Compensation, Total Direct Compensation, and Benefit Programs

Present Findings

- Prepare and present initial report
- Collaborate with compensation study workgroup

Next Steps

- Finalize report and any recommendations
- Implementation support as needed

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Scope of Work
Peer Groups

CalOptima recruits and retains talent in the Southern California competitive job market for all positions, and broader regions - even national - for senior level management positions. Our peer groups have been customized to reflect the geographic pool for talent for these different positions.

Despite being a government agency, CalOptima competes with like health plan organizations, whether government, tax-exempt, or for-profit. Therefore, Grant Thornton (GT) conducted the competitive market analysis using a combined peer group of blended data from the following sectors of health plans on an equally blended basis:

- Government Peers
- Not-for-Profit Peers
- For-Profit Peers

Examples: An Accounts Payable Clerk was benchmarked using like positions, with equal weight on government, not-for-profit, and for-profit organizations regionally since this represents the labor pool. Alternatively, a senior executive position is benchmarked relative to the same peers, but looking at comparable organizations nationally.

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
Government Health Plan Peer Group	§ Contains government health plan organizations of similar size and business focus to CalOptima, including LA Care and Inland Empire § GT kept the same constituents of CalOptima's prior government health plan peer group (used in GT's 2017 CEO/CLO report) § Used for comparison to CalOptima's executive team
Tax Exempt Health Plan Peer Group	§ Contains tax exempt health plan organizations of similar size and business focus to CalOptima § GT kept the same constituents of CalOptima's prior tax exempt health plan peer group (used in GT's 2017 CEO/CLO report) § Used for comparison to CalOptima's executive team
For-Profit Health Plan Peer Group	§ Contains for-profit health plan organizations of similar size and business focus to CalOptima § GT kept the same constituents of CalOptima's prior public health plan peer group (used in GT's 2017 CEO/CLO report) § Used for comparison to CalOptima's executive team

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Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
ERI	§ Economic Research Institute ("ERI") is a nationally recognized for profit regression based survey § We have pulled compensation data for the "Medical, Dental, & Disability Plans" sector for organizations with $700M in assets § Used for comparison to CalOptima's executive team, directors, managers, and staff level positions
Health Plan Survey	§ Lastly, we have used a confidential health plan survey that has compensation information for executives, directors, managers, and staff in tax exempt and public health plans. § Used for comparison to CalOptima's executive team, directors, managers, and staff level positions

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Executive Summary

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Executive Summary
Current Total Rewards Environment

CalOptima reviewed their total rewards program in 2013. To provide context on the current market, we highlighted the following total rewards trends for the last five years:

- Salaries
  - 3% to 4% annual salary increase in market, totaling an average market movement of 15% to 20% over the last five years
- Annual Incentives
  - Almost universal use of incentives in the health plan market, across all ownership types, with payouts often averaging above target or expected levels
- Long-Term Incentives
  - Universal use with for-profit health plans, and majority practice for large health plans
- Total Compensation (Inclusive of Benefits)
  - Increases at a rate consistent with salaries, since benefits and incentive values are typically expressed/provided as a percent of salary
  - Generally, benefit cost increases are shared partially employees/participants
- The market's total compensation increases are above the standard levels described above for growing job levels, considering that market total compensation increases by 5% to 20% for every doubling in organizational size (e.g., $3B health plan pay levels would tend to be 5% to 20% higher then $1.5B health plan)
  - Leadership position pay values are more sensitive to organizational size than staff levels
- The current labor market is an employees market due to the historically low unemployment rate

Executive Summary
Compensation Program

- Base Salary
  - On average:
    - Executives are positioned 13% below market median
    - Directors are positioned 13% below market median
    - Managers are positioned 6% below market median
    - Staff are positioned 4% below market median
- Total Cash Compensation (Base Salary + Annual Incentives)
  - On average:
    - Executives are positioned 30% below market median
    - Directors are positioned 24% below market median
    - Managers are positioned 13% below market median
    - Staff are positioned 7% below market median
    - Disparities are due to the limited incentive compensation offered
- Total Direct Compensation (Base Salary + Annual Incentives + Long-Term Incentives)
  - On average, executives are positioned 43% below market median
  - Disparity is due to the lack of a long-term incentive plan at CalOptima

Executive Summary
Compensation Program

- While we used a blend of data from government, tax exempt, and for-profit health plans in our study, we wanted to show how CalOptima pay compares against only government health plan pay data.
- We looked at the median market base salaries of 5 executives, 5 managers, and 5 staff positions to see how the government data compared against the blended data and CalOptima's midpoints. The charts below and on the next slide outline our findings:

Base Salary

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$320,216	$397,000	$351,640	-11%
Chief Operating Officer	$320,216	$335,000	$284 380	-15%
Chief Medical Officer	$320,216	$380,000	$374,060	-2%
Chief Information Officer	$266,968	$299,000	$260,000	-13%
Chief Counsel	$266,968	$343,000	$293,800	-14%
			Average	**-11%**

Total Cash

Title	CalOptima Total Cash Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$520,000	$393,900	-24%
Chief Opera ing Officer	$352,238	$444,000	$318,500	-28%
Chief Medical Officer	$352,238	$453,000	$421,260	-7%
Chief Information Officer	$293,665	$370,000	$262,600	-29%
Chief Counsel	$293,665	$494,000	$382,200	-23%
			Average	**-22%**

Total Direct

Title	CalOptima Total Direct Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$663,000	$439,400	-34%
Chief Operating Officer	$352,238	$480,000	$352,300	-27%
Chief Medical Officer	$352 238	$619,000	$456,660	-26%
Chief Informa ion Officer	$293,665	$392,000	$330,200	-16%
Chief Counsel	$293,665	$500,000	$442,500	-12%
			Average	**-23%**

- On average, the government peer group data is 11% lower than the blended peer group data for executive base salaries.
- On average, the government peer group data is 22% lower than the blended peer group data for executive total cash compensation.
- On average, the government peer group data is 23% lower than the blended peer group data for executive total direct compensation.

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Executive Summary
Compensation Program

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Manager Accounting	$93,184	$120,000	$119,800	0%
Manager Communications	$93,184	$100,000	$95,000	-5%
Manager Customer Service	$93,184	$85,000	$83,500	-2%
Manager Facilities	$93,184	$89,000	$82,200	-8%
Manager Finance	$93,184	$117,000	$114,000	-3%
			Average	**-3%**

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Actuary	$107,328	$126,000	$110,000	-13%
Accountant Intermediate	$70,512	$73,000	$70,000	-4%
Accounting Clerk	$46,384	$42,000	$45,000	7%
Payroll Specialist	$53,352	$53,000	$52,000	-2%
Buyer Intermediate	$61,360	$69,000	$65,000	-6%
			Average	**-3%**

- On average, the government peer group data is 3% lower than the blended peer group data for manager and staff base salaries.
- While government health plans tend to have lower pay levels, it is important to consider organizational size and complexity when analyzing pay levels. Due to CalOptima's expansion of programs and members, which has resulted in increased complexity and more than doubling in size since 2014, we looked at data for labor markets for bigger organizations, including a blend of government, tax exempt, and for-profit health plans, comparable in size and revenue, in our analysis.
- With the increased complexity and size, CalOptima should expect to see a significant impact in salary for employees in management positions and above to account for growth and greater responsibilities.

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Executive Summary
Benefits Program

- Health and Welfare Programs
  - Offering four medical plans allow employees more choice and flexibility
  - The health plans offered by CalOptima offer a high level of benefits
  - HMO plans have much lower employee contributions and slightly better cost-sharing than market
  - HDHP and PPO plans have average employee contributions and cost-sharing compared to market
  - Prescription drug, dental, vision, life, LTD, and STD benefits are competitive or above market
- Retirement Programs
  - Participants receive employer contributions in both the defined contribution (PARS) and a defined benefit plan (CalPERS)
- Vacation/Paid Time-Off Programs
  - Offers more time-off than the composite benchmark, but less than other public agencies

This analysis was based on composite benchmarks of organizations of similar size, geography, and industry

Executive Summary
Benefits Program

- CalOptima is above market from a total benefits program perspective
- Time-off programs are above market but less than other public agencies
- The strongest benefit is the CalPERS defined benefit plan, though CalOptima adopted one of the lowest benefit formulas as compared to other public agency peers

Market Competitiveness*	
Retirement Benefits	Above Market
Medical Benefits	Above Market
Dental Benefits	Above Market
Vision Benefits	At Market
Disability Benefits	At Market
Life Insurance Benefits	At Market
Time-Off Programs	Above Market
Total Benefits Program	**Above Market**

* This analysis was based on composite benchmarks of organizations of similar size, geography, and industry.

Executive Summary
Total Compensation

- By group, with compensation generally being below median and benefits being above median, average total compensation is as follows:
  - Executives and Directors are well below median
    - Driven primarily by aggressive incentive practices in peers
    - Compensation gap is not closed by above market benefits
  - Managers are moderately below median
    - Compensation gap is moderated based on above market benefits
  - Staff are positioned close to median
    - Compensation gap is made up due to highly competitive benefits

Recommendations

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Compensation Recommendations
Total Compensation Philosophy

The following are principles that can be used as the foundation of CalOptima's total compensation program:

- To reinforce the mission of the organization
- To achieve balance between the needs and concerns of CalOptima employees, and the communities it serves
- To attract and retain outstanding employees
- To motivate and reward outstanding performance
- To link compensation to consistent merit principles, including both individual and organizational performance
- To base decisions on appropriate comparability data provided by independent sources
- To ensure that compensation and benefits programs comply with all pertinent laws and regulations
- To maintain consistency and fairness, to the extent possible, without violating other principles
- To provide benefits in a manner that allows employees to participate in determining how best to meet their needs and those of their families

Compensation Recommendations
Total Rewards Competitive Positioning

- CalOptima wishes to recruit, retain, and motivate staff in order to accomplish organizational mission, vison, and strategic objectives. With this goal in mind, CalOptima intends to provide a total compensation program that is competitive with organizations that represent the competitive labor market for CalOptima's various staff positions.
- To achieve competitiveness, total compensation will be positioned at the:
  - 50th percentile for executives
  - 50th percentile for directors and managers
  - 50th percentile for most staff positions
  - Approximately the 62.5 percentile (between the 50th and 75th) for hard to fill staff positions, i.e. nursing, legal, and accounting staff.
- Base salaries, limited incentives and recognition and rewards, targeted at market median.
- Benefits targeted above market median.
- Pay for performance provides flexibility to position pay 10% to 20% above market for sustained outstanding performance.

Compensation Recommendations

Overall, CalOptima compensation is positioned below market, with the executives and directors most significantly lagging the market due to a combination of low salaries and low or no incentives. Our conceptual considerations are as follows:

- Base Salary
  - Implement CalOptima's compensation philosophy with market-based salary ranges, with market adjustments for those that are below market positioning and that have performed at a "meets expectations" level for a period of years.
  - With benefits above market, target base salary as follows:
    - 10% below 50th percentile total cash executives
    - 50th percentile total cash for directors and managers
    - 50th percentile total cash for most staff
    - For hard to recruit positions, we recommend positioning between the 50th and 75th percentile (62.5 percentile)

Compensation Recommendations

- Annual Incentive Compensation
  - Maintain existing annual incentive plan structure, with 10% target incentives, which would position target pay at the 50th percentile total cash
  - However, potentially add Directors and Managers to the annual incentive plan over the next two years

- Other Incentives
  - No additional incentives, for the time being, given the administrative difficulty on introducing higher incentives, either on an annual or long-term incentive basis

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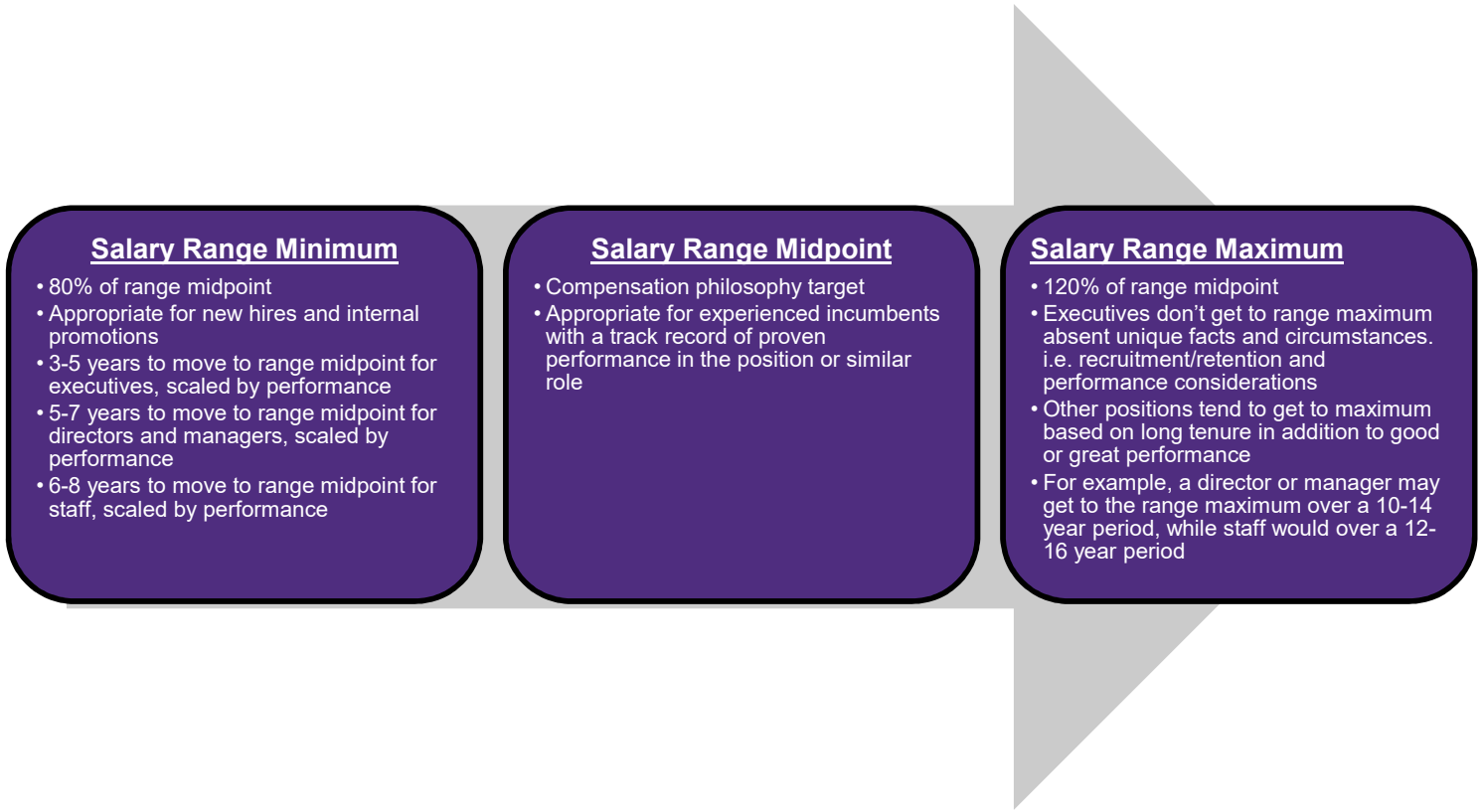
Compensation Recommendations
Base Salary Administration Guidelines

- The following is an example of competitive salary administration guidelines to help manage salaries around market-based compensation philosophy



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Compensation Recommendations

- Adjustments for FY 2019-20:
  - Move employees who are below proposed salary range minimum to the minimum (as required by CalPERS reporting)
  - Move employees with a track record of proven performance in the same level or position at CalOptima to midpoint based on methodology identified on the previous slide

- Ongoing for FY 2020-21:
  - Increase the aggregate merit pool from 3% to 5%
  - Apply market adjustments per current policy if necessary

- ***Methodology will deal with internal equity and compression issues inherently within each job, and amongst like jobs***

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Other Compensation Recommendations

- Upon implementation of 50th percentile total cash salary ranges, total compensation will still lag market for the executives and some directors
- We would suggest addressing a portion of this gap by implementing a non-qualified deferred compensation plan for executives and other select leadership positions, structured either as
  - A mid-term retention plan, whereby anywhere from 5% to 20% of salary is set aside per year, subject to a three to five year cliff vest (i.e., the dollars set aside are only earned and paid out to the extent the leader is employed by the organization at the end of the vesting period, or
  - Supplemental executive retirement plan, whereby a certain amount is set aside at the same value as the qualified retirement plan for those earnings above and beyond the qualified plan limits (i.e., restoration plan)
- The above strategy would still result in leadership pay being below market – but would assist in having incentives to retain key talent

Recommended Salary Structure

Grade Level	Minimum	Midpoint	Maximum
X	$ 347,000	$ 434,000	$ 521,000
W	$ 295,000	$ 369,000	$ 443,000
V	$ 251,000	$ 314,000	$ 377,000
U	$ 214,000	$ 267,000	$ 320,000
T	$ 182,000	$ 227,000	$ 272,000
S	$ 154,000	$ 193,000	$ 232,000
R	$ 144,000	$ 174,000	$ 204,000
Q	$ 130,000	$ 157,000	$ 184,000
P	$ 117,000	$ 141,000	$ 165,000
O	$ 105,000	$ 127,000	$ 149,000
N	$ 95,000	$ 114,000	$ 133,000
M	$ 85,000	$ 103,000	$ 121,000

Grade Level	Minimum	Midpoint	Maximum
L	$ 77,000	$ 93,000	$ 109,000
K	$ 70,000	$ 84,000	$ 98,000
J	$ 65,000	$ 78,000	$ 91,000
I	$ 61,000	$ 73,000	$ 85,000
H	$ 59,000	$ 68,000	$ 77,000
G	$ 55,000	$ 63,000	$ 71,000
F	$ 51,000	$ 59,000	$ 67,000
E	$ 48,000	$ 55,000	$ 62,000
D	$ 44,000	$ 51,000	$ 58,000
C	$ 41,000	$ 47,000	$ 53,000
B	$ 38,000	$ 44,000	$ 50,000
A	$ 36,000	$ 41,000	$ 46,000

*Please note that recommendation for CEO pay range is not included as part of this study

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Benefits Recommendations
General Overview

- Annual Strategic Analysis
  - Develop a formalized annual review process to review the goals and strategies of CalOptima's benefits program
    - Develop broad strategies and goals for CalOptima's compensation and benefits programs
    - Develop the general framework of the programs and how they will support the needs of employees and the financial constraints
    - Determine the employee's value of the benefit offerings versus the cost and, if appropriate, shift resources to items that employees value
  - Prepare a written benefit program philosophy that can create guiding principles to make benefit program decisions such as plan design changes. (For example, employees should pay low medical premiums, but have higher cost sharing.)
- Financial Modeling and Projections
  - Analyze the relative costing information for each alternative to understand financial implications of the benefit program decisions
  - Analyze advantages and disadvantages of each alternative, including the financial implications, and document them
  - Prepare a cost/benefit analysis to assess the benefits as well as the employer and employee costs. (For example, reinstituting the employer HSA contributions can increase participant enrollment and save both the employee and employer money.)

Benefits Recommendations
Program Issues

Overall, CalOptima benefits are positioned above market. The benefits recommendations below would not significantly change CalOptima's position in the market.

- Medical/Health Insurance
  - CalOptima offers medical plans with above market benefit levels and high employer cost share. CalOptima should consider reviewing its benefit strategy in order to reduce total plan costs, such as
    - Plan designs changes to encourage in-network utilization
    - Promote participant consumerism and cost-effective decisions
- Prescription Drug Programs
  - Consider pharmacy cost-saving measures, such as:
    - Excluding certain drugs with lower cost alternatives
    - Encouraging participation in the mail-order program
    - Implementing step-therapy for certain high-cost drugs
- Life and Disability Insurance Programs
  - Consider increasing the basic life insurance maximum to $500,000 to give an increased benefit to highly paid employees
  - Consider a cost/benefit analysis to join the California Short-Term Disability Insurance
- Retirement Programs
  - Consider consolidating the 457(b) Plan and 401(a) PARS Plan to a single vendor in order to reduce administrative and investment fees that will benefit participants by increasing their investment returns

Financial Impact

(Estimated costs include benefits)

Recommendations	Financial Impact (12 months)
Bring employees up to minimum	3,180,000
Adjustments based on GT methodology	1,840,000
Merit pool increase from 3% to 5%	3,620,000
Market adjustments as needed	400,000
Total:	**$ 9,040,000**

% of Total Salary	5.5%
Impact to ALR	0.2%

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Disclosure

Our review was limited to the documents provided by CalOptima and did not include the underlying plan documents and summary plan descriptions. Our findings were based on the documents provided including employment agreements, policies, and summaries.

Our conclusions relate only to our understanding of the facts provided by CalOptima which are stated in this analysis. We have not independently verified these facts, and if any of these facts prove to be in error, the conclusions reached in this memorandum do not apply. Our conclusions are based on the Department of Labor, Internal Revenue Code, regulations and interpretations thereunder in their form as of the date of this analysis. We are under no obligation to update our conclusions for future changes in these authorities. Our conclusions are based on our interpretation of the tax law. Another party, such as the Internal Revenue Service or a court, hearing the same facts may reach different conclusions.

In accordance with applicable professional regulations, please understand that, unless expressly stated otherwise, any written advice contained in, forwarded with, or attached to this document is not intended or written by Grant Thornton LLP to be used, and cannot be used, by any person for the purpose of avoiding any penalties that may be imposed under the Internal Revenue Code.

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RESOLUTION NO. 20-0206-01

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies: GA.8057 Compensation Program and GA.8058 Salary Schedule.

Section 2. That the Chief Executive Officer is authorized to implement the revised Salary Schedule effective March 1, 2020.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this February 6, 2020.

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, Clerk of the Board

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Policy ~~#~~:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/2014
~~Last Review Date:~~	TBD~~07/18~~
Last Revised Date:	~~06/07/18~~

~~*Board Approved Policy*~~

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which ~~is a document that~~ defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation ~~administration~~ procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.

~~2.~~ Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and ~~current pay level, as well as~~the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The ~~Chief Executive Officer (~~CEO~~)~~ is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration ~~Guideline~~Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

~~A. 06/07/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 06/04/15: Regular Meeting of the CalOptima Board of Directors~~
~~C. 03/05/15: Regular Meeting of the CalOptima Board of Directors~~
~~D. 12/04/14: Regular Meeting of the CalOptima Board of Directors~~
~~E. 11/06/14: Regular Meeting of the CalOptima Board of Directors~~
~~F. 08/07/14: Regular Meeting of the CalOptima Board of Directors~~
~~G. 05/01/14: Regular Meeting of the CalOptima Board of Directors~~

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	TBD	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Policy: GA.8057
Title: **Compensation Program**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 05/01/2014
Last Revised Date: TBD

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;

2. Attract, retain, and motivate employees;

3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and

4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.

2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations

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4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
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06/07/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	TBD	GA.8057	Compensation Program	Administrative

1

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

~~Pay administration guidelines~~

Revised February 06, 2020

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Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These ~~guidelines:~~

- ~~Help~~*Guidelines help maintain the integrity of the base pay program by introducing a common set of standards*

~~Assist~~ *and assist managers in ongoing compensation program administration.*

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within ~~proposed guidelines~~the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

Proposed Pay Administration Guidelines

~~***Pay ranges and pay levels***~~

- ~~Pay range targets~~
- ~~Range minimums and maximums~~

Pay ranges and pay levels

- ~~Pay range thirds~~
- ~~Pay range halves~~
- ~~Compa-ratio~~

~~***Periodic pay adjustments/increases***~~

- ~~New hire/Rehire~~
- ~~Promotion~~

Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio

- ~~Demotion~~
- ~~Temporary assignment~~
- ~~Secondary job~~

Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

- ~~Market adjustment~~
- ~~Merit pay~~
- ~~Step increase~~
- ~~Base pay program maintenance~~
- ~~Salary structure adjustment~~
- ~~Annual competitive assessment~~
- ~~Market sensitive jobs~~

1

Annual pay adjustments/increases

- Register/Certified status

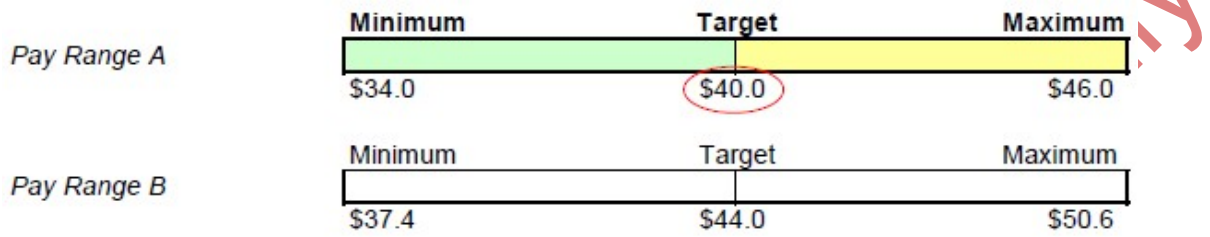
Special one-time pay considerations

- Recruitment incentive

Pay Ranges and Pay Levels

Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

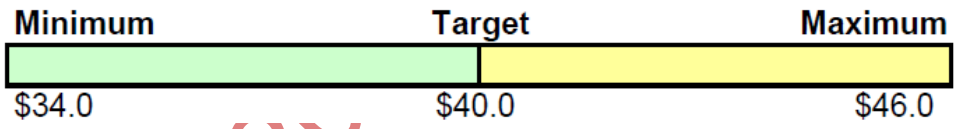
- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Market Median Base Salary $41.5

Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

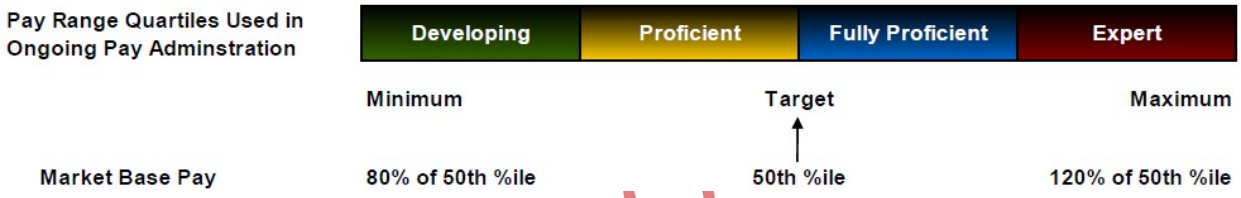
Range Maximum: represents the maximum rate paid to individuals who ~~posses~~possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: ~~as a rule, employees~~ Employees are not ~~to be~~ paid above the range maximum.

- Employees ~~paid~~whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.
- In lieu of future base pay increases, these ~~individuals~~employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.
- As the pay structures and pay ranges move ~~(~~every twelve (12~~—~~) – thirty-six (36) months or as necessary~~)~~, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.
- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100~~%~~%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.
- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.
- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
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Note: *Range minimums and maximums will be based on the developed salary range spreads.*

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Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range ~~rates~~grades based on market pay practices.

- A market adjustment ~~results~~may result in base pay increases for full-time, part-time, and some as- needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target~~)~~).
    - For some market-sensitive jobs, a market adjustment may also be granted to full- time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10~~%)~~%).

~~**Market Adjustment:**~~

- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- ~~Market adjustments are made prior to determining merit pay~~

- .

- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects ~~individuals'~~employees' base pay; it recognizes ~~individuals'~~employees' job proficiency and performance of job duties.

  - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.

  - To be eligible for merit pay, the employee must have started work on or before March ~~31st~~31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires~~)~~] prior to the annual pay adjustment date.

  - Merit pay will typically be an increase to base pay; however, it may also be delivered as a ~~onetime~~one-time lump sum bonus for individuals paid above the pay range maximum.

  - The budgeted amount for merit pay, if any, is based on~~:~~ 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.

  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked ~~and the salary earned~~ during ~~those months~~the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.

  - Managers have the discretion to determine the actual increase amount within the published ~~guidelines~~Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.

  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.

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- Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
- Merit pay is typically awarded once a year at a specific time.
- Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
- Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible ~~for~~ before submitting to HR.
- HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below ~~([~~assumes a three percent (3~~%~~%) merit increase budget~~)]~~ is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and~~,~~
4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

** ~~**~~*The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.
- The increase may be ~~held all together~~withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be ~~retro-active~~retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.
- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty-four (24) months of hire.

New Hires/Rehires

- A new hire's pay level ~~should correspond~~corresponds to the appropriate pay range ~~but~~quartile and typically should not exceed the pay range target~~; offers~~. Offers above the pay range target require the approval of the ~~Compensation Analyst in consultation with the~~ Executive Director of Human Resources~~,~~ and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: ~~what~~What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: ~~what~~What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: ~~is~~Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate~~)~~).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, ~~current pay level,~~ as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint~~; starting~~. Starting pay rates above the pay range midpoint must have approval of the ~~appropriate Compensation Analyst,~~ Executive Director of Human Resources~~,~~ and CEO ~~approval~~, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical~~)~~).

- Pay rates for all ~~management~~ positions ~~must be~~are reviewed with the Compensation ~~Analyst~~Unit before an offer is made. The Compensation ~~Analyst~~Unit will review internal

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equity across the system to ensure that the appropriate offer is made.

- ~~Any questions or concerns about new hire offers should be directed to the Compensation Analyst or Executive Director of Human Resources. The Compensation Analyst will review any concerns with the Executive Director of Human Resources as necessary~~

- Rehires to the same ~~position~~classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.
- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

~~Promotion:~~ An employee receives a promotion when ~~he/she~~the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of ~~his/her~~the new pay range.
- The amount of a promotional increase will ~~vary and the actual amount will~~ be determined based on the incumbent's qualifications, performance, and ~~the~~ internal pay practices ~~of other similarly situated employees.~~. The typical promotional increase for a promotion without external competition is ~~4%~~up to ~~5% of~~five percent (5%) of the employee's base pay ~~for~~per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

~~Lateral transfer:~~ It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the ~~Compensation Analyst and~~ Executive Director of Human Resources.

- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

~~Demotion:~~ An employee is classified as having been demoted if ~~he/she~~the employee moves to a job with a lower pay range target.

- ~~An~~The pay of an employee demoted due to an organizational restructure, ~~no pay decrease~~ will not be ~~given~~decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.
    - ~~An~~For an involuntary demotion, due to performance ~~will follow the guidelines below~~, or for ~~reducing base pay~~
    - ~~A~~a voluntary demotion ~~based on an application for an open position will typically result in a pay decrease between 0 – 4% for each salary~~, the pay grade of the demoted
- ~~The demoted~~ employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced ~~to the next lower pay grade. Target, or~~ up to five percent (5%) for each pay grade ~~maximum, whichever is appropriate using the 0 – 4% guideline above~~demoted.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.
- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

~~Temporary assignment:~~ An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.
- This increased secondary pay rate is eliminated when the temporary assignment ends.
- The amount of the temporary assignment increase should be consistent with the promotion policy.

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Job Re-Evaluations

~~Job Re-Evaluations:~~ Job re-evaluations will be reviewed in the following priority order:

1. New Positions.
2. Change of thirty-five percent (35~~%~~%) or more of duties ~~([~~any change in responsibilities less than thirty-five percent (35~~%~~%) will not be considered~~)]~~.
    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

- Additional duties that do not require the above will not be considered for reclassification.
- All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation ~~Analyst~~Unit.
- In the case of management positions being re-classified, the appropriate Chief must sign the documentation.
- The request must include the incumbent's current job description and revised job description with enhancements highlighted.
- The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation ~~Analyst~~Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.
2. Available market data.
3. ~~2.~~ Appropriate title identification. The Compensation ~~Analyst~~Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.
4. ~~3.~~ Job family.
5. ~~4.~~ Fair Labor Standards Act (FLSA) status.
6. ~~5.~~ Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists ~~– there will be no~~. No new pay grades created.
7. ~~6.~~ A pay rate will be determined.
8. ~~7.~~ A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

- If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date
- . The manager will be informed of the decision to move the job to a higher pay grade by the Compensation ~~Analyst~~
- Unit. The amount of the pay increase should follow the guidelines in the ~~promotion~~Promotion section

. If the upgrade and a pay change ~~occurs~~occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director

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of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
  - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
  - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On ~~an annual~~a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
  - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
  - Based on market findings, the pay grade and ranges will be updated.
  - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
  - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues~~;~~.
  - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

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expenses to identify jobs with potential recruiting issues;.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues;.

- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%%.
- Review all market-sensitive jobs and those on the "watch list"."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- Each yearOn a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
  - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs an annual, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).).
- HR identifies the cost implications for the market adjustment by identifying the difference between: 1) current pay rates and new pay range minimums, and, 2) current pay rates.

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- The market adjustment approval process will work as follows:
    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.
    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the ~~position~~classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.
    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.
    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.
- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:
    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.
    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.
    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.
    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
        - a competitive market rate significantly higher ~~(~~[approximately ten percent (10~~%)~~%)] than its current pay range target, or
        - a competitive market rate with significantly higher pay practices ~~(~~[approximately ten percent (10~~%)~~%)] in the labor market than the average of current internal pay practices.
- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.
- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.
    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.
    - When a job is no longer considered market-sensitive, the job's pay range and grade

is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.
    - If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

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Compensation Administration Guidelines

Revised February 06, 2020

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Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

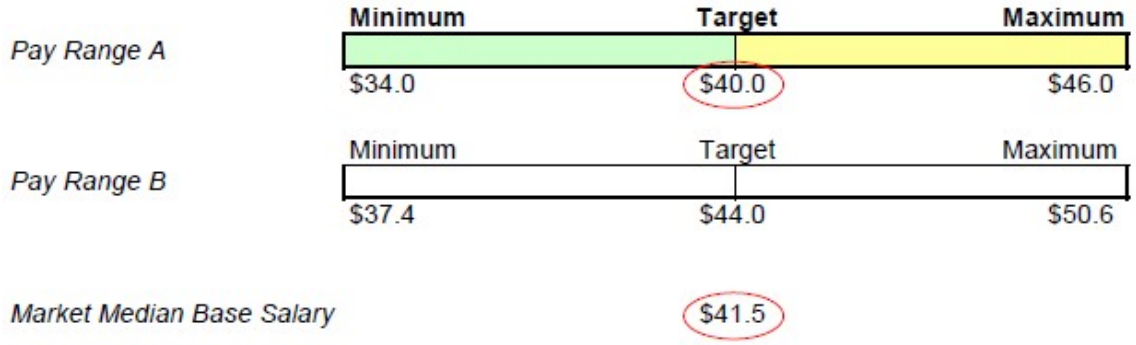
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

Pay Ranges and Pay Levels

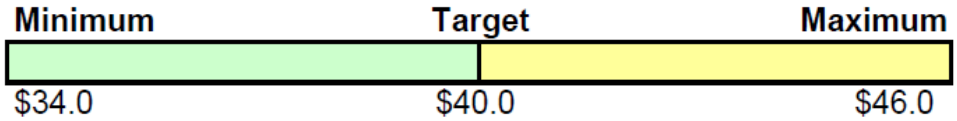
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

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- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full- time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
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- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
    - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
    - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
    - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
    - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
    - Merit pay is typically awarded once a year at a specific time.
    - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
    - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
    - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
  - Recruitment incentives require the approval of the CEO.
  - Board approval is required for recruitment incentives offered to Executive Director and above positions.
  - Incentives are provided with a "pay-back" provision if the employee terminates within twenty-four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or

education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be

decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.

2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].

    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

    - Additional duties that do not require the above will not be considered for reclassification.

    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.

    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.

    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.

    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.

2. Available market data.

3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.

4. Job family.

5. Fair Labor Standards Act (FLSA) status.

6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date.

The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.

- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.

- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.

- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.

- The salary structure adjustment approval process includes:

    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.

    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.

    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.

    - Based on market findings, the pay grade and ranges will be updated.

    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.

- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.

- The following criteria is typically used to determine which jobs to market price each year:

    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.

    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
  - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

Policy~~#~~:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	~~*Michael Schrader*~~
Effective Date:	05/01/2014
Revised Date:	~~08/01/2019~~02/06/2020

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper

to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule~~,~~ meet~~s~~ing the requirements above and is~~, are~~ available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of ~~08/01/2019~~02/06/2020)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy~~#~~	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	02/06/2020	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	02/06/2020

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper

to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of02/06/2020)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
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Date	Meeting
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02/07/2019	Regular Meeting of the CalOptima Board of Directors
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02/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	02/06/2020	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised February 6, 2020, to be implemented March 1, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Accountant	H	39	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accountant Int	I	634	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accountant Sr	K	68	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accounting Clerk	D	334	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accounting Clerk Sr	E	TBD	$48,000	$55,000	$62,000	New Position
Activity Coordinator (PACE)	E	TBD	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Actuarial Analyst	I	558	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Actuary	O	357	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Administrative Assistant	D	19	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Analyst	H	562	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Analyst Int	I	563	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Analyst Sr	J	564	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Applications Analyst	H	232	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Applications Analyst Int	I	233	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Applications Analyst Sr	K	298	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Assistant Director	P	TBD	$117,000	$141,000	$165,000	New Position
~~Associate Director Customer Service~~	~~O~~	~~593~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Associate Director Informa ion Services	Q	557	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Associate Director Provider Network~~	~~O~~	~~647~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Auditor	I	565	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Auditor Sr	J	566	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Behavioral Health Manager	M	383	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Biostatistics Manager	M	418	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Board Services Specialist	E	435	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Business Analyst	J	40	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Business Analyst Sr	L	611	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Buyer	G	29	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Buyer Int	H	49	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Buyer Sr	I	67	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Care Manager	K	657	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Care Transition Interven ion Coach (RN)	L	417	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Certified Coder	H	399	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Certified Coding Specialist	H	639	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Change Control Administrator	I	499	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Change Control Administrator Int	J	500	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Change Management Analyst Sr~~	~~N~~	~~465~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
** Chief Counsel	X	132	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Executive Officer	Z	138	$319,740	$431,600	$543,600	Wage grade letter adjustment based on Grant Thornton revised salary structure, but no changes to pay range.
** Chief Financial Officer	X	134	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Information Officer	W	131	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Medical Officer	X	137	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Operating Officer	X	136	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims - Lead	G	574	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Examiner	C	9	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Examiner Sr	E	20	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims QA Analyst	E	28	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clerk of the Board	O	59	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Auditor	L	567	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Documenta ion Specialist (RN)	M	641	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Pharmacist	P	297	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Communications Specialist	G	188	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Partner	F	575	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Partner Sr	H	612	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Rela ions Specialist	G	288	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Rela ions Specialist Sr	I	646	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contract Administrator	K	385	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Manager	M	207	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Manager, Sr.	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Specialist	I	257	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Specialist Int	J	469	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Controller	T	464	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Customer Service Rep	C	5	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Analyst	K	337	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Analyst Int	L	341	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Analyst Sr	M	342	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data and Repor ing Analyst - Lead	M	654	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Entry Tech	A	3	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Data Warehouse Project Manager~~	~~O~~	~~362~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Database Administrator	L	90	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Deputy Chief Counsel	W	160	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Deputy Chief Medical Officer	W	561	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	~~Director Accounting~~	~~P~~	~~122~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Applications Management~~	~~R~~	~~170~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	~~Director Business Development~~	~~P~~	~~351~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Business Integration~~	~~Q~~	~~543~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position

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* Director Case Management	S	318	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Claims Administra ion	R	112	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Clinical Outcomes~~	~~Q~~	~~602~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Coding Initiatives	S	375	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Communications	R	361	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Community Relations~~	~~P~~	~~292~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* ~~Director Configuration & Coding~~	~~Q~~	~~596~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Contracting	R	184	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director COREC~~	~~Q~~	~~369~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Customer Service	R	118	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Electronic Business~~	~~P~~	~~358~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Facili ies	Q	428	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Finance & Procurement~~	~~P~~	~~157~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Financial Analysis	T	374	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Financial Compliance	R	460	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Government Affairs~~	~~P~~	~~277~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Health Services~~	~~Q~~	~~328~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Human Resources	R	322	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Information Services	T	547	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Long Term Support Services	S	128	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director Medi Cal Plan Operations~~	~~P~~	~~370~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Network Management	R	125	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* ~~Director OneCare Operations~~	~~P~~	~~425~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* ~~Director Organizational Training & Education~~	~~P~~	~~579~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director PACE Program	S	449	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Population Health Management	Q	675	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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*	Director Program and Process Management	R	447	$144,000	$174,000	$204,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
*	Director Program Implementa ion	R	489	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	~~Director Project Management~~	~~Q~~	~~447~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
*	Director Provider Data Management Services	Q	655	$130,000	$157,000	$184,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
*	~~Director Provider Services~~	~~P~~	~~597~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Public Policy~~	~~P~~	~~459~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Quality (LTSS)~~	~~Q~~	~~613~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	~~Director Systems Development~~	~~R~~	~~169~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Disease Management Coordinator~~	~~M~~	~~70~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~Disease Management Coordinator - Lead~~	~~M~~	~~472~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~EDI Project Manager~~	~~O~~	~~403~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Executive Assistant	G	339	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Executive Assistant to CEO	I	TBD	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Clinical Operations	V	501	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Compliance	V	493	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Human Resources	V	494	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Network Opera ions	V	632	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Opera ions	V	276	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Program Implementation	V	490	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director Public Affairs	V	290	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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**	Executive Director Quality & Population Health Management	V	676	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
**	Executive Director, Behavioral Heal h Integra ion	V	614	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Facilities & Support Services Coordinator, Sr.	F	TBD	$51,000	$59,000	$67,000	New Position
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Financial Analyst	J	51	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Gerontology Resource Coordinator~~	~~M~~	~~204~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Graphic Designer	K	387	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Health Coach	K	556	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Health Educator	H	47	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Health Educator Sr	I	355	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~HEDIS Case Manager (LVN)~~	~~M~~	~~552~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Help Desk Technician	E	571	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	HR Assistant	D	181	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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HR Business Partner	M	584	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~HR Compensation Specialist Sr~~	~~N~~	~~663~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Posi ion
HR Coordinator	F	316	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Representative	J	278	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Representative Sr	L	350	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Specialist	G	505	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Specialist Sr	H	608	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~HRIS Analyst Sr~~	~~M~~	~~468~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
~~ICD-10 Project Manager~~	~~O~~	~~411~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Inpa ient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Intern	A	237	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Investigator Sr	I	553	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Coordinator	E	365	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Manager	N	424	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Specialist	K	549	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Kitchen Assistant	A	585	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Legisla ive Program Manager~~	~~N~~	~~330~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Li igation Support Specialist	K	588	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
LVN (PACE)	K	533	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
LVN Specialist	K	TBD	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Mailroom Clerk	A	1	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Manager Accounting	O	98	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Actuary	Q	453	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Applications Management~~	~~P~~	~~271~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Business Integration	O	544	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Case Management	P	270	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Claims	O	92	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Coding Quality	N	382	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Communications	N	398	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Community Rela ions	N	384	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Contracting	O	329	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Creative Branding	M	430	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Customer Service	M	94	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Decision Support~~	~~O~~	~~454~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Electronic Business	N	422	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Employment Services~~	~~N~~	~~420~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Encounters	M	516	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Facilities~~	~~N~~	~~209~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Finance	O	148	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Government Affairs~~	~~N~~	~~437~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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~~Manager Health Education~~	~~N~~	~~173~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
~~Manager HEDIS~~	~~O~~	~~427~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Human Resources	O	526	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Information Services	P	560	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Information Technology~~	~~P~~	~~110~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
~~Manager Integration Government Liaison~~	~~N~~	~~455~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Medical Data Management~~	~~O~~	~~519~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
~~Manager Medi-Cal Program Operations~~	~~N~~	~~483~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Member Outreach Education & Provider Relations~~	~~O~~	~~576~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager MSSP	O	393	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager OneCare Regulatory~~	~~N~~	~~197~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
~~Manager OneCare Sales~~	~~O~~	~~248~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager PACE Center	N	432	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Population Health Management	N	674	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Process Excellence	O	622	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Program Implementation	N	488	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Project Management~~	~~O~~	~~532~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Provider Network	O	191	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Provider Relations	M	171	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Manager Provider Services~~	~~O~~	~~656~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Purchasing	O	275	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager QI Initiatives	M	433	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Manager Strategic Operations~~	~~N~~	~~446~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
	~~Manager Systems Development~~	~~P~~	~~515~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Assistant	C	535	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Case Manager	L	72	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Medical Director	V	306	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Occupa ional Therapist	L	531	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Occupa ional Therapist Assistant	H	623	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Office Clerk	A	335	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
OneCare Partner - Service	C	231	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Outreach Specialist	C	218	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Payroll Specialist	E	554	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Payroll Specialist, Sr.	G	TBD	$55,000	$63,000	$71,000	New Position
Performance Analyst	I	538	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Attendant	A	485	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Coordinator	C	525	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Coordinator, Sr.	D	TBD	$44,000	$51,000	$58,000	New Position
Pharmacy Resident	G	379	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Physical Therapist	L	530	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Privacy Manager	N	536	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Privacy Officer	O	648	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Process Excellence Manager	N	529	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Assistant	C	24	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Coordinator	C	284	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Program Development Analyst Sr~~	~~M~~	~~492~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
Program Manager	L	421	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Program Manager Sr	M	594	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Specialist	E	36	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Specialist Int	G	61	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Specialist Sr	I	508	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Programmer	K	43	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Programmer Int	M	74	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Programmer Sr	N	80	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Manager	L	81	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Manager - Lead	M	467	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Manager Sr	N	105	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Specialist	E	291	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Specialist Sr	I	503	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Projects Analyst	G	254	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000	Revised posi ion title and pay range adjustment based on internal alignment and equity analysis
Provider Data Management Services Coordinator, Sr	F	586	$51,000	$59,000	$67,000	Revised posi ion title and pay range adjustment based on internal alignment and equity analysis
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Network Specialist	H	44	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Relations Rep	G	205	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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	Publications Coordinator	G	293	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QA Analyst	I	486	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QA Analyst Sr	L	380	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QI Nurse Specialist	M	82	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Receptionist	B	140	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Recreational Therapist	H	487	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Recruiter~~	~~L~~	~~406~~	~~$54,288~~	~~$70,512~~	~~$86,736~~	Remove Position
	~~Recruiter Sr~~	~~M~~	~~497~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Registered Dietitian	I	57	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	RN (PACE)	M	480	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Security Analyst Int	M	534	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Security Analyst Sr	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Security Officer	B	311	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Social Worker	J	463	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Social Worker, Sr.	K	TBD	$70,000	$84,000	$98,000	New Position
*	Special Counsel	T	317	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	~~Sr Director Regulatory Affairs and Compliance~~	~~R~~	~~658~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Sr Manager Government Affairs~~	~~O~~	~~451~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	~~Sr Manager Human Resources~~	~~P~~	~~649~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Sr Manager Informa ion Services	Q	650	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	~~Sr Manager Provider Network~~	~~O~~	~~651~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Staff Attorney	P	195	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Staff Attorney, Sr	R	TBD	$144,000	$174,000	$204,000	New Position
Supervisor Accoun ing	M	434	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Budge ing	N	466	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Case Management	M	86	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Claims	I	219	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Credentialing	I	671	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Customer Service	I	34	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Data Entry	H	192	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Encounters	I	253	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Facilities	J	162	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Finance	M	419	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Supervisor Health Education~~	~~M~~	~~381~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
Supervisor Information Services	N	457	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Member Outreach and Educa ion	K	TBD	$70,000	$84,000	$98,000	New Position
Supervisor MSSP	M	348	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Payroll	M	517	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Supervisor Systems Development~~	~~O~~	~~456~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
~~Systems Manager~~	~~N~~	~~512~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Analyst Int	I	64	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Analyst Sr	K	75	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Writer	H	247	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Writer Sr	J	470	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Therapy Aide	E	521	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Training Administrator	I	621	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Training Program Coordinator	H	471	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Transla ion Specialist	B	241	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Web Architect	N	366	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

*** A training rate of 10% below the minimum applies to all grades.

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Accountant	H	39	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accountant Int	I	634	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accountant Sr	K	68	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accounting Clerk	D	334	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Accounting Clerk Sr	E	TBD	$48,000	$55,000	$62,000	New Position
Activity Coordinator (PACE)	E	TBD	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Actuarial Analyst	I	558	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Actuary	O	357	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Administrative Assistant	D	19	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Analyst	H	562	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Analyst Int	I	563	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Analyst Sr	J	564	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Applications Analyst	H	232	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Applications Analyst Int	I	233	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Applications Analyst Sr	K	298	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Assistant Director	P	TBD	$117,000	$141,000	$165,000	New Position
Associate Director Informa ion Services	Q	557	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Auditor	I	565	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Auditor Sr	J	566	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Behavioral Health Manager	M	383	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Biostatistics Manager	M	418	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Board Services Specialist	E	435	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Business Analyst	J	40	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Business Analyst Sr	L	611	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Buyer	G	29	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Buyer Int	H	49	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Buyer Sr	I	67	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Care Manager	K	657	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Care Transition Interven ion Coach (RN)	L	417	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Certified Coder	H	399	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Certified Coding Specialist	H	639	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Change Control Administrator	I	499	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Change Control Administrator Int	J	500	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Counsel	X	132	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Executive Officer	Z	138	$319,740	$431,600	$543,600	Wage grade letter adjustment based on Grant Thornton revised salary structure, but no changes to pay range.
** Chief Financial Officer	X	134	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Information Officer	W	131	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Medical Officer	X	137	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Chief Operating Officer	X	136	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims - Lead	G	574	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Examiner	C	9	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Examiner Sr	E	20	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims QA Analyst	E	28	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clerk of the Board	O	59	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Auditor	L	567	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Documenta ion Specialist (RN)	M	641	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Pharmacist	P	297	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Communications Specialist	G	188	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Partner	F	575	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Partner Sr	H	612	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Rela ions Specialist	G	288	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Community Rela ions Specialist Sr	I	646	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contract Administrator	K	385	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Manager	M	207	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Manager, Sr.	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Specialist	I	257	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Specialist Int	J	469	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Controller	T	464	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Credentialing Coordinator	E	41	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Customer Service Coordinator	E	182	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Customer Service Rep	C	5	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Analyst	K	337	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Analyst Int	L	341	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Analyst Sr	M	342	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data and Repor ing Analyst - Lead	M	654	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Entry Tech	A	3	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Warehouse Architect	N	363	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Database Administrator	L	90	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Database Administrator Sr	N	179	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Deputy Chief Counsel	W	160	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Deputy Chief Medical Officer	W	561	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Audit & Oversight	R	546	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Budget and Procurement	S	527	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Case Management	S	318	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Claims Administra ion	R	112	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Coding Initiatives	S	375	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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* Director Communications	R	361	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Contracting	R	184	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Customer Service	R	118	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Facili ies	Q	428	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Financial Analysis	T	374	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Financial Compliance	R	460	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Human Resources	R	322	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Information Services	T	547	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Long Term Support Services	S	128	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Network Management	R	125	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director PACE Program	S	449	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Population Health Management	Q	675	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Program and Process Management	R	447	$144,000	$174,000	$204,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
* Director Program Implementa ion	R	489	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Provider Data Management Services	Q	655	$130,000	$157,000	$184,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
* Director Quality Analytics	R	591	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Quality Improvement	R	172	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Strategic Development	R	121	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
* Director Utilization Management	S	265	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Executive Assistant	G	339	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Executive Assistant to CEO	I	TBD	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Clinical Operations	V	501	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Compliance	V	493	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Human Resources	V	494	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Network Opera ions	V	632	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Opera ions	V	276	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Program Implementation	V	490	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Public Affairs	V	290	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director Quality & Population Health Management	V	676	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
** Executive Director, Behavioral Heal h Integra ion	V	614	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Facilities & Support Services Coordinator, Sr.	F	TBD	$51,000	$59,000	$67,000	New Position
Facilities Coordinator	E	438	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Financial Analyst	J	51	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Financial Analyst Sr	L	84	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Graphic Designer	K	387	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Health Coach	K	556	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Health Educator	H	47	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Health Educator Sr	I	355	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HEDIS Case Manager	M	443	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Help Desk Technician	E	571	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Assistant	D	181	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Business Partner	M	584	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Coordinator	F	316	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Representative	J	278	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Representative Sr	L	350	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Specialist	G	505	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
HR Specialist Sr	H	608	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Inpa ient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Intern	A	237	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Investigator Sr	I	553	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Coordinator	E	365	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Manager	N	424	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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IS Project Manager Sr	O	509	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Specialist	K	549	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Kitchen Assistant	A	585	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Li igation Support Specialist	K	588	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
LVN (PACE)	K	533	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
LVN Specialist	K	TBD	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Mailroom Clerk	A	1	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Accounting	O	98	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Actuary	Q	453	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Business Integration	O	544	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Case Management	P	270	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Claims	O	92	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Coding Quality	N	382	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Communications	N	398	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Community Rela ions	N	384	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Contracting	O	329	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Creative Branding	M	430	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Manager Customer Service	M	94	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Electronic Business	N	422	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Encounters	M	516	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Finance	O	148	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Human Resources	O	526	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Information Services	P	560	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager MSSP	O	393	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager PACE Center	N	432	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Population Health Management	N	674	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Process Excellence	O	622	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Program Implementation	N	488	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Provider Network	O	191	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Manager Provider Relations	M	171	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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	Manager Purchasing	O	275	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Assistant	C	535	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Case Manager	L	72	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
*	Medical Director	V	306	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Occupa ional Therapist	L	531	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Occupa ional Therapist Assistant	H	623	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Office Clerk	A	335	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
OneCare Partner - Service	C	231	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Outreach Specialist	C	218	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Payroll Specialist	E	554	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Payroll Specialist, Sr.	G	TBD	$55,000	$63,000	$71,000	New Position
Performance Analyst	I	538	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Attendant	A	485	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Coordinator	C	525	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Personal Care Coordinator, Sr.	D	TBD	$44,000	$51,000	$58,000	New Position
Pharmacy Resident	G	379	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Physical Therapist	L	530	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Privacy Manager	N	536	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Privacy Officer	O	648	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Process Excellence Manager	N	529	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Assistant	C	24	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Coordinator	C	284	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Program Manager	L	421	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Manager Sr	M	594	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Specialist	E	36	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Specialist Int	G	61	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program Specialist Sr	I	508	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Programmer	K	43	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Programmer Int	M	74	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Programmer Sr	N	80	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Manager	L	81	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Manager - Lead	M	467	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Manager Sr	N	105	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Specialist	E	291	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Project Specialist Sr	I	503	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Projects Analyst	G	254	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000	Revised posi ion title and pay range adjustment based on internal alignment and equity analysis
Provider Data Management Services Coordinator, Sr	F	586	$51,000	$59,000	$67,000	Revised posi ion title and pay range adjustment based on internal alignment and equity analysis
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Network Specialist	H	44	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Provider Relations Rep	G	205	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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	Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
	Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Publications Coordinator	G	293	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QA Analyst	I	486	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QA Analyst Sr	L	380	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QI Nurse Specialist	M	82	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Receptionist	B	140	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Recreational Therapist	H	487	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Registered Dietitian	I	57	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	RN (PACE)	M	480	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Security Analyst Int	M	534	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Security Analyst Sr	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Security Officer	B	311	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Social Worker	J	463	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Social Worker, Sr.	K	TBD	$70,000	$84,000	$98,000	New Position
*	Special Counsel	T	317	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Sr Manager Informa ion Services	Q	650	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Staff Attorney	P	195	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
	Staff Attorney, Sr	R	TBD	$144,000	$174,000	$204,000	New Position
	Supervisor Accoun ing	M	434	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Budge ing	N	466	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Case Management	M	86	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Claims	I	219	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Credentialing	I	671	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Customer Service	I	34	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Data Entry	H	192	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Encounters	I	253	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Facilities	J	162	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Finance	M	419	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Information Services	N	457	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Member Outreach and Educa ion	K	TBD	$70,000	$84,000	$98,000	New Position
Supervisor MSSP	M	348	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Payroll	M	517	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

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Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Analyst Int	I	64	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Analyst Sr	K	75	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Writer	H	247	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Technical Writer Sr	J	470	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Therapy Aide	E	521	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Training Administrator	I	621	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Training Program Coordinator	H	471	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Transla ion Specialist	B	241	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.
Web Architect	N	366	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evalua ion of job responsibilities.

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

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Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

*** A training rate of 10% below the minimum applies to all grades.

CalOptima - Annual Base Salary Schedule - Revised February 6, 2020

Summary of Changes to Salary Schedule
GA.8058 Salary Schedule Attachment A

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Accountant	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Accountant Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Accountant Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Accounting Clerk	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	February 2020
Accounting Clerk, Sr (Proposed title)	NA	E	Department requesting new title due to growth.	-	$48,000		$55,000		$62,000	February 2020
Activity Coordinator (PACE)	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020

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Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Actuarial Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Actuarial Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Actuary	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Administrative Assistant	~~H~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$44,000	~~$42,224~~	$51,000	~~$50,648~~	$58,000	February 2020
Analyst	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Analyst Sr	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	February 2020
Applications Analyst	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Applications Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Applications Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Assistant Director (Proposed title)	NA	P	Establishing title to assist departments organization wide with management leveling.	-	$117,000	-	$141,000	-	$165,000	February 2020
~~Associate Director Customer Service~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Associate Director Information Services	~~Q~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	February 2020
~~Associate Director Provider Network~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Auditor	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020
Auditor Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020
Behavioral Health Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Biostatistics Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Board Services Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Business Analyst	~~J~~		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$65,000	~~$53,352~~	$78,000	~~$65,624~~	$91,000	February 2020
Business Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Business Systems Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Buyer	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	February 2020
Buyer Int	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Buyer Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Care Manager	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Care Transition Intervention Coach (RN)	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
Certified Coder	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Certified Coding Specialist	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Certified Coding Specialist Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Change Control Administrator	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Change Control Administrator Int	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	February 2020
~~Change Management Analyst Sr~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Chief Counsel	~~T~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$347,000	~~$266,968~~	$434,000	~~$336,024~~	$521,000	February 2020
Chief Executive Officer	~~V~~	Z	Wage grade letter adjustment based on Grant Thornton revised salary structure, but no changes to pay range.							February 2020
Chief Financial Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$347,000	~~$320,216~~	$434,000	~~$403,312~~	$521,000	February 2020
Chief Information Officer	~~T~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$295,000	~~$266,968~~	$369,000	~~$336,024~~	$443,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Chief Medical Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$347,000	~~$320,216~~	$434,000	~~$403,312~~	$521,000	February 2020
Chief Operating Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$347,000	~~$320,216~~	$434,000	~~$403,312~~	$521,000	February 2020
Claims - Lead	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	February 2020
Claims Examiner	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	February 2020
Claims Examiner - Lead	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Claims Examiner Sr	~~I~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$48,000	~~$46,384~~	$55,000	~~$55,640~~	$62,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Claims QA Analyst	~~I~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$48,000	~~$46,384~~	$55,000	~~$55,640~~	$62,000	February 2020
Claims QA Analyst Sr.	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Claims Recovery Specialist	~~I~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$51,000	~~$46,384~~	$59,000	~~$55,640~~	$67,000	February 2020
Claims Resolution Specialist	~~I~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$51,000	~~$46,384~~	$59,000	~~$55,640~~	$67,000	February 2020
Clerk of the Board	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Clinical Auditor	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Clinical Auditor Sr	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Clinical Documentation Specialist (RN)	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	February 2020
Clinical Pharmacist	~~P~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	February 2020
Clinical Systems Administrator	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Clinician (Behavioral Health)	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Communications Specialist	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Community Partner	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	February 2020
Community Partner Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	February 2020
Community Relations Specialist	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	February 2020
Community Relations Specialist Sr	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020
Compliance Claims Auditor	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Compliance Claims Auditor Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Contract Administrator	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Contracts Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Contracts Manager, Sr (Proposed title)	NA	N	Department requesting new title due to growth and to establish levels.	-	$95,000	-	$114,000	-	$133,000	February 2020
Contracts Specialist	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020
Contracts Specialist Int	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020
Contracts Specialist Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Controller	~~Q~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$182,000	~~$154,440~~	$227,000	~~$194,480~~	$272,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Credentialing Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Credentialing Coordinator - Lead	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Customer Service Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Customer Service Rep	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	February 2020
Customer Service Rep - Lead	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Customer Service Rep Sr	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Data Analyst	K-		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$70,000	~~$61,360~~	$84,000	~~$75,504~~	$98,000	February 2020
Data Analyst Int	L		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$77,000	~~$70,512~~	$93,000	~~$86,736~~	$109,000	February 2020
Data Analyst Sr	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020
Data and Reporting Analyst - Lead	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	February 2020
Data Entry Tech	~~F~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$36,000	~~$34,840~~	$41,000	~~$41,808~~	$46,000	February 2020
Data Warehouse Architect	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Data Warehouse Programmer/Analyst	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
~~Data Warehouse Project Manager~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Data Warehouse Reporting Analyst	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Data Warehouse Reporting Analyst Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Database Administrator	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Database Administrator Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Deputy Chief Counsel	~~S~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$295,000	~~$222,352~~	$369,000	~~$280,072~~	$443,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Deputy Chief Medical Officer	~~T~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$295,000	~~$266,968~~	$369,000	~~$336,024~~	$443,000	February 2020
~~Director Accounting~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Director Applications Management~~	~~R~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Audit & Oversight	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Director Behavioral Health Services	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	February 2020
Director Budget and Procurement	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	February 2020
~~Director Business Development~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Director Business Integration~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Case Management	Q	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	February 2020
Director Claims Administration	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
~~Director Clinical Outcomes~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Clinical Pharmacy	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	February 2020
Director Coding Initiatives	~~P~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$154,000	~~$128,752~~	$193,000	~~$162,032~~	$232,000	February 2020
Director Communications	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
~~Director Community Relations~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Director Configuration & Coding~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Contracting	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144.000	~~$128,752~~	$174.000	~~$162,032~~	$204,000	February 2020
~~Director COREC~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Customer Service	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
~~Director Electronic Business~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Enterprise Analytics	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Director Facilities	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	February 2020
~~Director Finance & Procurement~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Financial Analysis	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Financial Compliance	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
Director Fraud Waste & Abuse and Privacy	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
~~Director Government Affairs~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Grievance & Appeals	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
~~Director Health Services~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Human Resources	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Director Information Services	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Long Term Support Services	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	February 2020
~~Director Medi-Cal Plan Operations~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Network Management	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
~~Director OneCare Operations~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Director Organizational Training & Education~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director PACE Program	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	February 2020
Director Population Health Management	Q-		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director ~~Process Excellence~~ Program & Process Management (Revised)	~~Q~~	R	Title changed due to department name change Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Director Program Implementation	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
~~Director Project Management~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Provider Data ~~Quality~~ Management Services (Revised)	Q		Title changed due to department name change Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	#N/A	~~$194,480~~	#N/A	February 2020
~~Director Provider Services~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Director Public Policy~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Director Quality (LTSS)~~	~~Q~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Quality Analytics	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Quality Improvement	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Director Regulatory Affairs and Compliance	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Director Strategic Development	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	February 2020
~~Director Systems Development~~	~~R~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Director Utilization Management	~~-~~Q	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	February 2020
~~Disease Management Coordinator~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Disease Management Coordinator - Lead~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~EDI Project Manager~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Enrollment Coordinator (PACE)	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	February 2020
Enterprise Analytics Manager	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	February 2020
Executive Administrative Services Manager	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	February 2020
Executive Assistant	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Executive Assistant to CEO	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Executive Director Clinical Operations	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Executive Director Compliance	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Executive Director Human Resources	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Executive Director Network Operations	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Executive Director Operations	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Executive Director Program Implementation	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Executive Director Public Affairs	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Executive Director Quality & Population Health Management	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Executive Director, Behavioral Health Integration	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Facilities & Support Services Coord - Lead	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	February 2020
Facilities & Support Services Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Facilities & Support Services Coordinator, Sr (Proposed title)	NA	F	Department requesting new title due to growth and to establish levels.	-	$51,000	-	$59,000	-	$67,000	February 2020
Facilities Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Financial Analyst	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Financial Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Financial Reporting Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
~~Gerontology Resource Coordinator~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Graphic Designer	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Grievance & Appeals Nurse Specialist	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Grievance Resolution Specialist	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Grievance Resolution Specialist - Lead	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Grievance Resolution Specialist Sr	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Health Coach	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Health Educator	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Health Educator Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Health Network Liaison Specialist (RN)	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
Health Network Oversight Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
HEDIS Case Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
~~HEDIS Case Manager (LVN)~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Help Desk Technician	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Help Desk Technician Sr	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	February 2020
HR Assistant	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	February 2020
HR Business Partner	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020
~~HR Compensation Specialist Sr~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
HR Coordinator	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
HR Representative	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020
HR Representative Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
HR Specialist	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
HR Specialist Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	February 2020
~~HRIS Analyst Sr~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~ICD-10 Project Manager~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Infrastructure Systems Administrator	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Infrastructure Systems Administrator Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Inpatient Quality Coding Auditor	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Intern	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	February 2020
Investigator Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
IS Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
IS Project Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
IS Project Manager Sr	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	February 2020
IS Project Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
IS Project Specialist Sr	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
Kitchen Assistant	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	February 2020
~~Legislative Program Manager~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Licensed Clinical Social Worker	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Litigation Support Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
LVN PACE	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
LVN Specialist (Proposed title, to be adjusted)	NA	K	Department requesting new title to clearly identify roles.	-	$70,000	-	$84,000	-	$98,000	February 2020
Mailroom Clerk	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	February 2020
Manager Accounting	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	February 2020
Manager Actuary	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	February 2020
~~Manager Applications Management~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Audit & Oversight	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Behavioral Health	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Business Integration	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Case Management	O	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	February 2020
Manager Claims	N	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	February 2020
Manager Clinic Operations	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Clinical Pharmacist	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	February 2020
Manager Coding Quality	N-		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	February 2020
Manager Communications	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	February 2020
Manager Community Relations	~~M~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$95,000	~~$81,120~~	$114,000	~~$99,840~~	$133,000	February 2020
Manager Contracting	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Creative Branding	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Cultural & Linguistic	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Manager Customer Service	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
~~Manager Decision Support~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Electronic Business	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
~~Manager Employment Services~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.	~~$71,760~~	#N/A	~~$93,184~~	#N/A	~~$114,712~~	#N/A	February 2020
Manager Encounters	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Manager Environmental Health & Safety	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	February 2020
~~Manager Facilities~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Finance	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	February 2020
Manager Financial Analysis	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	February 2020
~~Manager Government Affairs~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Grievance & Appeals	N	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	February 2020
~~Manager Health Education~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Manager HEDIS~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Human Resources	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Information Services	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Manager Information Technology~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Manager Integration Government Liaison~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Long Term Support Services	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Marketing & Enrollment (PACE)	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
~~Manager Medical Data Management~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Manager Medi-Cal Program Operations~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Member Liaison Program	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Manager Member Outreach & Education	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
~~Manager Member Outreach Education & Provider Relations~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager MSSP	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager OneCare Clinical	O	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	February 2020
Manager OneCare Customer Service	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
~~Manager OneCare Regulatory~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Manager OneCare Sales~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Outreach & Enrollment	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Manager PACE Center	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Population Health Management	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Manager Process Excellence	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Program Implementation	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
~~Manager Project Management~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Provider Data Management Services	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Manager Provider Network	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Provider Relations	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Manager Provider Services~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Purchasing	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	February 2020
Manager QI Initiatives	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Manager Quality Analytics	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Manager Quality Improvement	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Manager Regulatory Affairs and Compliance	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
Manager Reporting & Financial Compliance	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Strategic Development	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	February 2020
~~Manager Strategic Operations~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Manager Systems Development~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Manager Utilization Management	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	February 2020
Marketing and Outreach Specialist	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Medical Assistant	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	February 2020
Medical Authorization Asst	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Medical Case Manager	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
Medical Case Manager (LVN)	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	February 2020
Medical Director	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	February 2020
Medical Records & Health Plan Assistant	~~G~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$30,576~~	$38,000	~~$38,272~~	$44,000	~~$45,968~~	$50,000	February 2020
Medical Records Clerk	~~E~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$38,000	~~$31,720~~	$44,000	~~$37,960~~	$50,000	February 2020
Medical Services Case Manager	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Member Liaison Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020
MMS Program Coordinator	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Nurse Practitioner (PACE)	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	February 2020
Occupational Therapist	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
Occupational Therapist Assistant	~~M~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$59,000	~~$81,120~~	$68,000	~~$99,840~~	$77,000	February 2020
Office Clerk	~~C~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$21,008~~	$36,000	~~$26,208~~	$41,000	~~$31,408~~	$46,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
OneCare Operations Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
OneCare Partner - Sales	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	February 2020
OneCare Partner - Sales (Lead)	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
OneCare Partner - Service	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020
OneCare Partner (Inside Sales)	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Outreach Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Paralegal/Legal Secretary	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020
Payroll Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Payroll Specialist, Sr (Proposed title)	NA	G	Department requesting new title due to growth and to establish levels.	-	$55,000	-	$63,000	-	$71,000	February 2020
Performance Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Personal Care Attendant	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	February 2020
Personal Care Attendant - Lead	~~E~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$38,000	~~$31,720~~	$44,000	~~$37,960~~	$50,000	February 2020
Personal Care Coordinator	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Personal Care Coordinator, Sr (Proposed title)	NA	D	Department requesting new title due to growth and to establish levels.	-	$44,000	-	$51,000	-	$58,000	February 2020
Pharmacy Resident	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Pharmacy Services Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020
Pharmacy Services Specialist Int	~~J~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$44,000	~~$53,352~~	$51,000	~~$65,624~~	$58,000	February 2020
Pharmacy Services Specialist Sr	~~K~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$48,000	~~$61,360~~	$55,000	~~$75,504~~	$62,000	February 2020
Physical Therapist	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
Physical Therapist Assistant	~~M~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$59,000	~~$81,120~~	$68,000	~~$99,840~~	$77,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Policy Advisor Sr	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	February 2020
Privacy Manager	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	February 2020
Privacy Officer	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	February 2020
Process Excellence Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Program Assistant	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020
Program Coordinator	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	February 2020
~~Program Development Analyst Sr~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.	~~$62,400~~	#N/A	~~$81,120~~	#N/A	~~$99,840~~	#N/A	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Program Manager	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Program Manager Sr	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	February 2020
Program Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Program Specialist Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Program Specialist Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Program/Policy Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Program/Policy Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020
Programmer	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	February 2020
Programmer Int	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Programmer Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Project Manager	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Project Manager - Lead	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Project Manager Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Project Specialist	~~K~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$48,000	~~$61,360~~	$55,000	~~$75,504~~	$62,000	February 2020
Project Specialist Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Projects Analyst	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Provider ~~(Enrollment)~~ Data Management Services Coordinator (Revised)	~~I~~	D	Title changed due to department name change Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Provider ~~(Enrollment)~~ Data Management Services Coordinator Sr (Revised)	~~J~~	F	Title changed due to department name change. Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Provider Enrollment Manager	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Provider Network Rep Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Provider Network Specialist	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Provider Network Specialist Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020
Provider Office Education Manager	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Provider Relations Rep	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Provider Relations Rep Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Publications Coordinator	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	February 2020
QA Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
QA Analyst Sr	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	February 2020
QI Nurse Specialist	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
QI Nurse Specialist (LVN)	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Receptionist	~~F~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$38,000	~~$34,840~~	$44,000	~~$41,808~~	$50,000	February 2020
Recreational Therapist	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	February 2020
~~Recruiter~~	~~L~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Recruiter Sr~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Registered Dietitian	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Regulatory Affairs and Compliance Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Regulatory Affairs and Compliance Analyst Sr	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	February 2020
Regulatory Affairs and Compliance Lead	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
RN (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Security Analyst Int	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Security Analyst Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.		$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Security Officer	~~F~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$38,000	~~$34,840~~	$44,000	~~$41,808~~	$50,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
SharePoint Developer/Administrator Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020
Social Worker	~~K~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$65,000	~~$61,360~~	$78,000	~~$75,504~~	$91,000	February 2020
Social Worker, Sr (Proposed title)	NA	K	Department requesting new title due to growth and to establish levels.	-	$70,000	-	$84,000	-	$98,000	February 2020
Special Counsel	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	February 2020
~~Sr Director Regulatory Affairs and Compliance~~	~~R~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Sr Manager Financial Analysis	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	February 2020
~~Sr Manager Government Affairs~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
~~Sr Manager Human Resources~~	~~P~~	#N/A	Job title is not in use nor is it planned for use.							February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Sr Manager Information Services	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.							February 2020
~~Sr Manager Provider Network~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Staff Attorney	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	February 2020
Staff Attorney, Sr. (Proposed title)	NA	R	Department requesting new title to establish levels.	-	$144,000	-	$174,000	-	$204,000	February 2020
Supervisor Accounting	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020
Supervisor Audit and Oversight	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Behavioral Health	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Budgeting	~~M~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$95,000	~~$81,120~~	$114,000	~~$99,840~~	$133,000	February 2020
Supervisor Case Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Claims	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020
Supervisor Coding Initiatives	-	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020
Supervisor Credentialing	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Supervisor Customer Service	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Data Entry	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Supervisor Day Center (PACE)	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Supervisor Dietary Services (PACE)	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	February 2020
~~Supervisor Disease Management~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Supervisor Encounters	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Supervisor Facilities	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020
Supervisor Finance	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Grievance and Appeals	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
~~Supervisor Health Education~~	~~M~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Supervisor Information Services	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	February 2020
Supervisor Long Term Support Services	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Member Outreach and Education (Proposed title)	NA	K	Department requesting new title to assist with supervision of staff.	-	$70,000	-	$84,000	-	$98,000	February 2020
Supervisor MSSP	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Nursing Services (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor OneCare Customer Service	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	February 2020
Supervisor Payroll	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020
Supervisor Pharmacist	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	February 2020
Supervisor Population Health Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor ~~(Provider Enrollment)~~ Provider Data Management Services (Revised)	K		Title changed due to department name change. Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$70,000	~~$61,360~~	$84,000	~~$75,504~~	$98,000	February 2020
Supervisor Provider Relations	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Quality Analytics	~~M~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	February 2020
Supervisor Quality Improvement	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Regulatory Affairs and Compliance	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Social Work (PACE)	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	February 2020
~~Supervisor Systems Development~~	~~O~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Supervisor Therapy Services (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Supervisor Utilization Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Systems Manager~~	~~N~~	#N/A	Job title is not in use nor is it planned for use.							February 2020
Systems Network Administrator Int	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	February 2020
Systems Network Administrator Sr	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	February 2020
Systems Operations Analyst	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	February 2020
Systems Operations Analyst Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	February 2020
Technical Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Technical Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Technical Writer	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	February 2020
Technical Writer Sr	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	February 2020
Therapy Aide	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	February 2020
Training Administrator	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	February 2020
Training Program Coordinator	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	February 2020
Translation Specialist	~~G~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$30,576~~	$38,000	~~$38,272~~	$44,000	~~$45,968~~	$50,000	February 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Web Architect	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	February 2020

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
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

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

Recommended Actions

The Whole Child Model Family Advisory Committee recommends:

1. New appointment of Monica Maier to fill a vacant Family Member seat for a term ending June 30, 2021; and
2. New appointment of Jacqui Knudsen to fill a Consumer Advocate seat for a term ending June 30, 2022.

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 system plans, including CalOptima. A provision of the Whole-Child Model program 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 the CalOptima Board relative to the Whole-Child Model program.

The WCM FAC is comprised of eleven voting members, seven to nine of whom are to be designated as family representatives and two to four of whom are to be designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's eleven seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill these seats.

For the current nomination process, the WCM FAC Ad Hoc members reviewed the applications from candidates on December 4, 2019 in preparation for the December 10, 2019 meeting.

Discussion

CalOptima staff conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included notification methods, such as sending 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 an application from interested candidates the application is submitted to the Nominations Ad Hoc Subcommittee for review.

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Prior to the WCM FAC Nominations Ad Hoc Subcommittee meeting on December 4, 2019, Subcommittee members received and evaluated three applications received from interested individuals for the open seats. The Ad Hoc, which included WCM FAC Chair Maura Byron, Sandra Cortez-Schultz 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 and approval at the December 10, 2019 meeting.

Applicants for the open seats are as follows:

Authorized Family Member Representative
Monica Maier (New Appointment) *

Monica Maier is the step-mother and main caregiver of a child who receives CCS services. Ms. Maier is interested in serving as an advocate on behalf of parents and their children with CCS conditions. Ms. Maier is currently a Marketing Manager with Eternal Word Television Network Global Catholic Network where she develops and maintains strong ongoing relationships with church leadership, diocesan staff, and volunteer leaders through regular visits and communications.

Community Based Organization or Consumer Advocates Representative
Jacqui Knudsen (New Appointment) *
Pamela Patterson

Jacqui Knudsen is the Outreach Education Manager for Family Voices of California and provides support and education to CCS families who are part of CalOptima's Whole-Child Model program. Prior to her current role with Family Voices, Ms. Knudsen held the Community Outreach Coordinator position with the Orange County Regional Center. Ms. Knudsen is also the mother of an adult who has received Medi-Cal services for the past 25 years.

Pamela Patterson is the mother of a special needs CalOptima Medi-Cal member. 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 a former member of the WCM FAC as an Authorized Family Member and severed as the Vice Chair of the WCM FAC.

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
The Chair of the Whole Child Model Family Advisory Committee established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The WCM FAC met on December 10, 2019 and approved the recommendation of the Ad Hoc committee to present the new appointments to the Board for consideration If the recommended candidates are appointed, it will bring the committee membership to nine members, with active recruitment continuing for the additional two currently vacant Family Member seats.

*Indicates WCM FAC recommended appointment

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. AA.1271: Whole Child Model Family Advisory Committee

/s/ Michael Schrader *01/28/2020*
Authorized Signature **Date**

*Indicates WCM FAC recommended appointment

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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 February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Event

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

Recommended Actions
1. Authorize expenditure for CalOptima's participation in the following community event:
    a. Up to $2,000 and staff participation at the Iranian American Community Group's 7th Annual Persian Nowruz Festival in Irvine on March 22, 2020;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background
CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended event will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

a. **Iranian American Community Group's 7th Annual Persian Nowruz Festival.** Staff recommends the authorization of expenditures for participation in the Iranian American Community Group's 7th Annual Persian Nowruz Festival. This is an educational event celebrating the Persian New Year that highlights the culture and traditions of the Persian community. The event will include cultural performances, traditional foods and resource

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tables. This event provides an opportunity to share information about CalOptima's programs and services with our members who speak Farsi, which is one of CalOptima's threshold languages. A $2,000 financial commitment for the Iranian American Community Group's 7th Annual Nowruz Festival includes: CalOptima's name and logo on recognition banner, event program and announcement on main stage, one (1) resource booth and invitation to VIP tent at the event. The event draws nearly 4,500 annually from the Persian community, Persian organizations and their members and Iranian-American community leaders. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Farsi and share information about CalOptima's programs and services.

CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $2,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support a community activity that offers an opportunity that is in alignment with CalOptima's mission, encourages broader participation in CalOptima's programs and services, promotes health and wellness, and/or develops and strengthens partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

1. Entities Covered by this Recommended Board Action
2. Nowruz 2020 Sponsorship Package

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 18

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Iranian American Community Group of Orange County	6789 Quail Hill Pkwy, Ste. 626	Irvine	CA	92603

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Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Dear Nowruz Sponsor:

On behalf of Nowruz 2020 Iranian American Community Group (IACG) Festival Committee, I am pleased to invite you to join our circle of sponsors to support this exciting cultural event.

On Sunday, **March 22, 2020, from 1-6 pm,** the Persian community will celebrate the **7th Annual Persian Nowruz Festival (Eid)** at the Rose Garden at Bill Barber Community Park (next to Irvine's city hall), in Irvine, California.

For thousands of years Iranians have celebrated Nowruz as the beginning of the year. The colorful celebration of Nowruz marks the beginning of spring and Persian New Year, which is a time to begin a new life, and the first day of spring.

Since 2014, volunteers from several supporting non-profit organizations gather annually to create an extraordinary event to showcase the rich Persian culture. This fun event includes free entrance to the festival, music, dance, children's activities, Persian cuisine, and much more. The number of participants has grown steadily over the years to nearly 4,500 annually. This year we expect that number to be even greater.

Sponsorship of Nowruz provides your business with a unique opportunity to reach thousands of Iranian-Americans living in Southern California. While engaging and inspiring, your participation will allow you to extend your loyalty to Persian culture among thousands of visitors to the festival.

The enclosed materials provide information on the levels of sponsorship and the benefits associated with each level. Please take this opportunity to become involved with the community while promoting Persian culture and your business to thousands of attendees.

We look forward to recognizing you as one of our major sponsors at Nowruz 2020. Please e-mail us at iacgroupoc@gmail.com with any questions you may have.

Best Regards,

Kamran Taghdiri, PhD, IAC Nowruz Executive Director & CFO
Nowruz Festival Committee

Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Sponsorship Levels

IAC Group is a 501 (c) (3) organization (**Tax ID #: 47-5363120**)

Your sponsorship is a valuable component of Nowruz celebration festival. Your support will help us to exhibit and represent diverse collection of traditional events and lively programs. It will also encourage children to learn about their rich heritage by participating in this cultural event.

PLATINUM Sponsor ($ 2,000 +)

- Name and logo display on a recognized banner at a recognized section at the event
- Name and logo display on recognized section of the program hand out to participants
- Announcement on main stage as platinum sponsor
- A table at the event for distributing company's information (no sales transactions)
- Invitation to VIP tent of the event

GOLD Sponsor ($ 1,000 +)

- Name display on banner at a recognized section at the event
- Name on gold sponsors section of the program hand out to participants
- A shared table with other gold sponsors to hand out company's information (no sales transactions)

SILVER Sponsor ($ 500 +)

- Name display on banner at the event
- Name on silver sponsors section of the program hand out to participants

Friends of Nowruz ($ 100 +)

- Name on Friends of Nowruz section of program hand out to participants

Iranian American Community Group of Orange County: 6789 Quail Hill Pkwy, Suite 626, Irvine CA. 92603
www.iac-group.org ***iacgroupoc@gmail.com***
Tel. 949-431-6858

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IAC Group
Iranian American Community Group

Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Sponsor Information

First Name: _____ Last Name: _____

Company/Organization: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____

Email: _____

Sponsorship Levels: (Please check options)

Description	Amount	Select
Platinum Sponsor	$ 2,000+	
Gold Sponsor	$ 1,000+	
Silver Sponsor	$ 500+	
Nowruz Friends	$ 100+	

Check: Check #_____ Bank Name_____

Sponsor Signature: ……. **Date:** ……...

Please Mail to: **Nowruz 2020 Celebration**
IAC Group
6789 Quail Hill Pkwy, Suite 626
Irvine, CA 92603

(Tax ID #: 47-5363120)

Board of Directors Meeting
February 6, 2020

Provider Advisory Committee (PAC) Update

December 12, 2019 PAC Meeting

At the December 12, 2019 meeting, the PAC members reviewed, discussed and approved recommended changes to the PAC membership seat composition, as recommended by the Recruitment Ad Hoc committee. Specifically, the proposed changes include taking one of the two Long-Term Services and Supports seats and creating an additional Allied Health Services seat which would allow for enhanced representation of providers that fall under the many allied health categories. PAC is also requesting the removal of the word "Traditional" from the Traditional/Safety Net seat. PAC is also interested in changing the term of the Chair and Vice-Chair from a one year to a two year term. The next step is to process the necessary paperwork for submission to the Board at a future meeting, and if approved, to recruit members to fill any vacant PAC seats based on the updated committee membership seats.

Michael Schrader, Chief Executive Officer, updated the members on the Cal-AIM Program and the Department of Health Care Services (DHCS) Managed Care Plans (MCP) state waiver proposal for 2021-2025.

David Ramirez, M.D., Chief Medical Officer, updated the members on CalOptima's incentives for Skilled Nursing Facilities (SNFs). Dr. Ramirez also discussed the Medication Assisted Therapy program's (MAT) pharmacy waiver.

Ladan Khamseh, Chief Operating Officer, updated the members on the transition of the administration of the Behavioral Health benefit for OneCare and OneCare Connect members from Magellan to CalOptima effective January 1, 2020. Ms. Khamseh also reported that phase one of the Health Homes Program (HHP) would also become effective January 1, 2020.

Tim Reilly, Partner, Pacific Health Consulting Group, presented an update on the CalOptima Delivery System evaluation to the PAC members.

PAC also received updates on Homeless Health, Proposition 56 (Tobacco Tax), and pending Federal and State Legislation.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

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Board of Directors Meeting
February 6, 2020

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

December 10, 2019 Special WCM FAC Meeting

The WCM FAC achieved a quorum at its December 10, 2019 meeting and approved its meeting schedule for fiscal year 2019-20. After discussion about the proposed February 25, 2020 meeting and potential scheduling conflicts, the committee members approved the schedule with the exception of the proposed February date and requested that Staff obtain availability information from the various committee members and recommend an alternate meeting date in March 2020.

The WCM FAC Nominations Ad Hoc Committee recommended the appointment of Monica Maier to the WCM FAC as an Authorized Family Member and the appointment of Jacqui Knudsen as a Community Based Organization Representative. The members were unanimous in their approval of these appointment recommendations.

The WCM FAC appreciates and thanks the CalOptima Board of Directors for the opportunity to present input and updates on the WCM FAC's current activities. The next WCM FAC meeting is scheduled for March 10, 2020.

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CalOptima
A Public Agency
Better. Together.

Intergovernmental Transfer (IGT) 9 and 10 Update

Board of Directors Meeting
February 6, 2020

Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

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IGT 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 as represented to CMS
  - IGTs 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- Contributions from eligible community funding partners can be matched through the IGT process up to upper rate range as established by the state's actuaries
- No guarantee of future availability of IGT funds
  - Best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries

IGT Funding Process

High-Level Steps:
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et. al.)
3. CalOptima submits Letter of Interest (LOI) to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contribution amount and additional 20 percent fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20 percent fee and where applicable, retained amount for Managed Care Organization tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic) March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations

- Recommended focus areas for IGT9 funds
  - Quality performance
  - Access to care
  - Data exchange and support
  - Other priority areas identified

IGT 9 Next Steps

- Discuss potential expenditures of IGT 9 funds with advisory committees and other stakeholders

- Discuss recommendations during the February 2020 Board of Directors' Quality Assurance and Finance and Audit Committees

- Present final recommendations Board of Directors Meeting before the end of the Fiscal Year

IGT 10 Status

- On December 20, 2019 CalOptima received DHCS Request for Medi-Cal Managed Care Plan's Proposal on
  - Rating Period 2019–2020 (July 1, 2019–December 31, 2020)
    - Covers 18 months
    - Prior IGTs covered 12 months
  - Estimated total contribution permitted from funding partners is approximately $69 million
    - CalOptima's share will be determined when DHCS advises the final IGT payment amount
    - Response due to DHCS by February 19, 2020
- CalOptima staff outreached to prior government funding entities
  - Requested letters of interest by February 14, 2020

IGT 10 Status (cont.)

- Previous government funding entities
  - University of California, Irvine
  - Children and Families Commission of Orange County
  - County of Orange
  - City of Orange
  - City of Newport Beach
- February Board Action request
  - Consider actions to secure Medi-Cal funds through the Voluntary IGT 10 Rate Range Program

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

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State Budget Overview

Board of Directors Meeting
February 6, 2020

TC Roady
Director, Office of Compliance

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Fiscal Outlook/Overview

- Total Budget: $222.2 billion
- General Fund: $153.1 billion
- Modest revenue growth anticipated – 3.8%
- Continued funding for FY 2019-20 priorities
- New funding for FY 2020-21 proposals
  - Homelessness
  - Medi-Cal Healthier California for All (formerly “CalAIM”)

Medi-Cal Budget

- FY 2020–21 Proposed Medi-Cal Budget

General Fund	**$26.4 billion**
Federal Funds	$67.5 billion
Other	$13.4 billion
Total	$107.4 billion

- Estimated (FY) 2020-21 Enrollment: 12.9 million

- MCO Tax uncertainty

Medi-Cal Healthier California for All

- Formerly Known as CalAIM
- FY 2020-21 budget proposes $695 million to fund:
  - Enhanced care management
  - In lieu of services
  - Infrastructure investments to expand whole person care-style programs statewide
  - Dental transformation initiative expansion
- Funding is expected to increase in upcoming fiscal years

Expanding Full Scope Medi-Cal

- FY 2020-21 budget proposes to expand full-scope Medi-Cal to cover individuals 65+ regardless of immigration status
  - No sooner than January 1, 2021
  - Projected to bring 27,000 new full-scope enrollees statewide
  - FY 2020-21 cost: $80.5 million ($64.2 million General Fund)
    - IHSS costs are included in this estimate
  - Substantial increase in projected costs for this population in coming fiscal years

Prescription Drugs

- FY 2019-20 budget: Executive Order N-01-19 (carving the pharmacy benefit out of Medi-Cal managed care)
- FY 2020-21 budget proposal:
  - Projects $178.3 million in savings associated with the carve-out
  - Majority of the state's financial benefit from the carve-out is not expected to accrue until FY 2022-23 and beyond
- Golden State Drug Pricing Schedule
- Generic Contracting Program

Office of Health Care Affordability

- FY 2020-21 budget proposes new Office of Health Care Affordability
  - Within the California Department of Health and Human Services
  - Prime directives:
    - Increase price and quality transparency by developing industry-specific strategies and cost targets
    - Enforce financial consequences for entities that fail to meet these targets

Other Health Priorities

- *Homelessness:*
  - FY 2019-20 budget: $1 billion
  - FY 2020-21 budget: additional $750 million to establish the California Access to Housing and Services Fund (administered by Dept. of Social Services)
- *Behavioral Health*:
  - FY 2020-21 proposes $45.1 million to help county mental health plans/substance use disorder systems to prep for CalAIM
  - Focus on data-sharing capabilities for care coordination, performance measurement, and payment reform.
- *Public Option*: Administration plans to leverage California's public Medi-Cal managed care plans and Covered California to "build an even more robust public option in California."

Next Steps

- State legislature will convene budget hearings
- Governor will publish the “May revision” to his budget proposal considering:
  - Revised economic forecast
  - Revised costs estimates for state programs
  - Federal policy changes
- State legislature has until June 15 to pass final budget bill
- Governor has until June 30 to sign

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Medi-Cal
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Medi-Cal Healthier California for All

Board of Directors Meeting
February 6, 2020

Candice Gomez, Executive Director, Program Implementation
TC Roady, Director, Regulatory Affairs and Compliance

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Background

- On October 28, the Department of Health Care Services (DHCS) released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future of the Medi-Cal delivery system framework.
  - Spans a five-year period from 2021 to 2026
  - Contains numerous core initiatives
  - Expands Medi-Cal managed care plans' responsibilities
- Beginning January 8, 2020, DHCS started referring to CalAIM as "Medi-Cal Healthier California for All."

Goals: Medi-Cal Healthier California for All

1. Identify and manage member risk and need through whole person care approaches and address social determinants of health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

DHCS Timeline

2019

- DHCS released Medi-Cal Healthier California for All proposal
- DHCS stakeholder meetings begin

2020

- July 1, 2020: CalOptima submit plan to DHCS for transitioning WPC, HHP, and TCM into ECM and ILOS
- WPC and HHP sunsets on December 31, 2020

2021

- January 1, 2021: Plan Incentives, Blended LTC/SPD Rate, and PHM, ECM and ILOS

2022

- Develop planning for 2023
- Full Integration Plan: 1. RFP 1/1/22; 2. Award 7/1/22; and 3. Readiness 7/1/22–12/31/23 (18 mos.)

WPC = Whole Person Care
HHP = Health Homes Program
TCM = Targeted Case Management

ECM = Enhanced Care Management
ILOS = In Lieu of Services
PHM = Population Health Management

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DHCS Timeline (cont.)

2023

- CMC transitions to D-SNPs and mandatory managed care enrollment for dually-eligible members.
- Regional Rates Phase II
- ECM model of care for re-entry population

2024

- January 1, 2024: Go-Live for Full Integration Plan

2025

- NCQA Accreditation of MCPs and delegated entities

2026

- January 1, 2026: Full implementation statewide of LTSS, LTC, D-SNPs

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Proposals with Direct Impact

Direct Impact	Implementation Date
Population Health Management Program	January 2021
Enhanced Care Management Benefit	January 2021
In Lieu of Services	January 2021
Regional Managed Care Capitation Rates	January 2023
Shared Risk/Savings and Incentive Payments	January 2021
Full Integration Plans[1]	January 2024
NCQA Accreditation	January 2025
Discontinue CMC and Require D-SNPs	January 2023

1. Current status: BH partially integrated; Dental not integrated
2. NCQA accreditation is new for health networks, may have new requirements for MCPs.

Internal Work Efforts

Finance

- Regional Rates
- Shared Risk/Savings and Incentives
- Blended Rates

Quality

- Population Health Management
- NQCA Accreditation

Medical

- Enhanced Care Management
- In Lieu of Services

Operations

- CMC to D-SNP Transition
- Full Integration Plans

Transition Plan

- DHCS expects MCP to submit a Transition Plan demonstrating:
  - How elements of existing programs such as the Health Homes Program (HHP) and Whole Person Care (WPC) will be transitioned into the new ECM and ILOS programs; and
  - A good faith effort to come into agreement with HHP, WPC and Local Governmental Agency providers rendering such services

Immediate Activities

Date	Milestone
February 2020	Transition Track DHCS Policy Development (ongoing)
March 2020	Prepare Draft Transition Plan
April 2020	Vet Transition Plan with MAC, OCC-MAC, PAC and WCM-FAC
May 2020	Vet Transition Plan with QAC and FAC
June 2020	Transition Plan Approval by BOD
July 1, 2020	CalOptima to Submit Transition Plan to DHCS

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Medi-Cal
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Health Homes Program Update

Board of Directors Meeting
February 6, 2020

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

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Health Homes Program (HHP) Update

- On January 1, 2020, CalOptima's HHP for eligible Medi-Cal members with chronic conditions and substance use disorders (Phase I), went live.
- Eligible members have been prioritized into outreach groups based upon select high-risk criteria and the likelihood of their participation.
- High-risk criteria include:
  - Recent diagnosis of opioid overdose
  - Recent hospitalization/inpatient stay
  - Cancer diagnosis
  - Recent or recurrent ER visit(s)
  - Age less than 26 years old

HHP Update (Cont.)

- Characteristics that may impact willingness to participate include:
  - Pregnancy
  - Another HHP-eligible member in household

- Information about how to participate in the program will be provided to the members via:
  - A letter in the beginning of the month of outreach
  - A robocall the following week and
  - Personal outreach by the Community-Based Care Management Entity (CB-CME) HHP care team if no response from the member

HHP Customer Service Update

- Since implementation, CalOptima's Customer Service department has received 72 HHP calls.
- Staff has provided information on topics such as:
  - Eligibility
  - Benefits of the Program
  - How to participate
- Progressive member outreach efforts continue in coordination with Case Management staff

HHP Phase I: Eligible Members

CB-CME	DHCS TEL*	FEL**	Eligible by Referral Only
CalOptima (CCN/COD)	3,321	2,200	1,121
AltaMed Health Services	832	562	270
AMVI Care Health Network	162	105	57
Arta Western Health Network	1,135	819	316
CHOC Health Alliance	802	653	149
Family Choice Health Network	583	356	227
Heritage-Regal Medical Group	108	63	45
Kaiser Permanente	425	291	134
Monarch Physician Group	1,503	1,007	496
Noble Mid-Orange County	394	283	111
Prospect Medical Group	661	450	211
Talbert Medical Group	486	340	146
United Care Medical Group	423	256	167
Total	**10,835**	**7,385**	**3,450**

* TEL- Targeted Engagement List
** FEL- Finalized Engagement List

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HHP: Next Steps

- Beginning July 2020, Phase 2 of CalOptima's HHP will go live for eligible Medi-Cal members with serious mental illnesses.
  - The stratification and prioritization process will be updated for Phase 2 members.

- CalOptima will continue to work collaboratively with the Orange County Health Care Agency to ensure coordination of services for members enrolled in both Whole-Person Care and HHP.

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Hospital Data Sharing Update

Board of Directors Meeting
February 6, 2020

Len Rosignoli
Chief Information Officer, CalOptima

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Overview

- The purpose of this initiative is to monitor hospital activities for CalOptima's members and to improve care management - ideally improving cost, quality, care, and satisfaction.

- The chosen solution/scope of work includes near-real-time notification from participating hospitals of Emergency Department (ED) visits and admissions, discharges, and transfers (ADT) through the clinical delivery system; notification of referrals to various Community Based Organizations; and some level of discharge planning.

- In addition to these notifications and tracking, the ability to receive and access relevant clinical electronic health records for these members/patients will exist from participating hospitals, enabling more effective care management.

Financial Review

- CalOptima planned for and received budget approval in June 2019 to invest in one or more data sharing platform(s)/system(s). The budget allows for approximately $2,500,000.

- The Orange County Health Care Agency (OCHCA) contributed $409,000 in support of Whole Person Care and has also offered the hospitals incentives for participation.

- Additional incentives for participation in this program are being evaluated as part of the funds from Intergovernmental Transfer number 9 and will be reviewed/discussed at the February Finance and Audit Committee meeting.

Selection Process and Timeline

- A Request For Proposal (RFP) was issued in July 2019 to identify one or more suitable platforms/systems.
- Nine proposals were received, reviewed, and scored by the selection panel.
- Four vendors were chosen to present demonstrations. All were conducted in October 2019. The demonstrations were also scored.
- Reference calls as well as follow-up questions and answers were handled in November 2019.
- The evaluation panel included input from 10 participants representing Medical Affairs, Enterprise Analytics, Information Services, and Procurement.

Evaluation Criteria

The evaluation criteria for selection included:

- Cost
- Completeness of proposal
- Ability to provide ED and ADT info/alerts in near-real time
- Custom alert capability
- Ability to identify homeless members
- Ability to support CalOptima's homeless initiatives
- Discharge planning support
- Shared care planning
- Analytics capabilities
- Integration with third-party systems
- Existing partnerships/interfaces with hospitals
- Vendor's Plan to participate with more hospitals
- Security features and architecture
- Overall ability to address CalOptima's requirements
- Partnership – ability to establish a good working relationship
- Volume of contract changes

Current Status

- In December 2019, the two top scoring vendors were identified as the finalists for this initiative.
  - Collective Medical Technologies
  - SafetyNetConnect

- In addition to the evaluation criteria, both finalist vendors were found to be already implemented at many Orange County hospitals, eliminating the need for CalOptima's provider partners to implement a new system, or to feel pressured to use one over the other.

- Reference calls supported the decision to recommend both vendors. Other Medi-Cal plans are also using both vendors for similar reasons.

- One of the finalist vendors is used by OCHCA for Whole Person Care, the other has been supported by the Hospital Association of Southern California.

Next Steps

- Next steps include a review by Privacy/Compliance, obtaining Board approval to contract, completion of contract negotiation, execution of contract, and implementation.

- System Implementation is anticipated to take 4-6 months, followed by collection of data from participating hospitals and new hospitals and/or Community Based Organizations over the next 18 months.

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PACE

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PACE Update

Board of Directors Meeting

February 6, 2020

Elizabeth Lee, Director

PACE Program

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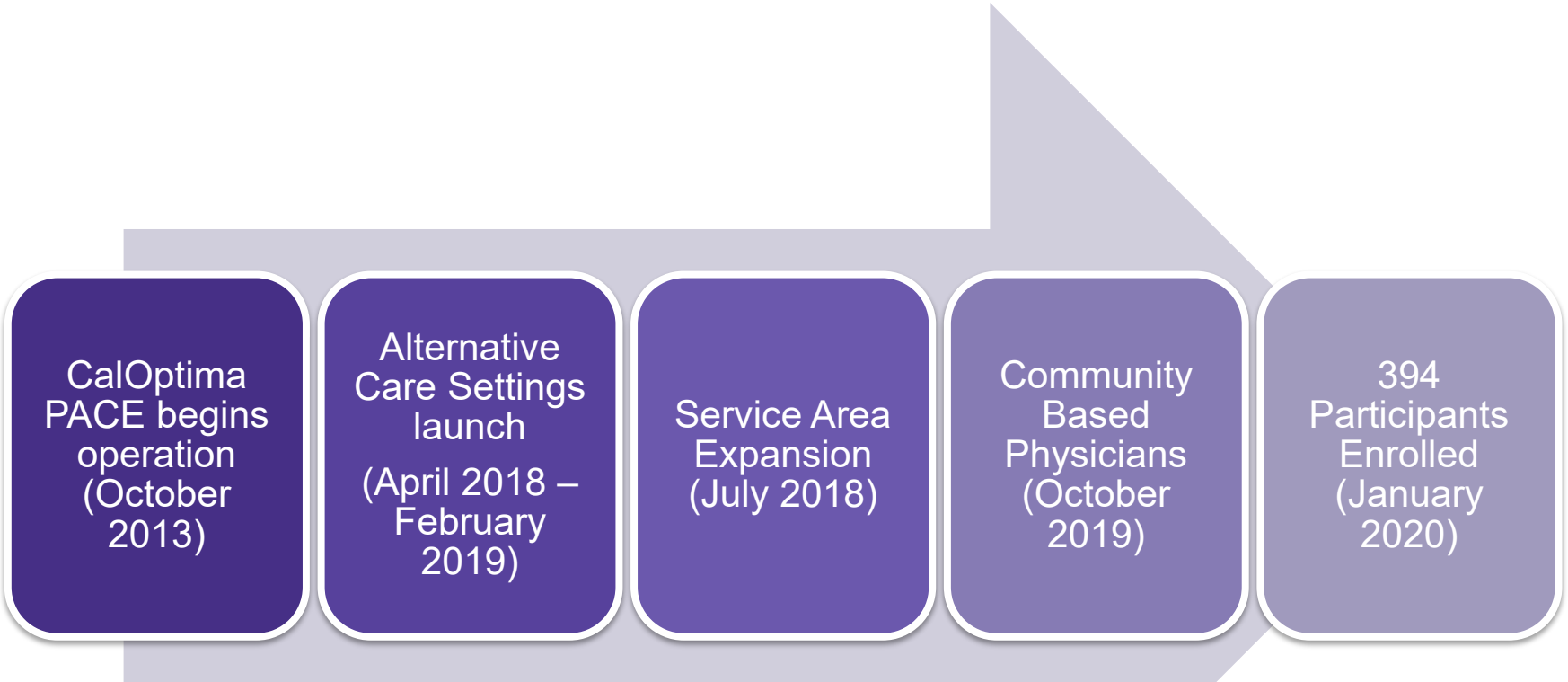
Background

- PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly
- Payor and provider of acute, chronic, and long-term care for nursing home certified seniors
- PACE prevents unnecessary institutionalization and maintains/improves the functional status of participants

PACE Milestones



Alternative Care Settings (ACS):
Acacia Adult Day Services (April 2018)
South County Adult Day Services (July 2018)
Meals on Wheels OC - Anaheim (October 2018)
Meals on Wheels OC - Santa Ana (October 2018)
Sultan ADHC (February 2019; Closed on short notice on January 17, 2020)

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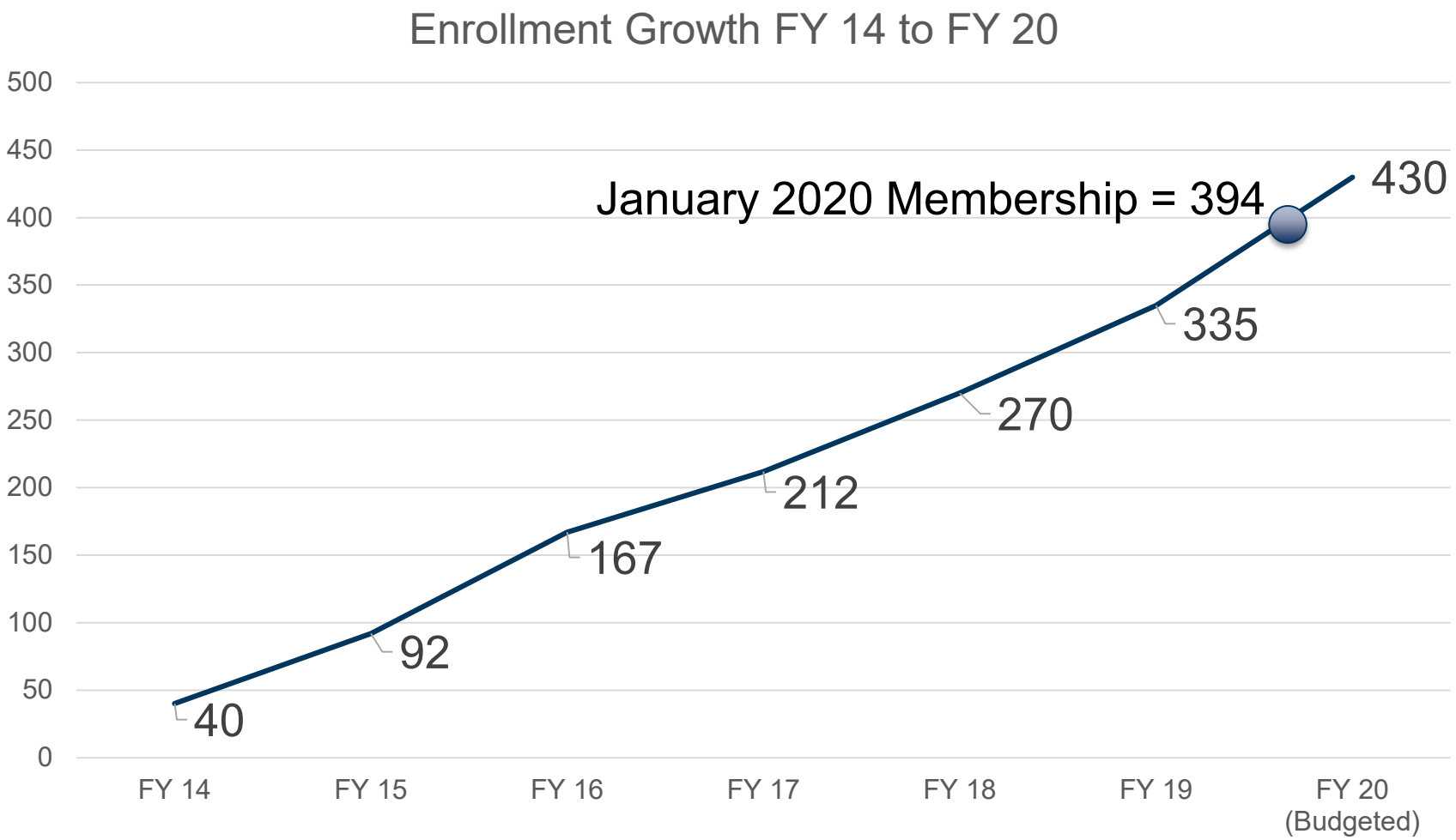
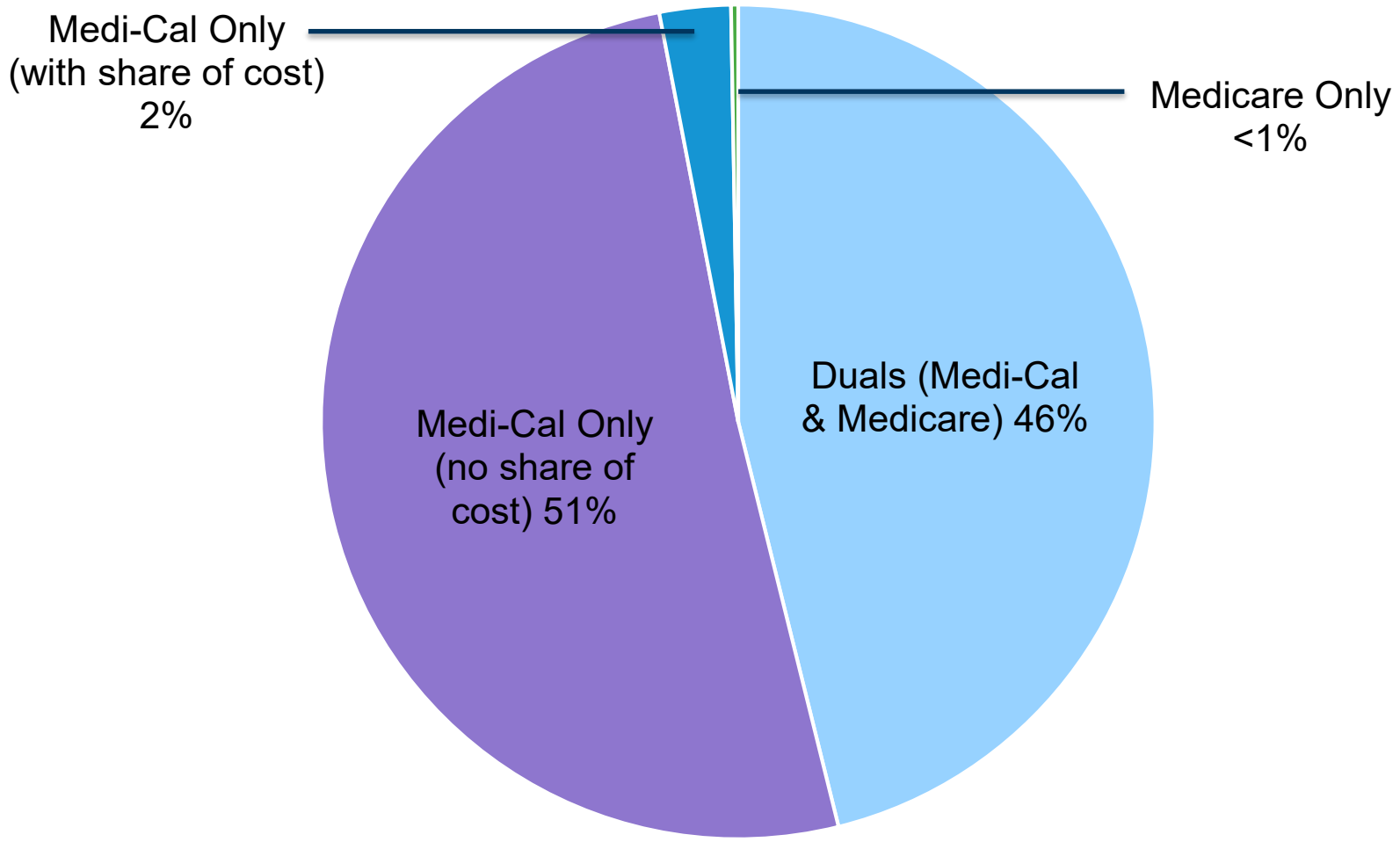
Enrollment



Note: Membership as of June of each fiscal year.

Enrollment by Payor Source



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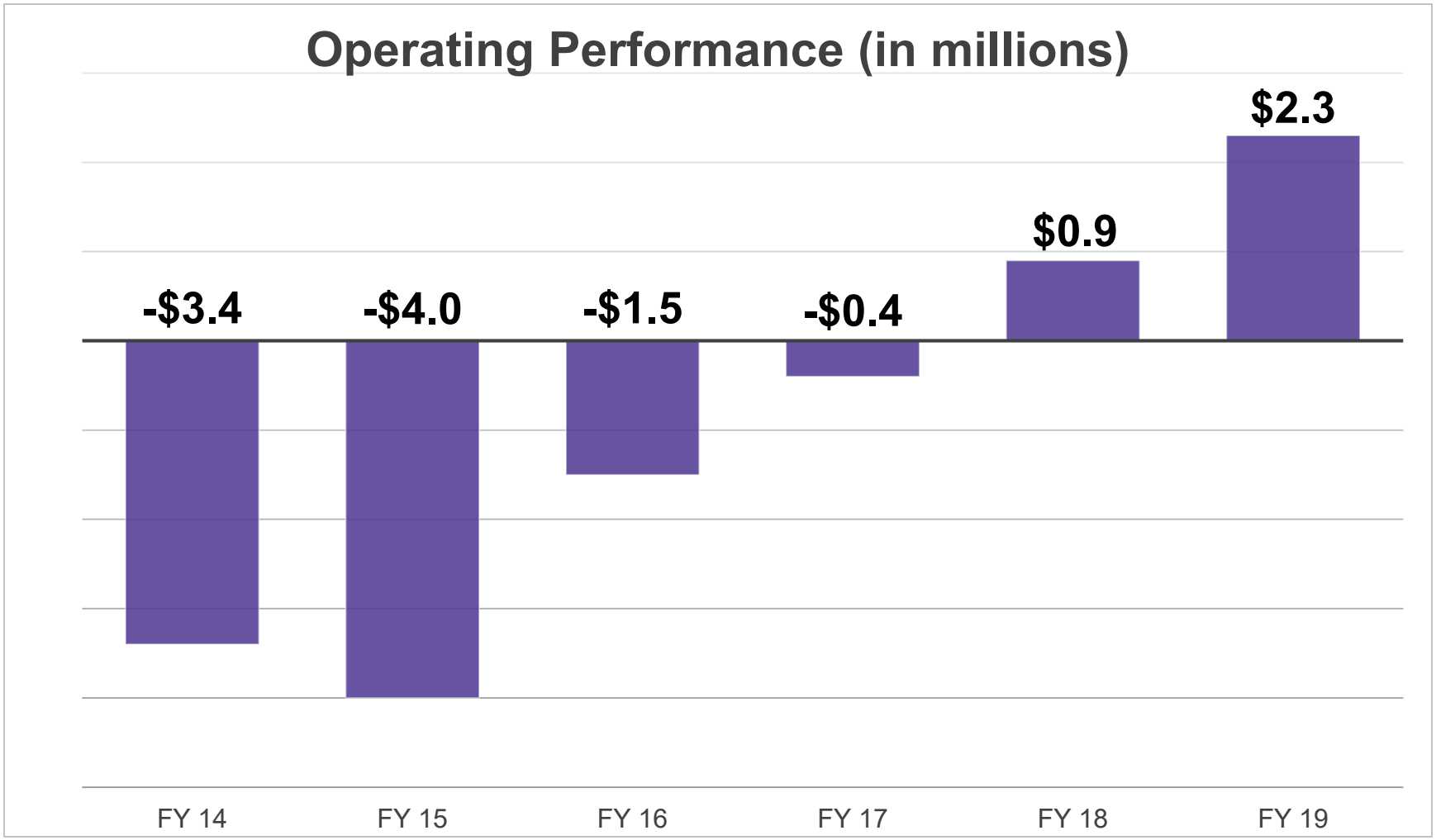
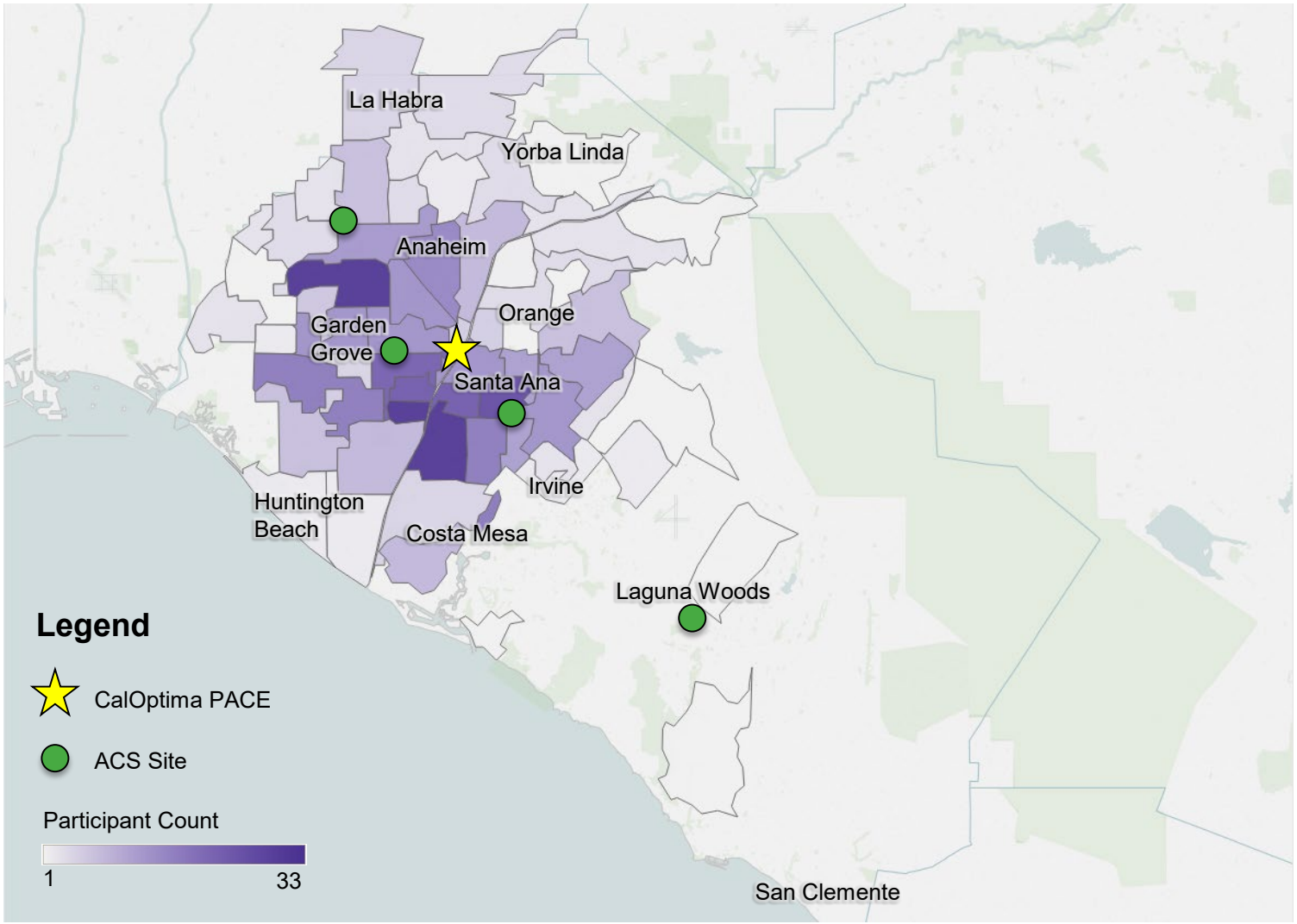
Financial Performance



PACE in Orange County



PACE in Orange County

- CalOptima PACE is the only PACE program operating in the County of Orange
- CalOptima submitted letters of support to DHCS for Innovate Integrated Health (IIH) and AltaMed to operate PACE programs independent of CalOptima (April 2019)
  - IIH and (now closed) Sultan ADHC share management
- Current DHCS listing of new and expansion applications does not include IIH or AltaMed as applicants in the County of Orange

PACE in Orange County

- CalOptima's Garden Grove PACE facility celebrated its 6th anniversary in October and there is much to celebrate.
- Capacity of facility being maximized assuming:
  - Extending hours of operation
  - Beginning Saturday services
  - Adding between 1-3 more Alternative Care Settings
  - Building on the community-based physician option
- Garden Grove facility projected to reach functional capacity in Quarter 3 of 2022
- Currently time to address capacity concerns
- When current Garden Grove facility fills, it will have been over 3 years since letters of support were provided for AltaMed and IIH
- Staff is continuing to track the approval progress with DHCS

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Financial Summary

November 2019

Board of Directors Meeting
February 6, 2020

Nancy Huang
Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

November 2019 MTD

Overall enrollment was 755,539 members

- Actual higher than budget 9,578 members or 1.3%
  - Medi-Cal favorable to budget 9,568 members or 1.3%
    - Medi-Cal Expansion (MCE) favorable variance of 522 members
    - Whole Child Model (WCM) unfavorable variance of 1,189 members
    - Seniors and Persons with Disabilities (SPD) favorable variance of 2,502 members
    - Temporary Assistance for Needy Families (TANF) favorable variance of 7,565
    - Long-Term Care (LTC) favorable variance of 168 members
  - OneCare Connect favorable to budget 10 members or 0.1%
  - OneCare unfavorable to budget 5 members or 0.3%
- 12,074 increase or 1.6% from October
    - Medi-Cal increase of 12,164 members
    - OneCare Connect decrease of 28 members
    - OneCare decrease of 69 members
    - PACE increase of 7 members

FY 2019-20: Consolidated Enrollment (cont.)

November 2019 YTD

Overall enrollment was 3,745,003 member months

- Actual lower than budget 1,908 members or 0.1%
  - Medi-Cal unfavorable to budget 2,137 members or 0.1%
    - MCE unfavorable variance of 11,225 members
    - WCM unfavorable variance of 5,465 members
    - SPD favorable variance of 5,576 members
    - TANF favorable variance of 8,711 members
    - LTC favorable variance of 266 members
  - OneCare Connect favorable to budget 14 members
  - OneCare favorable to budget 212 members or 2.8%
  - PACE favorable to budget 3 members or 0.2%

FY 2019-20: Consolidated Revenues

November 2019 MTD

- Actual higher than budget $7.1 million or 2.4%
  - ➢ Medi-Cal favorable to budget $6.6 million or 2.5%
    - Favorable volume variance of $3.5 million
    - Favorable price variance of $3.1 million
      - $3.0 million of fiscal year (FY) 2020 Department of Health Care Services (DHCS) year to date (YTD) acuity rate adjustment
      - $2.8 million of FY 2020 LTC revenue from non-LTC members
      - Offset by $3.3 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $0.3 million or 1.4%
    - Favorable volume variance of $16.8 thousand
    - Favorable price variance of $318.3 thousand

FY 2019-20: Consolidated Revenues (cont.)

November 2019 MTD (cont.)

- OneCare unfavorable to budget $40.3 thousand or 2.5%
  - Unfavorable volume variance of $5.4 thousand
  - Unfavorable price variance of $34.9 thousand
- PACE favorable to budget $210.4 thousand or 7.3%
  - Favorable volume variance of $38.8 thousand
  - Favorable price variance of $171.6 thousand

FY 2019-20: Consolidated Revenues (cont.)

November 2019 YTD

- Actual higher than budget $126.7 million or 8.5%
  - ➢ Medi-Cal favorable to budget $122.9 million 9.1%
    - Unfavorable volume variance of $0.8 million
    - Favorable price variance of $123.7 million
      - $104.3 million of directed payment (DP) revenue
      - $15.0 million due to DHCS acuity rate adjustment
      - $6.8 million of Coordinated Care Initiative (CCI) revenue
      - Offset by $15.9 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $2.9 million or 2.4%
    - Favorable volume variance of $23.6 thousand
    - Favorable price variance of $2.9 million

FY 2019-20: Consolidated Revenues (cont.)

November 2019 YTD (cont.)

- OneCare favorable to budget $697.4 thousand or 8.6%
  - Favorable volume variance of $230.3 thousand
  - Favorable price variance of $467.1 thousand
- PACE favorable to budget $189.7 thousand or 1.4%
  - Favorable volume variance of $23.3 thousand
  - Favorable price variance of $166.4 thousand

FY 2019-20: Consolidated Medical Expenses

November 2019 MTD

- Actual higher than budget $13.6 million or 4.9%
  - ➢ Medi-Cal unfavorable variance of $13.6 million or 5.4%
    - Unfavorable volume variance of $3.3 million
    - Unfavorable price variance of $10.3 million
      - Facilities expenses unfavorable variance of $10.1 million due to claims Incurred But Not Reported (IBNR)
  - ➢ OneCare Connect unfavorable variance of $14.4 thousand or 0.1%
    - Unfavorable volume variance of $16.3 thousand
    - Favorable price variance of $1.9 thousand

FY 2019-20: Consolidated Medical Expenses (cont.)

November 2019 YTD

- Actual higher than budget $143.4 million or 10.2%
  - ➢ Medi-Cal unfavorable variance of $141.4 million or 11.1%
    - Favorable volume variance of $0.7 million
    - Unfavorable price variance of $142.2 million
      - Reinsurance and Other Expense category unfavorable variance of $96.5 million due to $104.0 million of DP, offset by favorable variance in homeless health initiative
      - Professional Claims expenses unfavorable variance of $18.1 million
      - MLTSS expenses unfavorable variance of $12.2 million
      - Facilities expenses unfavorable variance of $17.5 million
  - ➢ OneCare Connect unfavorable variance of $2.6 million or 2.2%
    - Unfavorable volume variance of $23.1 thousand
    - Unfavorable price variance of $2.6 million

Medical Loss Ratio (MLR)

- November 2019 MTD: Actual: 96.4% Budget: 94.2%
- November 2019 YTD: Actual: 96.5% Budget: 95.0%

FY 2019-20: Consolidated Administrative Expenses

November 2019 MTD

- Actual lower than budget $1.2 million or 9.6%
  - Salaries, wages and benefits: favorable variance of $0.1 million
  - Other categories: favorable variance of $1.0 million

November 2019 YTD

- Actual lower than budget $9.1 million or 14.1%
  - Salaries, wages and benefits: favorable variance of $4.3 million
  - Other categories: favorable variance of $4.9 million

Administrative Loss Ratio (ALR)

- November 2019 MTD: Actual: 3.6% Budget: 4.1%
- November 2019 YTD: Actual: 3.4% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% YTD

FY 2019-20: Change in Net Assets

November 2019 MTD

- $1.3 million change in net assets
- $5.0 million unfavorable to budget
  - Higher than budgeted revenue of $7.1 million
  - Higher than budgeted medical expenses of $13.6 million
  - Lower than budgeted administrative expenses of $1.2 million
  - Higher than budgeted investment and other income of $0.3 million

November 2019 YTD

- $16.4 million change in net assets
- $0.9 million favorable to budget
  - Higher than budgeted revenue of $126.7 million
  - Higher than budgeted medical expenses of $143.4 million
  - Lower than budgeted administrative expenses of $9.1 million
  - Higher than budgeted investment and other income of $8.5 million

Enrollment Summary: November 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
66,470	65,714	756	1.2%	Aged	327,902	327,256	646	0.2%
545	615	(70)	(11.4%)	BCCTP	2,727	3,075	(348)	(11.3%)
45,542	43,726	1,816	4.2%	Disabled	224,258	218,980	5,278	2.4%
287,130	282,069	5,061	1.8%	TANF Child	1,429,118	1,424,158	4,960	0.3%
88,675	86,171	2,504	2.9%	TANF Adult	439,438	435,687	3,751	0.9%
3,572	3,404	168	4.9%	LTC	17,286	17,020	266	1.6%
235,916	235,394	522	0.2%	MCE	1,164,865	1,176,090	(11,225)	(1.0%)
11,751	12,940	(1,189)	(9.2%)	WCM	59,235	64,700	(5,465)	(8.4%)
739,601	**730,033**	**9,568**	**1.3%**	**Medi-Cal**	**3,664,829**	**3,666,966**	**(2,137)**	**(0.1%)**
14,065	**14,055**	**10**	**0.1%**	**OneCare Connect**	**70,691**	**70,677**	**14**	**0.0%**
1,498	**1,503**	**(5)**	**(0.3%)**	**OneCare**	**7,704**	**7,492**	**212**	**2.8%**
375	**370**	**5**	**1.4%**	**PACE**	**1,779**	**1,776**	**3**	**0.2%**
755,539	**745,961**	**9,578**	**1.3%**	**CalOptima Total**	**3,745,003**	**3,746,911**	**(1,908)**	**(0.1%)**

Financial Highlights: November 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
755,539	745,961	9,578	1.3%	Member Months	3,745,003	3,746,911	(1,908)	-0.1%
303,891,806	296,774,801	7,117,005	2.4%	Revenues	1,613,344,704	1,486,671,484	126,673,220	8.5%
293,046,697	279,471,749	(13,574,948)	-4.9%	Medical Expenses	1,556,088,581	1,412,664,307	(143,424,274)	-10.2%
11,035,135	12,209,263	1,174,128	9.6%	Administrative Expenses	55,649,233	64,791,847	9,142,614	14.1%
(190,026)	**5,093,789**	**(5,283,815)**	**-103.7%**	**Operating Margin**	**1,606,890**	**9,215,330**	**(7,608,440)**	**-82.6%**
1,506,949	1,250,000	256,949	20.6%	Non Operating Income (Loss)	14,791,800	6,250,000	8,541,800	136.7%
1,316,923	**6,343,789**	**(5,026,866)**	**-79.2%**	**Change in Net Assets**	**16,398,690**	**15,465,330**	**933,360**	**6.0%**
96.4%	94.2%	-2.3%		Medical Loss Ratio	96.5%	95.0%	-1.4%	
3.6%	4.1%	0.5%		Administrative Loss Ratio	3.4%	4.4%	0.9%	
-0.1%	1.7%	-1.8%		Operating Margin Ratio	0.1%	0.6%	-0.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per Department of Healthcare Services instructions

Consolidated Performance Actual vs. Budget: November 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.0)	6.0	(6.0)	Medi-Cal	5.2	16.0	(10.7)
(0.6)	(1.1)	0.6	OCC	(5.3)	(6.9)	1.6
0.0	(0.1)	0.1	OneCare	0.8	(0.6)	1.4
0.4	0.3	0.1	PACE	0.9	0.7	0.1
(0.2)	**5.1**	**(5.3)**	**Operating**	**1.6**	**9.2**	**(7.6)**
1.5	1.3	0.3	Inv./Rental Inc, MCO tax	14.8	6.3	8.5
1.5	**1.3**	**0.3**	**Non-Operating**	**14.8**	**6.3**	**8.5**
1.3	**6.3**	**(5.0)**	**TOTAL**	**16.4**	**15.5**	**0.9**

Consolidated Revenue & Expense: November 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	491,934	235,916	11,751	739,601	14,065	1,498	375	755,539
REVENUES								
Capitation Revenue	145,240,253	$ 106,968,328	$ 23,055,078	$ 275,263,660	$ 23,964,600	$ 1,579,623	$ 3,083,924	$ 303,891,806
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	145,240,253	106,968,328	23,055,078	275,263,660	23,964,600	1,579,623	3,083,924	303,891,806
MEDICAL EXPENSES								
Provider Capitation	38,389,739	44,529,292	8,415,082	91,334,114	10,514,674	467,378		102,316,166
Facilities	30,356,443	23,324,620	4,758,128	58,439,191	3,844,912	405,449	629,626	63,319,178
Ancillary	-	-	-	-	561,484	62,654	-	624,138
Professional Claims	17,749,716	7,719,070	1,918,925	27,387,711	-	-	633,485	28,021,196
Prescription Drugs	14,405,454	22,082,169	5,625,863	42,113,487	5,450,006	451,124	229,342	48,243,959
MLTSS	34,355,385	2,584,913	3,206,243	40,146,541	1,260,375	20,747	40,767	41,468,430
Medical Management	1,976,560	1,199,442	248,676	3,424,679	958,486	32,872	694,054	5,110,091
Quality Incentives	829,329	462,075	141,236	1,432,639	210,620		4,688	1,647,947
Reinsurance & Other	912,450	845,219	59,194	1,816,863	197,807		280,923	2,295,593
Total Medical Expenses	138,975,077	102,746,801	24,373,348	266,095,225	22,998,363	1,440,223	2,512,885	293,046,697
Medical Loss Ratio	95.7%	96.1%	105.7%	96.7%	96.0%	91.2%	81.5%	96.4%
GROSS MARGIN	**6,265,176**	**4,221,528**	**(1,318,269)**	**9,168,435**	**966,237**	**139,399**	**571,039**	**10,845,109**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,292,660	713,908	71,598	149,313	7,227,479
Professional fees				284,410	11,963	15,000	123	311,496
Purchased services				770,655	133,133	12,289	(381)	915,695
Printing & Postage				354,374	123,566	4,163	9,594	491,697
Depreciation & Amortization				330,613			2,087	332,700
Other expenses				1,384,981	32,470	426	3,627	1,421,504
Indirect cost allocation & Occupancy				(224,635)	519,792	35,589	3,818	334,565
Total Administrative Expenses				9,193,058	1,534,831	139,065	168,181	11,035,135
Admin Loss Ratio				3.3%	6.4%	8.8%	5.5%	3.6%
INCOME (LOSS) FROM OPERATIONS				(24,623)	(568,595)	334	402,858	(190,026)
INVESTMENT INCOME								1,505,220
NET RENTAL INCOME								(1)
TOTAL MCO TAX								-
TOTAL GRANT INCOME				1,687				1,687
QAF/IGT								-
OTHER INCOME				43				43
CHANGE IN NET ASSETS				**$ (22,893)**	**$ (568,595)**	**$ 334**	**$ 402,858**	**$ 1,316,924**
BUDGETED CHANGE IN NET ASSETS				6,025,348	(1,118,964)	(97,337)	284,742	6,343,789
VARIANCE TO BUDGET - FAV (UNFAV)				$ (6,048,242)	$ 550,369	$ 97,671	$ 118,116	$ (5,026,866)

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Consolidated Revenue & Expense: November 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,440,729	1,164,865	59,235	3,664,829	70,691	7,704	1,779	3,745,003
REVENUES								
Capitation Revenue	780,167,507	$ 571,804,960	$ 116,636,098	$ 1,468,608,565	$ 121,900,087	$ 8,836,215	$ 13,999,836	$ 1,613,344,704
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	780,167,507	571,804,960	116,636,098	1,468,608,565	121,900,087	8,836,215	13,999,836	1,613,344,704
MEDICAL EXPENSES								
Provider Capitation	195,249,196	225,311,491	49,397,460	469,958,146	55,218,590	2,381,773		527,558,510
Facilities	131,385,014	109,472,492	17,560,517	258,418,023	18,549,468	1,915,924	3,482,362	282,365,776
Ancillary	-	-	-	-	3,326,021	241,105	-	3,567,125
Professional Claims	91,535,076	35,858,448	5,908,077	133,301,601	-	-	2,832,781	136,134,382
Prescription Drugs	85,284,171	107,610,817	27,691,705	220,586,693	28,321,586	2,576,275	1,120,004	252,604,557
MLTSS	174,408,991	13,621,668	9,183,658	197,214,317	6,831,795	59,993	175,073	204,281,177
Medical Management	10,702,412	5,996,453	1,291,673	17,990,538	5,116,885	179,895	3,447,824	26,735,142
Quality Incentives	4,201,852	2,345,857	707,610	7,255,319	1,022,675		22,599	8,300,593
Reinsurance & Other	64,678,933	47,594,116	160,258	112,433,307	951,413		1,156,598	114,541,318
Total Medical Expenses	757,445,645	547,811,341	111,900,959	1,417,157,944	119,338,432	7,354,964	12,237,241	1,556,088,581
Medical Loss Ratio	97.1%	95.8%	95.9%	96.5%	97.9%	83.2%	87.4%	96.5%
GROSS MARGIN	**22,721,862**	**23,993,620**	**4,735,139**	**51,450,621**	**2,561,655**	**1,481,251**	**1,762,596**	**57,256,123**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				31,741,856	3,543,407	298,821	711,058	36,295,141
Professional fees				966,602	444,486	114,371	1,013	1,526,472
Purchased services				3,760,561	841,999	78,805	45,784	4,727,148
Printing & Postage				1,380,274	297,270	20,651	54,204	1,752,399
Depreciation & Amortization				1,861,769			10,455	1,872,224
Other expenses				7,483,525	76,207	1,427	18,666	7,579,824
Indirect cost allocation & Occupancy				(990,404)	2,657,716	191,216	37,496	1,896,024
Total Administrative Expenses				46,204,182	7,861,086	705,291	878,674	55,649,233
Admin Loss Ratio				3.1%	6.4%	8.0%	6.3%	3.4%
INCOME (LOSS) FROM OPERATIONS				5,246,439	(5,299,431)	775,960	883,921	1,606,890
INVESTMENT INCOME								14,798,702
NET RENTAL INCOME								(0)
TOTAL MCO TAX								-
TOTAL GRANT INCOME				(7,079)				(7,079)
QAF/IGT								-
OTHER INCOME				177				177
CHANGE IN NET ASSETS				**$ 5,239,538**	**$ (5,299,431)**	**$ 775,960**	**$ 883,921**	**$ 16,398,690**
BUDGETED CHANGE IN NET ASSETS				15,973,419	(6,888,554)	(607,203)	737,668	15,465,330
VARIANCE TO BUDGET - FAV (UNFAV)				$ (10,733,881)	$ 1,589,123	$ 1,383,163	$ 146,253	$ 933,360

Balance Sheet:
As of November 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$516,875,446	Accounts Payable	$5,671,058
Investments	480,312,226	Medical Claims liability	762,212,657
Capitation receivable	291,253,021	Accrued Payroll Liabilities	10,671,064
Receivables - Other	28,231,556	Deferred Revenue	61,175,372
Prepaid expenses	5,962,576	Deferred Lease Obligations	12,718
		Capitation and Withholds	158,544,500
Total Current Assets	**1,322,634,825**	**Total Current Liabilities**	**998,287,369**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,376,533		
505 City Parkway West	50,489,717		
	97,952,615		
Less: accumulated depreciation	(49,431,106)		
Capital assets, net	48,521,509	Other (than pensions) post employment benefits liability	25,334,747
Other Assets		Net Pension Liabilities	23,621,483
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,047,243,600**
Cash and Cash Equivalents	5,636,128		
Long-term Investments	560,210,171	**Deferred Inflows**	
Total Board-designated Assets	565,846,299	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	624,345,212	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**1,995,501,545**	TNE	93,903,325
		Funds in Excess of TNE	858,038,235
Deferred Outflows		**TOTAL NET POSITION**	951,941,560
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	**2,006,591,994**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,006,591,994**

Board Designated Reserve and TNE Analysis
As of November 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	155,127,701				
	Tier 1 - Logan Circle	153,938,061				
	Tier 1 - Wells Capital	154,353,406				
Board-designated Reserve		463,419,168	313,333,389	487,863,410	150,085,779	(24,444,242)
TNE Requirement	Tier 2 - Logan Circle	102,427,130	93,903,325	93,903,325	8,523,806	8,523,806
	Consolidated:	**565,846,298**	**407,236,714**	**581,766,734**	**158,609,584**	**(15,920,436)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

November 2019

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CalOptima - Consolidated
Financial Highlights
For the Five Months Ended November 30, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
755,539	745,961	9,578	1.3%	Member Months	3,745,003	3,746,911	(1,908)	-0.1%
303,891,806	296,774,801	7,117,005	2.4%	Revenues	1,613,344,704	1,486,671,484	126,673,220	8.5%
293,046,697	279,471,749	(13,574,948)	-4.9%	Medical Expenses	1,556,088,581	1,412,664,307	(143,424,274)	-10.2%
11,035,135	12,209,263	1,174,128	9.6%	Administrative Expenses	55,649,233	64,791,847	9,142,614	14.1%
(190,026)	**5,093,789**	**(5,283,815)**	**-103.7%**	**Operating Margin**	**1,606,890**	**9,215,330**	**(7,608,440)**	**-82.6%**
1,506,949	1,250,000	256,949	20.6%	Non Operating Income (Loss)	14,791,800	6,250,000	8,541,800	136.7%
1,316,923	**6,343,789**	**(5,026,866)**	**-79.2%**	**Change in Net Assets**	**16,398,690**	**15,465,330**	**933,360**	**6.0%**
96.4%	94.2%	-2.3%		Medical Loss Ratio	96.5%	95.0%	-1.4%	
3.6%	4.1%	0.5%		Administrative Loss Ratio	3.4%	4.4%	0.9%	
-0.1%	1.7%	-1.8%		Operating Margin Ratio	0.1%	0.6%	-0.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Five Months Ended November 30, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	739,601	730,033	9,568	1 3%
OneCare Connect	14,065	14,055	10	0 1%
OneCare	1,498	1,503	(5)	(0 3%)
PACE	375	370	5	1 4%
Total	755,539	745,961	9,578	1 3%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (23)	$ 6,025	$ (6,048)	(100 4%)
OneCare Connect	(569)	(1,119)	550	49 2%
OneCare	-	(97)	97	100 0%
PACE	403	285	118	41 4%
505 Bldg	-	-	-	0 0%
Investment Income & Other	1,505	1,250	255	20 4%
Total	$ 1,316	$ 6,344	$ (5,028)	(79 3%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 7%	94 0%	(2 7)
OneCare Connect	96 0%	97 3%	1 3
OneCare	91 2%	97 2%	6 1

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,193	$ 10,134	$ 941	9 3%
OneCare Connect	1,535	1,765	230	13 0%
OneCare	139	142	3	2 1%
PACE	168	169	1	0 3%
Total	$ 11,035	$ 12,209	$ 1,174	9 6%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,001	1,183	182
OneCare Connect	177	210	33
OneCare	10	9	(1)
PACE	71	93	21
Total	1,260	1,495	235

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	739	617	122
OneCare Connect	79	67	12
OneCare	145	162	(17)
PACE	5	4	1
Total	969	850	119

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,664,829	3,666,966	(2,137)	(0 1%)
OneCare Connect	70,691	70,676	15	0 0%
OneCare	7,704	7,492	212	2 8%
PACE	1,779	1,776	3	0 2%
Total	3,745,003	3,746,910	(1,907)	(0 1%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 5,240	$ 15,973	$ (10,733)	(67 2%)
OneCare Connect	(5,299)	(6,889)	1,590	23 1%
OneCare	776	(607)	1,383	227 8%
PACE	884	738	146	19 8%
505 Bldg	-	-	-	0 0%
Investment Income & Other	14,799	6,250	8,549	136 8%
Total	$ 16,400	$ 15,465	$ 935	6 0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 5%	94 8%	(1 7)
OneCare Connect	97 9%	98 1%	0 2
OneCare	83 2%	98 4%	15 2

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 46,204	$ 54,019	$ 7,815	14 5%
OneCare Connect	7,861	9,124	1,263	13 8%
OneCare	705	736	30	4 1%
PACE	879	913	34	3 8%
Total	$ 55,649	$ 64,792	$ 9,143	14 1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	4,790	5,765	975
OneCare Connect	895	1,009	113
OneCare	40	47	6
PACE	355	459	103
Total	6,080	7,279	1,198

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	765	636	129
OneCare Connect	79	70	9
OneCare	191	161	30
PACE	5	4	1
Total	1,041	871	169

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended November 30, 2019

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	755,539		745,961		9,578	
REVENUE						
Medi-Cal	$ 275,263,660	$ 372 18	$ 268,651,866	$ 368 00	$ 6,611,794	$ 4 18
OneCare Connect	23,964,600	1,703 85	23,629,470	1,681 21	335,130	22 64
OneCare	1,579,623	1,054 49	1,619,938	1,077 80	(40,315)	(23 31)
PACE	3,083,924	8,223 80	2,873,527	7,766 29	210,397	457 51
Total Operating Revenue	303,891,806	402 22	296,774,801	397 84	7,117,005	4 38
MEDICAL EXPENSES						
Medi-Cal	266,095,225	359 78	252,492,580	345 86	(13,602,645)	(13 92)
OneCare Connect	22,998,363	1,635 15	22,983,918	1,635 28	(14,445)	0 13
OneCare	1,440,223	961 43	1,575,160	1,048 01	134,937	86 58
PACE	2,512,885	6,701 03	2,420,091	6,540 79	(92,794)	(160 24)
Total Medical Expenses	293,046,697	387 86	279,471,749	374 65	(13,574,948)	(13 21)
GROSS MARGIN	10,845,109	14 36	17,303,052	23 19	(6,457,943)	(8 83)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,227,479	9 57	7,359,644	9 87	132,165	0 30
Professional fees	311,496	0 41	473,968	0 64	162,472	0 23
Purchased services	915,695	1 21	1,233,276	1 65	317,581	0 44
Printing & Postage	491,697	0 65	573,630	0 77	81,933	0 12
Depreciation & Amortization	332,700	0 44	457,866	0 61	125,166	0 17
Other expenses	1,421,504	1 88	1,728,179	2 32	306,675	0 44
Indirect cost allocation & Occupancy expense	334,565	0 44	382,700	0 51	48,135	0 07
Total Administrative Expenses	11,035,135	14 61	12,209,263	16 37	1,174,128	1 76
INCOME (LOSS) FROM OPERATIONS	(190,026)	(0 25)	5,093,789	6 83	(5,283,815)	(7 08)
INVESTMENT INCOME						
Interest income	2,608,596	3 45	1,250,000	1 68	1,358,596	1 77
Realized gain/(loss) on investments	130,410	0 17	-	-	130,410	0 17
Unrealized gain/(loss) on investments	(1,233,785)	(1 63)	-	-	(1,233,785)	(1 63)
Total Investment Income	1,505,220	1 99	1,250,000	1 68	255,220	0 31
NET RENTAL INCOME	(1)	-	-	-	(1)	-
TOTAL MCO TAX	-	-	-	-	-	-
TOTAL GRANT INCOME	1,687	-	-	-	1,687	-
QAF/IGT	-	-	-	-	-	-
OTHER INCOME	43	-	-	-	43	-
CHANGE IN NET ASSETS	**1,316,924**	**1.74**	**6,343,789**	**8.50**	**(5,026,866)**	**(6.76)**
MEDICAL LOSS RATIO	**96.4%**		**94.2%**		**-2.3%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.1%**		**0.5%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2019

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	3,745,003		3,746,911		(1,908)	
REVENUE						
Medi-Cal	$ 1,468,608,565	$ 400 73	$ 1,345,728,498	$ 366 99	$ 122,880,067	$ 33 74
OneCare Connect	121,900,087	1,724 41	118,994,053	1,683 66	2,906,034	40 75
OneCare	8,836,215	1,146 96	8,138,812	1,086 33	697,403	60 63
PACE	13,999,836	7,869 50	13,810,121	7,775 97	189,715	93 53
Total Operating Revenue	1,613,344,704	430 80	1,486,671,484	396 77	126,673,220	34 03
MEDICAL EXPENSES						
Medi-Cal	1,417,157,944	386 69	1,275,735,851	347 90	(141,422,093)	(38 79)
OneCare Connect	119,338,432	1,688 17	116,758,830	1,652 03	(2,579,602)	(36 14)
OneCare	7,354,964	954 69	8,010,346	1,069 19	655,382	114 50
PACE	12,237,241	6,878 72	12,159,280	6,846 44	(77,961)	(32 28)
Total Medical Expenses	1,556,088,581	415 51	1,412,664,307	377 02	(143,424,274)	(38 49)
GROSS MARGIN	57,256,123	15 29	74,007,177	19 75	(16,751,054)	(4 46)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	36,295,141	9 69	40,577,433	10 83	4,282,292	1 14
Professional fees	1,526,472	0 41	2,346,257	0 63	819,785	0 22
Purchased services	4,727,148	1 26	6,166,380	1 65	1,439,232	0 39
Printing & Postage	1,752,399	0 47	2,836,493	0 76	1,084,094	0 29
Depreciation & Amortization	1,872,224	0 50	2,289,330	0 61	417,106	0 11
Other expenses	7,579,824	2 02	8,651,660	2 31	1,071,836	0 29
Indirect cost allocation & Occupancy expense	1,896,024	0 51	1,924,294	0 51	28,270	-
Total Administrative Expenses	55,649,233	14 86	64,791,847	17 29	9,142,614	2 43
INCOME (LOSS) FROM OPERATIONS	1,606,890	0 43	9,215,330	2 46	(7,608,440)	(2 03)
INVESTMENT INCOME						
Interest income	14,358,803	3 83	6,250,000	1 67	8,108,803	2 16
Realized gain/(loss) on investments	1,052,085	0 28	-	-	1,052,085	0 28
Unrealized gain/(loss) on investments	(612,186)	(0 16)	-	-	(612,186)	(0 16)
Total Investment Income	14,798,702	3 95	6,250,000	1 67	8,548,702	2 28
NET RENTAL INCOME	(0)	-	-	-	(0)	-
TOTAL MCO TAX	-	-	-	-	-	-
TOTAL GRANT INCOME	(7,079)	-	-	-	(7,079)	-
QAF/IGT	-	-	-	-	-	-
OTHER INCOME	177	-	-	-	177	-
CHANGE IN NET ASSETS	**16,398,690**	**4.38**	**15,465,330**	**4.13**	**933,360**	**0.25**
MEDICAL LOSS RATIO	**96.5%**		**95.0%**		**-1.4%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.4%**		**0.9%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended November 30, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	491,934	235,916	11,751	739,601	14,065	1,498	375	755,539
REVENUES								
Capitation Revenue	145,240,253	$ 106,968,328	$ 23,055,078	$ 275,263,660	$ 23,964,600	$ 1,579,623	$ 3,083,924	$ 303,891,806
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	145,240,253	106,968,328	23,055,078	275,263,660	23,964,600	1,579,623	3,083,924	303,891,806
MEDICAL EXPENSES								
Provider Capitation	38,389,739	44,529,292	8,415,082	91,334,114	10,514,674	467,378		102,316,166
Facilities	30,356,443	23,324,620	4,758,128	58,439,191	3,844,912	405,449	629,626	63,319,178
Ancillary	-	-	-	-	561,484	62,654	-	624,138
Professional Claims	17,749,716	7,719,070	1,918,925	27,387,711	-	-	633,485	28,021,196
Prescription Drugs	14,405,454	22,082,169	5,625,863	42,113,487	5,450,006	451,124	229,342	48,243,959
MLTSS	34,355,385	2,584,913	3,206,243	40,146,541	1,260,375	20,747	40,767	41,468,430
Medical Management	1,976,560	1,199,442	248,676	3,424,679	958,486	32,872	694,054	5,110,091
Quality Incentives	829,329	462,075	141,236	1,432,639	210,620		4,688	1,647,947
Reinsurance & Other	912,450	845,219	59,194	1,816,863	197,807		280,923	2,295,593
Total Medical Expenses	138,975,077	102,746,801	24,373,348	266,095,225	22,998,363	1,440,223	2,512,885	293,046,697
Medical Loss Ratio	95 7%	96 1%	105 7%	96 7%	96 0%	91 2%	81 5%	96 4%
GROSS MARGIN	**6,265,176**	**4,221,528**	**(1,318,269)**	**9,168,435**	**966,237**	**139,399**	**571,039**	**10,845,109**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,292,660	713,908	71,598	149,313	7,227,479
Professional fees				284,410	11,963	15,000	123	311,496
Purchased services				770,655	133,133	12,289	(381)	915,695
Printing & Postage				354,374	123,566	4,163	9,594	491,697
Depreciation & Amortization				330,613			2,087	332,700
Other expenses				1,384,981	32,470	426	3,627	1,421,504
Indirect cost allocation & Occupancy				(224,635)	519,792	35,589	3,818	334,565
Total Administrative Expenses				9,193,058	1,534,831	139,065	168,181	11,035,135
Admin Loss Ratio				3 3%	6 4%	8 8%	5 5%	3 6%
INCOME (LOSS) FROM OPERATIONS				(24,623)	(568,595)	334	402,858	(190,026)
INVESTMENT INCOME								1,505,220
NET RENTAL INCOME								(1)
TOTAL MCO TAX								-
TOTAL GRANT INCOME				1,687				1,687
QAF/IGT								-
OTHER INCOME				43				43
CHANGE IN NET ASSETS				**$ (22,893)**	**$ (568,595)**	**$ 334**	**$ 402,858**	**$ 1,316,924**
BUDGETED CHANGE IN NET ASSETS				6,025,348	(1,118,964)	(97,337)	284,742	6,343,789
VARIANCE TO BUDGET - FAV (UNFAV)				$ (6,048,242)	$ 550,369	$ 97,671	$ 118,116	$ (5,026,866)

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Five Months Ended November 30, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,440,729	1,164,865	59,235	3,664,829	70,691	7,704	1,779	3,745,003
REVENUES								
Capitation Revenue	780,167,507	$ 571,804,960	$ 116,636,098	$ 1,468,608,565	$ 121,900,087	$ 8,836,215	$ 13,999,836	$ 1,613,344,704
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	780,167,507	571,804,960	116,636,098	1,468,608,565	121,900,087	8,836,215	13,999,836	1,613,344,704
MEDICAL EXPENSES								
Provider Capitation	195,249,196	225,311,491	49,397,460	469,958,146	55,218,590	2,381,773		527,558,510
Facilities	131,385,014	109,472,492	17,560,517	258,418,023	18,549,468	1,915,924	3,482,362	282,365,776
Ancillary	-	-	-	-	3,326,021	241,105	-	3,567,125
Professional Claims	91,535,076	35,858,448	5,908,077	133,301,601	-	-	2,832,781	136,134,382
Prescription Drugs	85,284,171	107,610,817	27,691,705	220,586,693	28,321,586	2,576,275	1,120,004	252,604,557
MLTSS	174,408,991	13,621,668	9,183,658	197,214,317	6,831,795	59,993	175,073	204,281,177
Medical Management	10,702,412	5,996,453	1,291,673	17,990,538	5,116,885	179,895	3,447,824	26,735,142
Quality Incentives	4,201,852	2,345,857	707,610	7,255,319	1,022,675		22,599	8,300,593
Reinsurance & Other	64,678,933	47,594,116	160,258	112,433,307	951,413		1,156,598	114,541,318
Total Medical Expenses	757,445,645	547,811,341	111,900,959	1,417,157,944	119,338,432	7,354,964	12,237,241	1,556,088,581
Medical Loss Ratio	97 1%	95 8%	95 9%	96 5%	97 9%	83 2%	87 4%	96 5%
GROSS MARGIN	**22,721,862**	**23,993,620**	**4,735,139**	**51,450,621**	**2,561,655**	**1,481,251**	**1,762,596**	**57,256,123**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				31,741,856	3,543,407	298,821	711,058	36,295,141
Professional fees				966,602	444,486	114,371	1,013	1,526,472
Purchased services				3,760,561	841,999	78,805	45,784	4,727,148
Printing & Postage				1,380,274	297,270	20,651	54,204	1,752,399
Depreciation & Amortization				1,861,769			10,455	1,872,224
Other expenses				7,483,525	76,207	1,427	18,666	7,579,824
Indirect cost allocation & Occupancy				(990,404)	2,657,716	191,216	37,496	1,896,024
Total Administrative Expenses				46,204,182	7,861,086	705,291	878,674	55,649,233
Admin Loss Ratio				3 1%	6 4%	8 0%	6 3%	3 4%
INCOME (LOSS) FROM OPERATIONS				5,246,439	(5,299,431)	775,960	883,921	1,606,890
INVESTMENT INCOME								14,798,702
NET RENTAL INCOME								(0)
TOTAL MCO TAX								-
TOTAL GRANT INCOME				(7,079)				(7,079)
QAF/IGT								-
OTHER INCOME				177				177
CHANGE IN NET ASSETS				**$ 5,239,538**	**$ (5,299,431)**	**$ 775,960**	**$ 883,921**	**$ 16,398,690**
BUDGETED CHANGE IN NET ASSETS				15,973,419	(6,888,554)	(607,203)	737,668	15,465,330
VARIANCE TO BUDGET - FAV (UNFAV)				$ (10,733,881)	$ 1,589,123	$ 1,383,163	$ 146,253	$ 933,360

November 30, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $1.3 million, $5.0 million unfavorable to budget
- Operating deficit is $0.2 million, with a surplus in non-operating income of $1.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $16.4 million, $0.9 million favorable to budget
- Operating surplus is $1.6 million, with a surplus in non-operating income of $14.8 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.0)	6.0	(6.0)	Medi-Cal	5.2	16.0	(10.7)
(0.6)	(1.1)	0.6	OCC	(5.3)	(6.9)	1.6
0.0	(0.1)	0.1	OneCare	0.8	(0.6)	1.4
0.4	0.3	0.1	PACE	0.9	0.7	0.1
(0.2)	**5.1**	**(5.3)**	**Operating**	**1.6**	**9.2**	**(7.6)**
1.5	1.3	0.3	Inv./Rental Inc, MCO tax	14.8	6.3	8.5
1.5	**1.3**	**0.3**	**Non-Operating**	**14.8**	**6.3**	**8.5**
1.3	**6.3**	**(5.0)**	**TOTAL**	**16.4**	**15.5**	**0.9**

CalOptima - Consolidated
Enrollment Summary
For the Five Months Ended November 30, 2019

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
66,470	65,714	756	1.2%	Aged	327,902	327,256	646	0.2%
545	615	(70)	(11.4%)	BCCTP	2,727	3,075	(348)	(11.3%)
45,542	43,726	1,816	4.2%	Disabled	224,258	218,980	5,278	2.4%
287,130	282,069	5,061	1.8%	TANF Child	1,429,118	1,424,158	4,960	0.3%
88,675	86,171	2,504	2.9%	TANF Adult	439,438	435,687	3,751	0.9%
3,572	3,404	168	4.9%	LTC	17,286	17,020	266	1.6%
235,916	235,394	522	0.2%	MCE	1,164,865	1,176,090	(11,225)	(1.0%)
11,751	12,940	(1,189)	(9.2%)	WCM	59,235	64,700	(5,465)	(8.4%)
739,601	**730,033**	**9,568**	**1.3%**	**Medi-Cal**	**3,664,829**	**3,666,966**	**(2,137)**	**(0.1%)**
14,065	**14,055**	**10**	**0.1%**	**OneCare Connect**	**70,691**	**70,677**	**14**	**0.0%**
1,498	**1,503**	**(5)**	**(0.3%)**	**OneCare**	**7,704**	**7,492**	**212**	**2.8%**
375	**370**	**5**	**1.4%**	**PACE**	**1,779**	**1,776**	**3**	**0.2%**
755,539	**745,961**	**9,578**	**1.3%**	**CalOptima Total**	**3,745,003**	**3,746,911**	**(1,908)**	**(0.1%)**

				Enrollment (By Network)				
160,633	161,983	(1,350)	(0.8%)	HMO	809,616	813,433	(3,817)	(0.5%)
207,353	208,741	(1,388)	(0.7%)	PHC	1,044,548	1,050,889	(6,341)	(0.6%)
178,041	187,009	(8,968)	(4.8%)	Shared Risk Group	915,010	939,786	(24,776)	(2.6%)
193,574	172,300	21,274	12.3%	Fee for Service	895,655	862,858	32,797	3.8%
739,601	**730,033**	**9,568**	**1.3%**	**Medi-Cal**	**3,664,829**	**3,666,966**	**(2,137)**	**(0.1%)**
14,065	**14,055**	**10**	**0.1%**	**OneCare Connect**	**70,691**	**70,677**	**14**	**0.0%**
1,498	**1,503**	**(5)**	**(0.3%)**	**OneCare**	**7,704**	**7,492**	**212**	**2.8%**
375	**370**	**5**	**1.4%**	**PACE**	**1,779**	**1,776**	**3**	**0.2%**
755,539	**745,961**	**9,578**	**1.3%**	**CalOptima Total**	**3,745,003**	**3,746,911**	**(1,908)**	**(0.1%)**

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	3,754	3,821	3,827								18,865
BCCTP	1	1	2	2	1								7
Disabled	6,539	6,547	6,572	6,613	6,633								32,904
TANF Child	54,046	53,703	52,620	53,069	52,791								266,229
TANF Adult	27,944	27,740	27,446	27,279	27,012								137,421
LTC	2	1	3	3	2								11
MCE	68,973	69,077	68,729	68,881	68,361								344,021
WCM	2,026	2,087	2,052	1,987	2,006								10,158
	163,254	**162,896**	**161,178**	**161,655**	**160,633**								**809,616**
PHC													
Aged	1,548	1,540	1,524	1,542	1,577								7,731
BCCTP	-	-	-	-	-								-
Disabled	5,416	5,499	5,323	5,425	5,500								27,163
TANF Child	148,665	148,131	143,994	146,390	145,734								732,914
TANF Adult	11,149	11,322	10,925	10,865	10,743								55,004
LTC	-	-	1	-	1								2
MCE	37,510	37,479	37,084	37,037	36,728								185,838
WCM	7,209	7,276	7,190	7,151	7,070								35,896
	211,497	**211,247**	**206,041**	**208,410**	**207,353**								**1,044,548**
Shared Risk Group													
Aged	3,569	3,523	3,470	3,501	3,527								17,590
BCCTP	-	-	-	-	-								-
Disabled	7,275	7,294	7,144	7,177	7,200								36,090
TANF Child	63,291	62,381	57,001	59,579	58,690								300,942
TANF Adult	28,681	28,390	27,842	27,428	26,946								139,287
LTC	1	3	3	2	1								10
MCE	84,595	83,922	82,492	81,749	80,096								412,854
WCM	1,732	1,706	1,620	1,598	1,581								8,237
	189,144	**187,219**	**179,572**	**181,034**	**178,041**								**915,010**
Fee for Service (Dual)													
Aged	51,730	52,454	52,097	52,050	52,649								260,980
BCCTP	15	18	17	18	19								87
Disabled	20,752	20,053	20,586	20,577	20,781								102,749
TANF Child	-	19	1	1	1								22
TANF Adult	964	1,923	949	941	963								5,740
LTC	3,044	3,097	3,061	3,161	3,204								15,567
MCE	2,116	2,171	1,935	1,717	1,737								9,676
WCM	15	15	15	16	15								76
	78,636	**79,750**	**78,661**	**78,481**	**79,369**								**394,897**
Fee for Service (Non-Dual)													
Aged	4,682	4,211	4,370	4,583	4,890								22,736
BCCTP	550	542	484	532	525								2,633
Disabled	4,928	5,692	4,374	4,930	5,428								25,352
TANF Child	25,571	32,106	16,125	25,295	29,914								129,011
TANF Adult	19,658	19,951	19,512	19,854	23,011								101,986
LTC	328	326	331	347	364								1,696
MCE	40,680	41,152	40,342	41,308	48,994								212,476
WCM	843	960	978	1,008	1,079								4,868
	97,240	**104,940**	**86,516**	**97,857**	**114,205**								**500,758**
MEDI-CAL TOTAL													
Aged	65,252	65,468	65,215	65,497	66,470								327,902
BCCTP	566	561	503	552	545								2,727
Disabled	44,910	45,085	43,999	44,722	45,542								224,258
TANF Child	291,573	296,340	269,741	284,334	287,130								1,429,118
TANF Adult	88,396	89,326	86,674	86,367	88,675								439,438
LTC	3,375	3,427	3,399	3,513	3,572								17,286
MCE	233,874	233,801	230,582	230,692	235,916								1,164,865
WCM	11,825	12,044	11,855	11,760	11,751								59,235
	739,771	**746,052**	**711,968**	**727,437**	**739,601**								**3,664,829**
OneCare Connect	14,257	14,090	14,186	14,093	14,065								70,691
OneCare	1,530	1,545	1,564	1,567	1,498								7,704
PACE	335	345	356	368	375								1,779
TOTAL	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**								**3,745,003**

ENROLLMENT:

Overall November enrollment was 755,539

- Favorable to budget 9,578 or 1.3%
- Increased 12,074 or 1.6% from prior month (PM) (October 2019)
- Decreased 13,677 or 1.8% from PY (November 2018)

Medi-Cal enrollment was 739,601

- Favorable to budget 9,568 or 1.3%
  - Medi-Cal Expansion (MCE) favorable 522
  - Whole Child Model (WCM) unfavorable 1,189
  - Seniors and Persons with Disabilities (SPD) favorable 2,502
  - Temporary Assistance for Needy Families (TANF) favorable 7,565
  - Long-Term Care (LTC) favorable 168
- Increased 12,164 from prior month

OneCare Connect enrollment was 14,065

- Favorable to budget 10 or 0.1%
- Decreased 28 from prior month

OneCare enrollment was 1,498

- Unfavorable to budget 5 or 0.3%
- Decreased 69 from prior month

PACE enrollment was 375

- Favorable to budget 5 or 1.4%
- Increased 7 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
739,601	**730,033**	**9,568**	**1.3%**	**Member Months**	**3,664,829**	**3,666,966**	**(2,137)**	**(0.1%)**
				Revenues				
275,263,660	268,651,866	6,611,794	2 5%	Capitation revenue	1,468,608,565	1,345,728,498	122,880,067	9 1%
-	-	-	0 0%	Other income	-	-	-	0 0%
275,263,660	**268,651,866**	**6,611,794**	**2.5%**	**Total Operating Revenue**	**1,468,608,565**	**1,345,728,498**	**122,880,067**	**9.1%**
				Medical Expenses				
92,766,753	94,927,115	2,160,361	2 3%	Provider capitation	477,213,466	476,084,874	(1,128,592)	(0 2%)
58,439,191	47,667,099	(10,772,093)	(22 6%)	Facilities	258,418,023	241,100,048	(17,317,975)	(7 2%)
27,387,711	22,733,178	(4,654,533)	(20 5%)	Professional Claims	133,301,601	115,250,905	(18,050,696)	(15 7%)
42,113,487	43,266,430	1,152,943	2 7%	Prescription drugs	220,586,693	219,775,465	(811,229)	(0 4%)
40,146,541	36,414,898	(3,731,643)	(10 2%)	MLTSS	197,214,317	185,164,764	(12,049,553)	(6 5%)
3,424,679	4,293,719	869,040	20 2%	Medical management	17,990,538	22,386,012	4,395,474	19 6%
1,816,863	3,190,143	1,373,280	43 0%	Reinsurance & other	112,433,307	15,973,785	(96,459,523)	(603 9%)
266,095,225	**252,492,580**	**(13,602,645)**	**(5.4%)**	**Total Medical Expenses**	**1,417,157,944**	**1,275,735,851**	**(141,422,093)**	**(11.1%)**
9,168,435	**16,159,286**	**(6,990,851)**	**(43.3%)**	**Gross Margin**	**51,450,621**	**69,992,647**	**(18,542,026)**	**(26.5%)**
				Administrative Expenses				
6,292,660	6,428,139	135,479	2 1%	Salaries, wages & employee benefits	31,741,856	35,523,464	3,781,608	10 6%
284,410	374,539	90,129	24 1%	Professional fees	966,602	1,849,112	882,510	47 7%
770,655	954,253	183,598	19 2%	Purchased services	3,760,561	4,771,266	1,010,705	21 2%
354,374	450,570	96,196	21 3%	Printing and postage	1,380,274	2,221,192	840,918	37 9%
330,613	455,750	125,137	27 5%	Depreciation and amortization	1,861,769	2,278,750	416,981	18 3%
1,384,981	1,647,417	262,436	15 9%	Other operating expenses	7,483,525	8,247,850	764,325	9 3%
(224,635)	(176,730)	47,905	27 1%	Indirect cost allocation, Occupancy Expense	(990,404)	(872,406)	117,998	13 5%
9,193,058	**10,133,938**	**940,880**	**9.3%**	**Total Administrative Expenses**	**46,204,182**	**54,019,228**	**7,815,046**	**14.5%**
				Operating Tax				
-	11,256,041	(11,256,041)	(100 0%)	Tax Revenue	-	56,534,741	(56,534,741)	(100 0%)
-	11,256,041	11,256,041	100 0%	Premium tax expense	-	56,534,741	56,534,741	100 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
13,217	-	13,217	0 0%	Grant Revenue	19,003	-	19,003	0 0%
(2,763)	-	2,763	0 0%	Grant expense - Service Partner	(20,480)	-	20,480	0 0%
14,293	-	(14,293)	0 0%	Grant expense - Administrative	46,562	-	(46,562)	0 0%
1,687	-	1,687	**0.0%**	**Total Grant Income**	(7,079)	-	(7,079)	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**(0)**	**-**	**(0)**	**0.0%**
43	**-**	**43**	**0.0%**	**Other income**	**177**	**-**	**177**	**0.0%**
(22,893)	**6,025,348**	**(6,048,242)**	**(100.4%)**	**Change in Net Assets**	**5,239,538**	**15,973,419**	**(10,733,881)**	**(67.2%)**
96.7%	***94.0%***	***(2.7%)***	***(2.9%)***	***Medical Loss Ratio***	***96.5%***	***94.8%***	***(1.7%)***	***(1.8%)***
3.3%	***3.8%***	***0.4%***	***11.5%***	***Admin Loss Ratio***	***3.1%***	***4.0%***	***0.9%***	***21.6%***

MEDI-CAL INCOME STATEMENT - NOVEMBER MONTH:

REVENUES of $275.3 million are favorable to budget $6.6 million driven by:

- Favorable volume related variance of $3.5 million
- Favorable price related variance of $3.1 million due to:
  - $3.0 million of fiscal year (FY) 2020 Department of Health Care Services (DHCS) year to date (YTD) acuity rate adjustment
  - $2.8 million of FY 2020 LTC revenue from non-LTC members
  - Offset by $3.3 million of WCM revenue

MEDICAL EXPENSES of $266.1 million are unfavorable to budget $13.6 million driven by:

- Unfavorable volume related variance of $3.3 million
- Unfavorable price variance of $10.3 million due to:
  - **Facilities** unfavorable variance of $10.1 million due to claims Incurred But Not Reported (IBNR)

ADMINISTRATIVE EXPENSES of $9.2 million are favorable to budget $0.9 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.1 million due
- Other Non-Salary expenses are favorable to budget $0.8 million

CHANGE IN NET ASSETS is ($22.9) thousand for the month, unfavorable to budget $6.0 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Five Months Ending November 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,065	**14,055**	**10**	**0.1%**	**Member Months**	**70,691**	**70,677**	**14**	**0.0%**
				Revenues				
2,543,688	2,768,973	(225,285)	(8 1%)	Medi-Cal Capitation revenue	12,153,113	13,962,613	(1,809,500)	(13 0%)
16,749,713	16,090,866	658,847	4 1%	Medicare Capitation revenue part C	84,009,061	81,093,720	2,915,341	3 6%
4,671,199	4,769,631	(98,432)	(2 1%)	Medicare Capitation revenue part D	25,737,913	23,937,720	1,800,193	7 5%
-	-	-	0 0%	Other Income	-	-	-	0 0%
23,964,600	**23,629,470**	**335,130**	**1.4%**	**Total Operating Revenue**	**121,900,087**	**118,994,053**	**2,906,034**	**2.4%**
				Medical Expenses				
10,725,294	10,811,618	86,324	0 8%	Provider capitation	56,241,265	54,589,720	(1,651,545)	(3 0%)
3,844,912	3,445,739	(399,173)	(11 6%)	Facilities	18,549,468	17,425,377	(1,124,091)	(6 5%)
561,484	669,924	108,440	16 2%	Ancillary	3,326,021	3,396,184	70,163	2 1%
1,260,375	1,513,586	253,211	16 7%	Long Term Care	6,831,795	7,776,769	944,974	12 2%
5,450,006	5,285,886	(164,120)	(3 1%)	Prescription drugs	28,321,586	26,989,211	(1,332,375)	(4 9%)
958,486	1,038,520	80,034	7 7%	Medical management	5,116,885	5,496,328	379,443	6 9%
197,807	218,645	20,838	9 5%	Other medical expenses	951,413	1,085,241	133,828	12 3%
22,998,363	**22,983,918**	**(14,445)**	**(0.1%)**	**Total Medical Expenses**	**119,338,432**	**116,758,830**	**(2,579,602)**	**(2.2%)**
966,237	**645,552**	**320,685**	**49.7%**	**Gross Margin**	**2,561,655**	**2,235,223**	**326,432**	**14.6%**
				Administrative Expenses				
713,908	756,191	42,283	5 6%	Salaries, wages & employee benefits	3,543,407	4,082,151	538,744	13 2%
11,963	77,796	65,834	84 6%	Professional fees	444,486	388,980	(55,506)	(14 3%)
133,133	242,989	109,856	45 2%	Purchased services	841,999	1,214,944	372,945	30 7%
123,566	95,860	(27,706)	(28 9%)	Printing and postage	297,270	479,301	182,031	38 0%
-	-	-	0 0%	Depreciation & amortization	-	-	-	0 0%
32,470	71,888	39,418	54 8%	Other operating expenses	76,207	359,441	283,234	78 8%
519,792	519,792	-	0 0%	Indirect cost allocation	2,657,716	2,598,960	(58,756)	(2 3%)
1,534,831	**1,764,516**	**229,685**	**13.0%**	**Total Administrative Expenses**	**7,861,086**	**9,123,777**	**1,262,691**	**13.8%**
				Operating Tax				
-	-	-	0 0%	Tax Revenue	-	-	-	0 0%
-	-	-	0 0%	Premium tax expense	-	-	-	0 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
(568,595)	**(1,118,964)**	**550,369**	**49.2%**	**Change in Net Assets**	**(5,299,431)**	**(6,888,554)**	**1,589,123**	**23.1%**
96.0%	***97.3%***	***1.3%***	***1.3%***	***Medical Loss Ratio***	***97.9%***	***98.1%***	***0.2%***	***0.2%***
6.4%	***7.5%***	***1.1%***	***14.2%***	***Admin Loss Ratio***	***6.4%***	***7.7%***	***1.2%***	***15.9%***

ONECARE CONNECT INCOME STATEMENT - NOVEMBER MONTH:

REVENUES of $24.0 million are favorable to budget $0.3 million driven by:

- Favorable volume related variance of $16.8 thousand
- Favorable price related variance of $318.3 thousand

MEDICAL EXPENSES of $23.0 million are unfavorable to budget $14.4 thousand

- Unfavorable volume related variance of $16.3 thousand
- Favorable price related variance of $1.9 thousand

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($0.6) million, favorable to budget $0.5 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,498	**1,503**	**(5)**	**(0.3%)**	**Member Months**	**7,704**	**7,492**	**212**	**2.8%**
				Revenues				
1,042,132	1,100,609	(58,477)	(5 3%)	Medicare Part C revenue	6,078,685	5,550,466	528,219	9 5%
537,491	519,329	18,162	3 5%	Medicare Part D revenue	2,757,530	2,588,346	169,184	6 5%
1,579,623	**1,619,938**	**(40,315)**	**(2.5%)**	**Total Operating Revenue**	**8,836,215**	**8,138,812**	**697,403**	**8.6%**
				Medical Expenses				
467,378	436,278	(31,100)	(7 1%)	Provider capitation	2,381,773	2,199,532	(182,241)	(8 3%)
405,449	495,413	89,964	18 2%	Inpatient	1,915,924	2,519,577	603,653	24 0%
62,654	54,149	(8,505)	(15 7%)	Ancillary	241,105	275,210	34,105	12 4%
20,747	44,466	23,719	53 3%	Skilled nursing facilities	59,993	226,078	166,085	73 5%
451,124	489,188	38,064	7 8%	Prescription drugs	2,576,275	2,496,114	(80,161)	(3 2%)
32,872	44,818	11,946	26 7%	Medical management	179,895	239,762	59,867	25 0%
-	10,848	10,848	100 0%	Other medical expenses	-	54,073	54,073	100 0%
1,440,223	**1,575,160**	**134,937**	**8.6%**	**Total Medical Expenses**	**7,354,964**	**8,010,346**	**655,382**	**8.2%**
139,399	**44,778**	**94,621**	**211.3%**	**Gross Margin**	**1,481,251**	**128,466**	**1,352,785**	**1053.0%**
				Administrative Expenses				
71,598	46,578	(25,020)	(53 7%)	Salaries, wages & employee benefits	298,821	257,984	(40,837)	(15 8%)
15,000	21,480	6,480	30 2%	Professional fees	114,371	107,400	(6,971)	(6 5%)
12,289	17,063	4,774	28 0%	Purchased services	78,805	85,315	6,510	7 6%
4,163	16,667	12,504	75 0%	Printing and postage	20,651	83,335	62,684	75 2%
426	4,738	4,312	91 0%	Other operating expenses	1,427	23,690	22,263	94 0%
35,589	35,589	-	0 0%	Indirect cost allocation, occupancy expens	191,216	177,945	(13,271)	(7 5%)
139,065	**142,115**	**3,050**	**2.1%**	**Total Administrative Expenses**	**705,291**	**735,669**	**30,378**	**4.1%**
334	**(97,337)**	**97,671**	**100.3%**	**Change in Net Assets**	**775,960**	**(607,203)**	**1,383,163**	**227.8%**
91.2%	***97.2%***	***6.1%***	***6.2%***	***Medical Loss Ratio***	***83.2%***	***98.4%***	***15.2%***	***15.4%***
8.8%	***8.8%***	***(0.0%)***	***(0.4%)***	***Admin Loss Ratio***	***8.0%***	***9.0%***	***1.1%***	***11.7%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
375	**370**	**5**	**1.4%**	**Member Months**	**1,779**	**1,776**	**3**	**0.2%**
				Revenues				
2,315,569	2,223,841	91,728	4 1%	Medi-Cal capitation revenue	11,032,648	10,677,098	355,550	3 3%
560,023	513,052	46,971	9 2%	Medicare Part C revenue	2,325,826	2,477,729	(151,903)	(6 1%)
208,332	136,634	71,698	52 5%	Medicare Part D revenue	641,363	655,294	(13,931)	(2 1%)
3,083,924	**2,873,527**	**210,397**	**7.3%**	**Total Operating Revenue**	**13,999,836**	**13,810,121**	**189,715**	**1.4%**
				Medical Expenses				
694,054	815,891	121,837	14 9%	Medical Management	3,447,824	4,361,058	913,234	20 9%
629,626	532,006	(97,620)	(18 3%)	Claims payments to hospitals	3,482,362	2,594,740	(887,622)	(34 2%)
633,485	582,939	(50,546)	(8 7%)	Professional claims	2,832,781	2,847,145	14,364	0 5%
280,923	234,239	(46,684)	(19 9%)	Patient transportation	1,156,598	1,128,076	(28,522)	(2 5%)
229,342	221,844	(7,498)	(3 4%)	Prescription drugs	1,120,004	1,082,076	(37,928)	(3 5%)
40,767	26,505	(14,262)	(53 8%)	MLTSS	175,073	112,851	(62,222)	(55 1%)
4,688	6,667	1,980	29 7%	Other Expenses	22,599	33,334	10,735	32 2%
2,512,885	**2,420,091**	**(92,794)**	**(3.8%)**	**Total Medical Expenses**	**12,237,241**	**12,159,280**	**(77,961)**	**(0.6%)**
571,039	**453,436**	**117,603**	**25.9%**	**Gross Margin**	**1,762,596**	**1,650,841**	**111,755**	**6.8%**
				Administrative Expenses				
149,313	128,736	(20,577)	(16 0%)	Salaries, wages & employee benefits	711,058	713,834	2,776	0 4%
123	153	30	19 4%	Professional fees	1,013	765	(248)	(32 4%)
(381)	18,971	19,352	102 0%	Purchased services	45,784	94,855	49,071	51 7%
9,594	10,533	939	8 9%	Printing and postage	54,204	52,665	(1,539)	(2 9%)
2,087	2,116	29	1 4%	Depreciation & amortization	10,455	10,580	125	1 2%
3,627	4,136	509	12 3%	Other operating expenses	18,666	20,679	2,013	9 7%
3,818	4,049	231	5 7%	Indirect cost allocation, Occupancy Expense	37,496	19,795	(17,701)	(89 4%)
168,181	**168,694**	**513**	**0.3%**	**Total Administrative Expenses**	**878,674**	**913,173**	**34,499**	**3.8%**
				Operating Tax				
5,565	-	5,565	0 0%	Tax Revenue	26,400	-	26,400	0 0%
5,565	-	(5,565)	0 0%	Premium tax expense	26,400	-	(26,400)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
402,858	**284,742**	**118,116**	**41.5%**	**Change in Net Assets**	**883,921**	**737,668**	**146,253**	**19.8%**
81.5%	***84.2%***	***2.7%***	***3.2%***	***Medical Loss Ratio***	***87.4%***	***88.0%***	***0.6%***	***0.7%***
5.5%	***5.9%***	***0.4%***	***7.1%***	***Admin Loss Ratio***	***6.3%***	***6.6%***	***0.3%***	***5.1%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
42,304	23,101	(19,203)	(83.1%)	Purchase services	239,733	115,505	(124,228)	(107.6%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	822,469	873,625	51,156	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	87,382	79,330	(8,052)	(10.2%)
109,456	140,162	30,706	21.9%	Repair and maintenance	551,736	700,810	149,074	21.3%
17,812	46,432	28,620	61.6%	Other Operating Expense	264,597	232,160	(32,437)	(14.0%)
(351,541)	(400,286)	(48,745)	(12.2%)	Indirect allocation, Occupancy	(1,965,917)	(2,001,430)	(35,513)	(1.8%)
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 - NOVEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $334, favorable to budget $97.7 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.1 million

CalOptima
Balance Sheet
November 30, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$516,875,446	Accounts Payable	$5,671,058
Investments	480,312,226	Medical Claims liability	762,212,657
Capitation receivable	291,253,021	Accrued Payroll Liabilities	10,671,064
Receivables - Other	28,231,556	Deferred Revenue	61,175,372
Prepaid expenses	5,962,576	Deferred Lease Obligations	12,718
		Capitation and Withholds	158,544,500
Total Current Assets	**1,322,634,825**	**Total Current Liabilities**	**998,287,369**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,376,533		
505 City Parkway West	50,489,717		
	97,952,615		
Less: accumulated depreciation	(49,431,106)		
Capital assets, net	48,521,509	Other (than pensions) post	
		employment benefits liability	25,334,747
Other Assets		Net Pension Liabilities	23,621,483
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,047,243,600**
Cash and Cash Equivalents	5,636,128		
Long-term Investments	560,210,171	Deferred Inflows	
Total Board-designated Assets	565,846,299	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	624,345,212	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**1,995,501,545**	TNE	93,903,325
		Funds in Excess of TNE	858,038,235
Deferred Outflows		**TOTAL NET POSITION**	951,941,560
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	**2,006,591,994**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,006,591,994**

CalOptima
Board Designated Reserve and TNE Analysis
as of November 30, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	155,127,701				
	Tier 1 - Logan Circle	153,938,061				
	Tier 1 - Wells Capital	154,353,406				
Board-designated Reserve		463,419,168	313,333,389	487,863,410	150,085,779	(24,444,242)
TNE Requirement	Tier 2 - Logan Circle	102,427,130	93,903,325	93,903,325	8,523,806	8,523,806
	Consolidated:	**565,846,298**	**407,236,714**	**581,766,734**	**158,609,584**	**(15,920,436)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
as of November 30, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	1,316,924	16,398,690
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	497,193	2,694,693
Changes in assets and liabilities:		
Prepaid expenses and other	(689,689)	(174,834)
Catastrophic reserves		
Capitation receivable	10,282,192	32,457,190
Medical claims liability	21,591,006	9,901,706
Deferred revenue	21,583,759	10,140,609
Payable to health networks	4,054,574	49,641,360
Accounts payable	(237,177)	(36,995,669)
Accrued payroll	(3,624,535)	312,758
Other accrued liabilities	(6,359)	(31,794)
Net cash provided by/(used in) operating activities	54,767,886	84,344,708
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	(28,308,793)	93,394,071
Change in Property and Equipment	(164,949)	(4,591,313)
Change in Board designated reserves	(107,355)	(5,700,891)
Change in Homeless Health reserve	-	1,801,087
Net cash provided by/(used in) investing activities	(28,581,096)	84,902,954
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	26,186,790	169,247,662
CASH AND CASH EQUIVALENTS, beginning of period	490,688,657	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**516,875,446**	**516,875,446**

BALANCE SHEET - NOVEMBER MONTH:

ASSETS of $2.0 billion increased $44.7 million from October or 2.3%

- **Investments** increased $28.3 million due timing of capitation received
- **Operating Cash** increased $26.2 million due to timing of capitation received
- **Receivables - Other** decreased $13.3 million due to timing of capitation received from DHCS and The Centers for Medicare & Medicaid Services (CMS)

LIABILITIES of $1.0 billion increased $43.4 million from October or 4.3%

- **Medical Claims Liability** increased $21.6 million due to increase in IBNR
- **Deferred Revenue** increased $21.6 million due to prepayment from CMS

NET ASSETS total $951.9 million

Homeless Health Initiative and Allocated Funds
as of November 30, 2019

		Amount
Program Commitment		**$ 100,000,000**
Funds Allocation, approved initiatives:		
Be Well OC	$	11,400,000
Recuperative Care		8,500,000
Housing Supportive Services		2,500,000
Clinical Field Team Start-Up & Federally Qualified Health Center (FQHC)		1,600,000
Homeless Response Team (CalOptima)		6,000,000
Homeless Coordination at Hospitals		10,000,000
CalOptima 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 November 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.

A Public Agency

CalOptima

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Financial Summary

December 2019

Board of Directors Meeting
February 6, 2020

Nancy Huang
Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

December 2019 MTD

Overall enrollment was 738,535 members

- Actual lower than budget 5,736 or 0.8%
  - Medi-Cal unfavorable to budget 5,959 or 0.8%
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 7,347
    - Whole Child Model (WCM) unfavorable variance of 1,439
    - Medi-Cal Expansion (MCE) unfavorable variance of 410
    - Long-Term Care (LTC) unfavorable variance of 125
    - Seniors and Persons with Disabilities (SPD) favorable variance of 3,361
  - OneCare Connect favorable to budget 249 or 1.8%
  - OneCare unfavorable to budget 41 or 2.7%
  - PACE favorable to budget 15 or 4.0%
- 17,004 decrease or 2.3% from November
    - Medi-Cal decrease of 17,188
    - OneCare Connect increase of 199
    - OneCare decrease of 33
    - PACE increase of 18

FY 2019-20: Consolidated Enrollment (cont.)

December 2019 YTD

Overall enrollment was 4,483,538 member months

- Actual lower than budget 7,644 or 0.2%
  - Medi-Cal unfavorable to budget 8,096 or 0.2%
    - MCE unfavorable variance of 11,635
    - WCM unfavorable variance of 6,904
    - SPD favorable variance of 8,937
    - TANF favorable variance 1,364
    - LTC favorable variance of 141
  - OneCare Connect favorable to budget 263 or 0.3%
  - OneCare favorable to budget 171 or 1.9%
  - PACE favorable to budget 18 or 0.8%

FY 2019-20: Consolidated Revenues

December 2019 MTD

- Actual higher than budget $10.1 million or 3.4%
  - ➢ Medi-Cal favorable to budget $7.6 million or 2.8%
    - Unfavorable volume variance of $2.2 million
    - Favorable price variance of $9.8 million
      - $6.4 million of Coordinated Care Initiative (CCI) revenue, $2.0 million from prior year
      - $3.0 million of fiscal year (FY) 2020 Department of Health Care Services (DHCS) acuity rate adjustment
      - $2.8 million of LTC revenue from non-LTC members
      - Offset by $3.3 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $2.1 million or 9.1%
    - Favorable volume variance of $0.4 million
    - Favorable price variance of $1.7 million

FY 2019-20: Consolidated Revenues (cont.)

December 2019 MTD (cont.)

- OneCare favorable to budget $252.5 thousand or 15.7%
  - Unfavorable volume variance of $43.7 thousand
  - Favorable price variance of $296.3 thousand
- PACE favorable to budget $185.0 thousand or 6.3%
  - Favorable volume variance of $116.4 thousand
  - Favorable price variance of $68.6 thousand

FY 2019-20: Consolidated Revenues (cont.)

December 2019 YTD

- Actual higher than budget $136.8 million or 7.7%
  - ➢ Medi-Cal favorable to budget $130.4 million or 8.1%
    - Unfavorable volume variance of $3.0 million
    - Favorable price variance of $133.4 million
      - $104.3 million of directed payment (DP) revenue
      - $18.0 million due to DHCS acuity rate adjustment
      - $15.0 million of CCI revenue
      - $7.0 million of Behavioral Health Treatment (BHT) revenue
      - $3.2 million of LTC revenue from non-LTC members
      - Offset by $19.6 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $5.0 million or 3.5%
    - Favorable volume variance of $0.4 million
    - Favorable price variance of $4.6 million

FY 2019-20: Consolidated Revenues (cont.)

December 2019 YTD (cont.)

- OneCare favorable to budget $949.9 thousand or 9.7%
  - Favorable volume variance of $185.2 thousand
  - Favorable price variance of $764.8 thousand
- PACE favorable to budget $374.8 thousand or 2.2%
  - Favorable volume variance of $139.9 thousand
  - Favorable price variance of $234.8 thousand

FY 2019-20: Consolidated Medical Expenses

December 2019 MTD

- Actual higher than budget $13.1 million or 4.6%
  - ➢ Medi-Cal unfavorable variance of $12.2 million or 4.7%
    - Favorable volume variance of $2.1 million
    - Unfavorable price variance of $14.3 million
      - Facilities Claims unfavorable variance of $11.6 million due to WCM
      - Provider Capitation unfavorable variance of $2.3 million due to Proposition 56
  - ➢ OneCare Connect unfavorable variance of $1.3 million or 5.5%
    - Unfavorable volume variance of $0.4 million
    - Unfavorable price variance of $0.9 million

FY 2019-20: Consolidated Medical Expenses (cont.)

December 2019 YTD

- Actual higher than budget $156.6 million or 9.2%
  - ➢ Medi-Cal unfavorable variance of $153.6 million or 10.0%
    - Favorable volume variance of $2.8 million
    - Unfavorable price variance of $156.4 million
      - Reinsurance and Other Expense category unfavorable variance of $96.0 million due to $104.0 million of DP, offset by favorable variance in homeless health initiative
      - Facilities Claims unfavorable variance of $29.1 million
      - Professional Claims unfavorable variance of $19.2 million
      - MLTSS unfavorable variance of $14.3 million
  - ➢ OneCare Connect unfavorable variance of $3.9 million or 2.8%
    - Unfavorable volume variance of $0.4 million
    - Unfavorable price variance of $3.4 million

Medical Loss Ratio (MLR)

- December 2019 MTD: Actual: 97.1% Budget: 96.0%
- December 2019 YTD: Actual: 96.6% Budget: 95.2%

FY 2019-20: Consolidated Administrative Expenses

December 2019 MTD

- Actual lower than budget $1.8 million or 14.0%
  - Salaries, wages and benefits: favorable variance of $0.6 million
  - Other categories: favorable variance of $1.2 million

December 2019 YTD

- Actual lower than budget $11.0 million or 14.1%
  - Salaries, wages and benefits: favorable variance of $4.9 million
  - Other categories: favorable variance of $6.1 million

Administrative Loss Ratio (ALR)

- December 2019 MTD: Actual: 3.6% Budget: 4.4%
- December 2019 YTD: Actual: 3.5% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% YTD

FY 2019-20: Change in Net Assets

December 2019 MTD

- $0.4 million change in net assets
- $0.3 million favorable to budget
  - Higher than budgeted revenue of $10.1 million
  - Higher than budgeted medical expenses of $13.1 million
  - Lower than budgeted administrative expenses of $1.8 million
  - Higher than budgeted investment and other income of $1.5 million

December 2019 YTD

- $16.8 million change in net assets
- $1.3 million favorable to budget
  - Higher than budgeted revenue of $136.8 million
  - Higher than budgeted medical expenses of $156.6 million
  - Lower than budgeted administrative expenses of $11.0 million
  - Higher than budgeted investment and other income of $10.0 million

Enrollment Summary: December 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
64,297	65,846	(1,549)	(2.4%)	Aged	392,199	393,102	(903)	(0.2%)
540	615	(75)	(12.2%)	BCCTP	3,267	3,690	(423)	(11.5%)
48,677	43,692	4,985	11.4%	Disabled	272,935	262,672	10,263	3.9%
269,845	280,701	(10,856)	(3.9%)	TANF Child	1,698,963	1,704,859	(5,896)	(0.3%)
89,202	85,693	3,509	4.1%	TANF Adult	528,640	521,380	7,260	1.4%
3,279	3,404	(125)	(3.7%)	LTC	20,565	20,424	141	0.7%
235,071	235,481	(410)	(0.2%)	MCE	1,399,936	1,411,571	(11,635)	(0.8%)
11,501	12,940	(1,439)	(11.1%)	WCM	70,736	77,640	(6,904)	(8.9%)
722,413	**728,372**	**(5,959)**	**(0.8%)**	**Medi-Cal Total**	**4,387,242**	**4,395,338**	**(8,096)**	**(0.2%)**
14,264	**14,015**	**249**	**1.8%**	**OneCare Connect**	**84,955**	**84,692**	**263**	**0.3%**
1,465	**1,506**	**(41)**	**(2.7%)**	**OneCare**	**9,169**	**8,998**	**171**	**1.9%**
393	**378**	**15**	**4.0%**	**PACE**	**2,172**	**2,154**	**18**	**0.8%**
738,535	**744,271**	**(5,736)**	**(0.8%)**	**CalOptima Total**	**4,483,538**	**4,491,182**	**(7,644)**	**(0.2%)**

Financial Highlights: December 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
738,535	744,271	(5,736)	(0.8%)	Member Months	4,483,538	4,491,182	(7,644)	(0.2%)
306,580,089	296,434,889	10,145,200	3.4%	Revenues	1,919,924,793	1,783,106,373	136,818,420	7.7%
297,836,656	284,699,585	(13,137,071)	(4.6%)	Medical Expenses	1,853,925,237	1,697,363,892	(156,561,345)	(9.2%)
11,137,046	12,956,600	1,819,554	14.0%	Administrative Expenses	66,786,278	77,748,447	10,962,169	14.1%
(2,393,612)	**(1,221,296)**	**(1,172,316)**	**(96.0%)**	**Operating Margin**	**(786,722)**	**7,994,034**	**(8,780,756)**	**(109.8%)**
2,748,312	1,250,000	1,498,312	119.9%	Non Operating Income (Loss)	17,540,112	7,500,000	10,040,112	133.9%
354,699	**28,704**	**325,996**	**1135.7%**	**Change in Net Assets**	**16,753,389**	**15,494,034**	**1,259,356**	**8.1%**
97.1%	96.0%	(1.1%)		Medical Loss Ratio	96.6%	95.2%	(1.4%)	
3.6%	4.4%	0.7%		Administrative Loss Ratio	3.5%	4.4%	0.9%	
(0.8%)	(0.4%)	(0.4%)		Operating Margin Ratio	(0.0%)	0.4%	(0.5%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed payments per Department of Health Care Services instructions

Consolidated Performance Actual vs. Budget: December 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.6)	0.4	(3.0)	Medi-Cal	2.7	16.4	(13.7)
(0.5)	(1.7)	1.1	OCC	(5.8)	(8.6)	2.7
0.1	(0.2)	0.2	OneCare	0.8	(0.8)	1.6
0.7	0.2	0.5	PACE	1.5	0.9	0.6
(2.4)	**(1.2)**	**(1.2)**	**Operating**	**(0.8)**	**8.0**	**(8.8)**
2.7	1.3	1.5	Inv./Rental Inc, MCO tax	17.5	7.5	10.0
2.7	**1.3**	**1.5**	**Non-Operating**	**17.5**	**7.5**	**10.0**
0.4	**0.0**	**0.3**	**TOTAL**	**16.8**	**15.5**	**1.3**

Consolidated Revenue & Expense: December 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	475,841	235,071	11,501	722,413	14,264	1,465	393	738,535
REVENUES								
Capitation Revenue	146,845,776	$ 106,356,246	$ 22,765,719	$ 275,967,740	$ 25,634,924	$ 1,858,375	$ 3,119,050	$ 306,580,089
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	146,845,776	106,356,246	22,765,719	275,967,740	25,634,924	1,858,375	3,119,050	306,580,089
MEDICAL EXPENSES								
Provider Capitation	39,236,442	45,000,600	10,663,970	94,901,012	11,257,299	464,784		106,623,094
Facilities	22,833,756	20,548,011	16,731,199	60,112,967	4,128,273	458,684	596,149	65,296,072
Ancillary	-	-	-	-	787,781	27,660	-	815,441
Professional Claims	16,190,145	6,466,456	1,763,936	24,420,537	-	-	465,224	24,885,761
Prescription Drugs	14,902,871	21,721,138	6,066,522	42,690,532	5,510,016	606,397	258,988	49,065,933
MLTSS	34,707,645	2,547,833	2,226,169	39,481,647	1,445,842	(7,830)	35,723	40,955,382
Medical Management	2,024,330	1,269,441	270,896	3,564,666	1,095,695	55,690	768,467	5,484,517
Quality Incentives	836,841	467,784	141,200	1,445,825	205,020		127,935	1,778,780
Reinsurance & Other	1,453,676	1,226,637	51,250	2,731,563	175,380		24,733	2,931,676
Total Medical Expenses	132,185,706	99,247,900	37,915,142	269,348,748	24,605,306	1,605,384	2,277,218	297,836,656
Medical Loss Ratio	90.0%	93.3%	166.5%	97.6%	96.0%	86.4%	73.0%	97.1%
GROSS MARGIN	**14,660,070**	**7,108,346**	**(15,149,423)**	**6,618,992**	**1,029,618**	**252,991**	**841,832**	**8,743,433**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,661,257	684,801	68,915	119,464	7,534,437
Professional fees				259,364	4,000	15,000	123	278,488
Purchased services				716,263	133,352	13,555	4,847	868,017
Printing & Postage				380,057	22,212	40,781	7,066	450,117
Depreciation & Amortization				296,109			2,087	298,195
Other expenses				1,342,959	30,781	(0)	4,175	1,377,914
Indirect cost allocation & Occupancy				(461,735)	693,393	51,701	46,518	329,877
Total Administrative Expenses				9,194,275	1,568,539	189,951	184,280	11,137,046
Admin Loss Ratio				3.3%	6.1%	10.2%	5.9%	3.6%
INCOME (LOSS) FROM OPERATIONS				(2,575,283)	(538,921)	63,040	657,552	(2,393,612)
INVESTMENT INCOME								2,744,132
TOTAL GRANT INCOME				3,983				3,983
OTHER INCOME				197				197
CHANGE IN NET ASSETS				**$ (2,571,103)**	**$ (538,921)**	**$ 63,040**	**$ 657,552**	**$ 354,699**
BUDGETED CHANGE IN NET ASSETS				416,117	(1,663,191)	(152,051)	177,829	28,704
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,987,220)	$ 1,124,270	$ 215,091	$ 479,723	$ 325,996

Consolidated Revenue & Expense: December 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,916,570	1,399,936	70,736	4,387,242	84,955	9,169	2,172	4,483,538
REVENUES								
Capitation Revenue	927,013,283	$ 678,161,206	$ 139,401,817	$ 1,744,576,305	$ 147,535,011	$ 10,694,591	$ 17,118,886	$ 1,919,924,793
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	927,013,283	678,161,206	139,401,817	1,744,576,305	147,535,011	10,694,591	17,118,886	1,919,924,793
MEDICAL EXPENSES								
Provider Capitation	234,485,638	270,312,091	60,061,429	564,859,158	66,475,888	2,846,557		634,181,604
Facilities	154,218,771	130,020,503	34,291,716	318,530,989	22,677,741	2,374,608	4,078,511	347,661,848
Ancillary	-	-	-	-	4,113,802	268,765	-	4,382,566
Professional Claims	107,725,220	42,324,904	7,672,013	157,722,137	-	-	3,298,005	161,020,142
Prescription Drugs	100,187,043	129,331,955	33,758,227	263,277,225	33,831,602	3,182,671	1,378,992	301,670,490
MLTSS	209,116,636	16,169,500	11,409,828	236,695,964	8,277,637	52,163	210,796	245,236,559
Medical Management	12,726,742	7,265,893	1,562,569	21,555,204	6,212,580	235,585	4,216,291	32,219,659
Quality Incentives	5,038,693	2,813,641	848,810	8,701,144	1,227,695		150,534	10,079,373
Reinsurance & Other	66,132,609	48,820,753	211,508	115,164,870	1,126,793		1,181,331	117,472,994
Total Medical Expenses	889,631,351	647,059,241	149,816,100	1,686,506,692	143,943,738	8,960,348	14,514,459	1,853,925,237
Medical Loss Ratio	96.0%	95.4%	107.5%	96.7%	97.6%	83.8%	84.8%	96.6%
GROSS MARGIN	**37,381,932**	**31,101,965**	**(10,414,283)**	**58,069,613**	**3,591,273**	**1,734,242**	**2,604,428**	**65,999,556**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				38,403,113	4,228,209	367,735	830,522	43,829,579
Professional fees				1,225,966	448,486	129,371	1,136	1,804,960
Purchased services				4,476,824	975,351	92,360	50,631	5,595,165
Printing & Postage				1,760,331	319,482	61,433	61,270	2,202,515
Depreciation & Amortization				2,157,878			12,541	2,170,419
Other expenses				8,826,484	106,988	1,427	22,841	8,957,739
Indirect cost allocation & Occupancy				(1,452,138)	3,351,109	242,917	84,014	2,225,902
Total Administrative Expenses				55,398,457	9,429,625	895,242	1,062,954	66,786,278
Admin Loss Ratio				3.2%	6.4%	8.4%	6.2%	3.5%
INCOME (LOSS) FROM OPERATIONS				2,671,157	(5,838,352)	839,000	1,541,473	(786,722)
INVESTMENT INCOME								17,542,834
TOTAL GRANT INCOME				(3,096)				(3,096)
OTHER INCOME				374				374
CHANGE IN NET ASSETS				**$ 2,668,435**	**$ (5,838,352)**	**$ 839,000**	**$ 1,541,473**	**$ 16,753,389**
BUDGETED CHANGE IN NET ASSETS				16,389,536	(8,551,745)	(759,254)	915,497	15,494,034
VARIANCE TO BUDGET - FAV (UNFAV)				$ (13,721,101)	$ 2,713,393	$ 1,598,254	$ 625,976	$ 1,259,356

Balance Sheet:
As of December 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$465,465,756	Accounts Payable	$89,098,516
Investments	456,122,997	Medical Claims liability	753,310,433
Capitation receivable	383,024,805	Accrued Payroll Liabilities	11,421,423
Receivables - Other	30,875,068	Deferred Revenue	32,885,838
Prepaid expenses	7,065,129	Deferred Lease Obligations	6,359
		Capitation and Withholds	131,892,675
Total Current Assets	**1,342,553,755**	**Total Current Liabilities**	**1,018,615,245**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,574,782		
505 City Parkway West	50,489,717		
	98,150,864		
Less: accumulated depreciation	(49,943,873)		
Capital assets, net	48,206,991	Other (than pensions) post employment benefits liability	25,440,671
Other Assets		Net Pension Liabilities	23,671,930
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,067,727,846**
Cash and Cash Equivalents	8,236,462		
Long-term Investments	558,844,370	Deferred Inflows	
Total Board-designated Assets	567,080,832	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	625,579,745	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,016,340,491**	TNE	95,518,594
		Funds in Excess of TNE	856,777,665
Deferred Outflows		**TOTAL NET POSITION**	952,296,259
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	**2,027,430,940**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,027,430,940**

Board Designated Reserve and TNE Analysis
As of December 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	155,430,553				
	Tier 1 - Logan Circle	154,299,315				
	Tier 1 - Wells Capital	154,707,630				
Board-designated Reserve		464,437,498	316,285,764	492,773,346	148,151,734	(28,335,848)
TNE Requirement	Tier 2 - Logan Circle	102,643,334	95,518,594	95,518,594	7,124,740	7,124,740
	Consolidated:	**567,080,832**	**411,804,358**	**588,291,940**	**155,276,474**	**(21,211,108)**
	Current reserve level	*1.93*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

December 2019

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CalOptima - Consolidated
Financial Highlights
For the Six Months Ended December 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
738,535	744,271	(5,736)	(0.8%)	Member Months	4,483,538	4,491,182	(7,644)	(0.2%)
306,580,089	296,434,889	10,145,200	3.4%	Revenues	1,919,924,793	1,783,106,373	136,818,420	7.7%
297,836,656	284,699,585	(13,137,071)	(4.6%)	Medical Expenses	1,853,925,237	1,697,363,892	(156,561,345)	(9.2%)
11,137,046	12,956,600	1,819,554	14.0%	Administrative Expenses	66,786,278	77,748,447	10,962,169	14.1%
(2,393,612)	**(1,221,296)**	**(1,172,316)**	**(96.0%)**	**Operating Margin**	**(786,722)**	**7,994,034**	**(8,780,756)**	**(109.8%)**
2,748,312	1,250,000	1,498,312	119.9%	Non Operating Income (Loss)	17,540,112	7,500,000	10,040,112	133.9%
354,699	**28,704**	**325,996**	**1135.7%**	**Change in Net Assets**	**16,753,389**	**15,494,034**	**1,259,356**	**8.1%**
97.1%	96.0%	(1.1%)		Medical Loss Ratio	96.6%	95.2%	(1.4%)	
3.6%	4.4%	0.7%		Administrative Loss Ratio	3.5%	4.4%	0.9%	
(0.8%)	(0.4%)	(0.4%)		Operating Margin Ratio	(0.0%)	0.4%	(0.5%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Six Months Ended December 31, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	722,413	728,372	(5,959)	(0 8%)
OneCare Connect	14,264	14,015	249	1 8%
OneCare	1,465	1,506	(41)	(2 7%)
PACE	393	378	15	4 0%
Total	738,535	744,271	(5,736)	(0 8%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (2,571)	$ 416	$ (2,987)	(718 0%)
OneCare Connect	(539)	(1,663)	1,124	67 6%
OneCare	63	(152)	215	141 4%
PACE	658	178	480	269 7%
505 Bldg	-	-	-	0 0%
Investment Income & Other	2,744	1,250	1,494	119 5%
Total	$ 355	$ 29	$ 326	1124 1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97 6%	95 8%	(1 8)
OneCare Connect	96 0%	99 3%	3 3
OneCare	86 4%	100 3%	14 0

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,194	$ 10,794	$ 1,600	14 8%
OneCare Connect	1,569	1,834	265	14 5%
OneCare	190	147	(43)	(29 5%)
PACE	184	182	(2)	(1 3%)
Total	$ 11,137	$ 12,957	$ 1,820	14 0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	976	1,183	207
OneCare Connect	174	210	36
OneCare	9	9	(0)
PACE	72	93	21
Total	1,231	1,495	263

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	740	616	124
OneCare Connect	82	67	15
OneCare	157	162	(5)
PACE	5	4	1
Total	984	849	136

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	4,387,242	4,395,338	(8,096)	(0 2%)
OneCare Connect	84,955	84,692	263	0 3%
OneCare	9,169	8,998	171	1 9%
PACE	2,172	2,154	18	0 8%
Total	4,483,538	4,491,182	(7,644)	(0 2%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 2,668	$ 16,390	$ (13,722)	(83 7%)
OneCare Connect	(5,838)	(8,552)	2,714	31 7%
OneCare	839	(759)	1,598	210 5%
PACE	1,541	915	626	68 4%
505 Bldg	-	-	-	0 0%
Investment Income & Other	17,543	7,500	10,043	133 9%
Total	$ 16,753	$ 15,494	$ 1,259	8 1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 7%	95 0%	(1 7)
OneCare Connect	97 6%	98 3%	0 7
OneCare	83 8%	98 7%	15 0

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 55,398	$ 64,813	$ 9,415	14 5%
OneCare Connect	9,430	10,958	1,528	13 9%
OneCare	895	882	(13)	(1 5%)
PACE	1,063	1,095	32	2 9%
Total	$ 66,786	$ 77,748	$ 10,962	14 1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,756	6,948	1,192
OneCare Connect	1,069	1,219	149
OneCare	50	56	6
PACE	427	551	124
Total	7,302	8,773	1,471

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	762	633	130
OneCare Connect	79	70	10
OneCare	185	161	24
PACE	5	4	1
Total	1,032	867	164

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended December 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	738,535		744,271		(5,736)	
REVENUE						
Medi-Cal	$ 275,967,740	$ 382.01	$ 268,400,817	$ 368.49	$ 7,566,924	$ 13.52
OneCare Connect	25,634,924	1,797 18	23,494,229	1,676.24	2,140,695	120.94
OneCare	1,858,375	1,268 52	1,605,835	1,066.29	252,540	202.23
PACE	3,119,050	7,936 51	2,934,008	7,761.93	185,042	174.58
Total Operating Revenue	306,580,089	415.12	296,434,889	398.29	10,145,200	16.83
MEDICAL EXPENSES						
Medi-Cal	269,348,748	372.85	257,190,594	353.10	(12,158,154)	(19.75)
OneCare Connect	24,605,306	1,724 99	23,323,461	1,664.06	(1,281,845)	(60.93)
OneCare	1,605,384	1,095.83	1,611,247	1,069.89	5,863	(25.94)
PACE	2,277,218	5,794.45	2,574,283	6,810.27	297,065	1,015.82
Total Medical Expenses	297,836,656	403.28	284,699,585	382.52	(13,137,071)	(20.76)
GROSS MARGIN	8,743,433	11.84	11,735,304	15.77	(2,991,871)	(3.93)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,534,437	10.20	8,117,930	10.91	583,493	0.71
Professional fees	278,488	0.38	473,968	0.64	195,480	0.26
Purchased services	868,017	1.18	1,233,276	1.66	365,259	0.48
Printing & Postage	450,117	0.61	565,973	0.76	115,856	0.15
Depreciation & Amortization	298,195	0.40	457,866	0.62	159,671	0.22
Other expenses	1,377,914	1.87	1,726,055	2.32	348,141	0.45
Indirect cost allocation & Occupancy expense	329,877	0.45	381,532	0.51	51,655	0.06
Total Administrative Expenses	11,137,046	15.08	12,956,600	17.41	1,819,554	2.33
INCOME (LOSS) FROM OPERATIONS	(2,393,612)	(3.24)	(1,221,296)	(1.64)	(1,172,316)	(1.60)
INVESTMENT INCOME						
Interest income	2,712,729	3.67	1,250,000	1.68	1,462,729	1.99
Realized gain/(loss) on investments	192,523	0.26	-	-	192,523	0.26
Unrealized gain/(loss) on investments	(161,120)	(0.22)	-	-	(161,120)	(0.22)
Total Investment Income	2,744,132	3.72	1,250,000	1.68	1,494,132	2.04
TOTAL GRANT INCOME	3,983	0.01	-	-	3,983	0.01
OTHER INCOME	197	-	-	-	197	-
CHANGE IN NET ASSETS	**354,699**	**0.48**	**28,704**	**0.04**	**325,996**	**0.44**
MEDICAL LOSS RATIO	**97.1%**		**96.0%**		**(1.1%)**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.4%**		**0.7%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	4,483,538		4,491,182		(7,644)	
REVENUE						
Medi-Cal	$ 1,744,576,305	$ 397.65	$ 1,614,129,315	$ 367.24	$ 130,446,991	$ 30.41
OneCare Connect	147,535,011	1,736.63	142,488,282	1,682.43	5,046,729	54.20
OneCare	10,694,591	1,166.39	9,744,647	1,082.98	949,944	83.41
PACE	17,118,886	7,881.62	16,744,129	7,773.50	374,757	108.12
Total Operating Revenue	1,919,924,793	428.22	1,783,106,373	397.02	136,818,420	31.20
MEDICAL EXPENSES						
Medi-Cal	1,686,506,692	384.41	1,532,926,445	348.76	(153,580,247)	(35.65)
OneCare Connect	143,943,738	1,694.35	140,082,291	1,654.02	(3,861,447)	(40.33)
OneCare	8,960,348	977.24	9,621,593	1,069.30	661,245	92.06
PACE	14,514,459	6,682.53	14,733,563	6,840.09	219,104	157.56
Total Medical Expenses	1,853,925,237	413.50	1,697,363,892	377.93	(156,561,345)	(35.57)
GROSS MARGIN	65,999,556	14.72	85,742,481	19.09	(19,742,925)	(4.37)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	43,829,579	9.78	48,695,363	10.84	4,865,784	1.06
Professional fees	1,804,960	0.40	2,820,225	0.63	1,015,266	0.23
Purchased services	5,595,165	1.25	7,399,656	1.65	1,804,491	0.40
Printing & Postage	2,202,515	0.49	3,402,466	0.76	1,199,951	0.27
Depreciation & Amortization	2,170,419	0.48	2,747,196	0.61	576,777	0.13
Other expenses	8,957,739	2.00	10,377,715	2.31	1,419,976	0.31
Indirect cost allocation & Occupancy expense	2,225,902	0.50	2,305,826	0.51	79,924	0.01
Total Administrative Expenses	66,786,278	14.90	77,748,447	17.31	10,962,169	2.41
INCOME (LOSS) FROM OPERATIONS	(786,722)	(0.18)	7,994,034	1.78	(8,780,756)	(1.96)
INVESTMENT INCOME						
Interest income	17,071,532	3.81	7,500,000	1.67	9,571,532	2.14
Realized gain/(loss) on investments	1,244,608	0.28	-	-	1,244,608	0.28
Unrealized gain/(loss) on investments	(773,307)	(0.17)	-	-	(773,307)	(0.17)
Total Investment Income	17,542,834	3.91	7,500,000	1.67	10,042,834	2.24
TOTAL GRANT INCOME	(3,096)	-	-	-	(3,096)	-
OTHER INCOME	374	-	-	-	374	-
CHANGE IN NET ASSETS	**16,753,389**	**3.74**	**15,494,034**	**3.45**	**1,259,356**	**0.29**
MEDICAL LOSS RATIO	**96.6%**		**95.2%**		**(1.4%)**	
ADMINISTRATIVE LOSS RATIO	**3 5%**		**4.4%**		**0.9%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended December 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	475,841	235,071	11,501	722,413	14,264	1,465	393	738,535
REVENUES								
Capitation Revenue	146,845,776	$ 106,356,246	$ 22,765,719	$ 275,967,740	$ 25,634,924	$ 1,858,375	$ 3,119,050	$ 306,580,089
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	146,845,776	106,356,246	22,765,719	275,967,740	25,634,924	1,858,375	3,119,050	306,580,089
MEDICAL EXPENSES								
Provider Capitation	39,236,442	45,000,600	10,663,970	94,901,012	11,257,299	464,784		106,623,094
Facilities	22,833,756	20,548,011	16,731,199	60,112,967	4,128,273	458,684	596,149	65,296,072
Ancillary	-	-	-	-	787,781	27,660	-	815,441
Professional Claims	16,190,145	6,466,456	1,763,936	24,420,537	-	-	465,224	24,885,761
Prescription Drugs	14,902,871	21,721,138	6,066,522	42,690,532	5,510,016	606,397	258,988	49,065,933
MLTSS	34,707,645	2,547,833	2,226,169	39,481,647	1,445,842	(7,830)	35,723	40,955,382
Medical Management	2,024,330	1,269,441	270,896	3,564,666	1,095,695	55,690	768,467	5,484,517
Quality Incentives	836,841	467,784	141,200	1,445,825	205,020		127,935	1,778,780
Reinsurance & Other	1,453,676	1,226,637	51,250	2,731,563	175,380		24,733	2,931,676
Total Medical Expenses	132,185,706	99,247,900	37,915,142	269,348,748	24,605,306	1,605,384	2,277,218	297,836,656
Medical Loss Ratio	90 0%	93 3%	166 5%	97 6%	96 0%	86 4%	73 0%	97 1%
GROSS MARGIN	**14,660,070**	**7,108,346**	**(15,149,423)**	**6,618,992**	**1,029,618**	**252,991**	**841,832**	**8,743,433**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,661,257	684,801	68,915	119,464	7,534,437
Professional fees				259,364	4,000	15,000	123	278,488
Purchased services				716,263	133,352	13,555	4,847	868,017
Printing & Postage				380,057	22,212	40,781	7,066	450,117
Depreciation & Amortization				296,109			2,087	298,195
Other expenses				1,342,959	30,781	(0)	4,175	1,377,914
Indirect cost allocation & Occupancy				(461,735)	693,393	51,701	46,518	329,877
Total Administrative Expenses				9,194,275	1,568,539	189,951	184,280	11,137,046
Admin Loss Ratio				3 3%	6 1%	10 2%	5 9%	3 6%
INCOME (LOSS) FROM OPERATIONS				(2,575,283)	(538,921)	63,040	657,552	(2,393,612)
INVESTMENT INCOME								2,744,132
TOTAL GRANT INCOME				3,983				3,983
OTHER INCOME				197				197
CHANGE IN NET ASSETS				**$ (2,571,103)**	**$ (538,921)**	**$ 63,040**	**$ 657,552**	**$ 354,699**
BUDGETED CHANGE IN NET ASSETS				416,117	(1,663,191)	(152,051)	177,829	28,704
VARIANCE TO BUDGET - FAV (UNFAV)				$ (2,987,220)	$ 1,124,270	$ 215,091	$ 479,723	$ 325,996

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Six Months Ended December 31, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,916,570	1,399,936	70,736	4,387,242	84,955	9,169	2,172	4,483,538
REVENUES								
Capitation Revenue	927,013,283	$ 678,161,206	$ 139,401,817	$ 1,744,576,305	$ 147,535,011	$ 10,694,591	$ 17,118,886	$ 1,919,924,793
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	927,013,283	678,161,206	139,401,817	1,744,576,305	147,535,011	10,694,591	17,118,886	1,919,924,793
MEDICAL EXPENSES								
Provider Capitation	234,485,638	270,312,091	60,061,429	564,859,158	66,475,888	2,846,557		634,181,604
Facilities	154,218,771	130,020,503	34,291,716	318,530,989	22,677,741	2,374,608	4,078,511	347,661,848
Ancillary	-	-	-	-	4,113,802	268,765	-	4,382,566
Professional Claims	107,725,220	42,324,904	7,672,013	157,722,137	-	-	3,298,005	161,020,142
Prescription Drugs	100,187,043	129,331,955	33,758,227	263,277,225	33,831,602	3,182,671	1,378,992	301,670,490
MLTSS	209,116,636	16,169,500	11,409,828	236,695,964	8,277,637	52,163	210,796	245,236,559
Medical Management	12,726,742	7,265,893	1,562,569	21,555,204	6,212,580	235,585	4,216,291	32,219,659
Quality Incentives	5,038,693	2,813,641	848,810	8,701,144	1,227,695		150,534	10,079,373
Reinsurance & Other	66,132,609	48,820,753	211,508	115,164,870	1,126,793		1,181,331	117,472,994
Total Medical Expenses	889,631,351	647,059,241	149,816,100	1,686,506,692	143,943,738	8,960,348	14,514,459	1,853,925,237
Medical Loss Ratio	96 0%	95 4%	107 5%	96 7%	97 6%	83 8%	84 8%	96 6%
GROSS MARGIN	**37,381,932**	**31,101,965**	**(10,414,283)**	**58,069,613**	**3,591,273**	**1,734,242**	**2,604,428**	**65,999,556**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				38,403,113	4,228,209	367,735	830,522	43,829,579
Professional fees				1,225,966	448,486	129,371	1,136	1,804,960
Purchased services				4,476,824	975,351	92,360	50,631	5,595,165
Printing & Postage				1,760,331	319,482	61,433	61,270	2,202,515
Depreciation & Amortization				2,157,878			12,541	2,170,419
Other expenses				8,826,484	106,988	1,427	22,841	8,957,739
Indirect cost allocation & Occupancy				(1,452,138)	3,351,109	242,917	84,014	2,225,902
Total Administrative Expenses				55,398,457	9,429,625	895,242	1,062,954	66,786,278
Admin Loss Ratio				3 2%	6 4%	8 4%	6 2%	3 5%
INCOME (LOSS) FROM OPERATIONS				2,671,157	(5,838,352)	839,000	1,541,473	(786,722)
INVESTMENT INCOME								17,542,834
TOTAL GRANT INCOME				(3,096)				(3,096)
OTHER INCOME				374				374
CHANGE IN NET ASSETS				**$ 2,668,435**	**$ (5,838,352)**	**$ 839,000**	**$ 1,541,473**	**$ 16,753,389**
BUDGETED CHANGE IN NET ASSETS				16,389,536	(8,551,745)	(759,254)	915,497	15,494,034
VARIANCE TO BUDGET - FAV (UNFAV)				$ (13,721,101)	$ 2,713,393	$ 1,598,254	$ 625,976	$ 1,259,356

December 31, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $0.4 million, $0.3 million favorable to budget
- Operating deficit is $2.4 million, with a surplus in non-operating income of $2.7 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $16.8 million, $1.3 million favorable to budget
- Operating deficit is $0.8 million, with a surplus in non-operating income of $17.5 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.6)	0.4	(3.0)	Medi-Cal	2.7	16.4	(13.7)
(0.5)	(1.7)	1.1	OCC	(5.8)	(8.6)	2.7
0.1	(0.2)	0.2	OneCare	0.8	(0.8)	1.6
0.7	0.2	0.5	PACE	1.5	0.9	0.6
(2.4)	**(1.2)**	**(1.2)**	**Operating**	**(0.8)**	**8.0**	**(8.8)**
2.7	1.3	1.5	Inv./Rental Inc, MCO tax	17.5	7.5	10.0
2.7	**1.3**	**1.5**	**Non-Operating**	**17.5**	**7.5**	**10.0**
0.4	**0.0**	**0.3**	**TOTAL**	**16.8**	**15.5**	**1.3**

CalOptima - Consolidated
Enrollment Summary
For the Six Months Ended December 31, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
64,297	65,846	(1,549)	(2.4%)	Aged	392,199	393,102	(903)	(0.2%)
540	615	(75)	(12.2%)	BCCTP	3,267	3,690	(423)	(11.5%)
48,677	43,692	4,985	11.4%	Disabled	272,935	262,672	10,263	3.9%
269,845	280,701	(10,856)	(3.9%)	TANF Child	1,698,963	1,704,859	(5,896)	(0.3%)
89,202	85,693	3,509	4.1%	TANF Adult	528,640	521,380	7,260	1.4%
3,279	3,404	(125)	(3.7%)	LTC	20,565	20,424	141	0.7%
235,071	235,481	(410)	(0.2%)	MCE	1,399,936	1,411,571	(11,635)	(0.8%)
11,501	12,940	(1,439)	(11.1%)	WCM	70,736	77,640	(6,904)	(8.9%)
722,413	**728,372**	**(5,959)**	**(0.8%)**	**Medi-Cal Total**	**4,387,242**	**4,395,338**	**(8,096)**	**(0.2%)**
14,264	**14,015**	**249**	**1.8%**	**OneCare Connect**	**84,955**	**84,692**	**263**	**0.3%**
1,465	**1,506**	**(41)**	**(2.7%)**	**OneCare**	**9,169**	**8,998**	**171**	**1.9%**
393	**378**	**15**	**4.0%**	**PACE**	**2,172**	**2,154**	**18**	**0.8%**
738,535	**744,271**	**(5,736)**	**(0.8%)**	**CalOptima Total**	**4,483,538**	**4,491,182**	**(7,644)**	**(0.2%)**
				Enrollment (by Network)				
159,384	161,635	(2,251)	(1.4%)	HMO	969,000	975,068	(6,068)	(0.6%)
202,278	208,003	(5,725)	(2.8%)	PHC	1,246,826	1,258,892	(12,066)	(1.0%)
175,852	186,538	(10,686)	(5.7%)	Shared Risk Group	1,090,862	1,126,324	(35,462)	(3.1%)
184,898	172,196	12,702	7.4%	Fee for Service	1,080,553	1,035,054	45,499	4.4%
722,413	**728,372**	**(5,959)**	**(0.8%)**	**Medi-Cal Total**	**4,387,242**	**4,395,338**	**(8,096)**	**(0.2%)**
14,264	**14,015**	**249**	**1.8%**	**OneCare Connect**	**84,955**	**84,692**	**263**	**0.3%**
1,465	**1,506**	**(41)**	**(2.7%)**	**OneCare**	**9,169**	**8,998**	**171**	**1.9%**
393	**378**	**15**	**4.0%**	**PACE**	**2,172**	**2,154**	**18**	**0.8%**
738,535	**744,271**	**(5,736)**	**(0.8%)**	**CalOptima Total**	**4,483,538**	**4,491,182**	**(7,644)**	**(0.2%)**

CalOptima
Enrollment Trend by Network
Fiscal Year 2020

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	YTD Actual	YTD Budget	Variance
HMOs									
Aged	3,723	3,740	3,754	3,821	3,827	3,743	22,608	22,803	(195)
BCCTP	1	1	2	2	1	1	8	6	2
Disabled	6,539	6,547	6,572	6,613	6,633	6,546	39,450	39,618	(168)
TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	317,871	318,204	(333)
TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	164,589	167,015	(2,426)
LTC	2	1	3	3	2	4	15	12	3
MCE	68,973	69,077	68,729	68,881	68,361	68,256	412,277	413,232	(955)
WCM	2,026	2,087	2,052	1,987	2,006	2,024	12,182	14,178	(1,996)
Total	**163,254**	**162,896**	**161,178**	**161,655**	**160,633**	**159,384**	**969,000**	**975,068**	**(6,068)**
PHCs									
Aged	1,548	1,540	1,524	1,542	1,577	1,579	9,310	9,180	130
BCCTP							-		0
Disabled	5,416	5,499	5,323	5,425	5,500	5,474	32,637	32,014	623
TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	873,151	882,838	(9,687)
TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	66,289	62,640	3,649
LTC			1		1	1	3		3
MCE	37,510	37,479	37,084	37,037	36,728	36,708	222,546	226,116	(3,570)
WCM	7 209	7 276	7 190	7 151	7 070	6 994	42 890	46 104	(3 214)
Total	**211,497**	**211,247**	**206,041**	**208,410**	**207,353**	**202,278**	**1,246,826**	**1,258,892**	**(12,066)**
Shared Risk Groups									
Aged	3,569	3,523	3,470	3,501	3,527	3,364	20,954	21,752	(798)
BCCTP						1	1		1
Disabled	7,275	7,294	7,144	7,177	7,200	7,139	43,229	41,079	2,150
TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	357,713	370,885	(13,172)
TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	166,556	171,814	(5,258)
LTC	1	3	3	2	1	1	11	6	5
MCE	84,595	83,922	82,492	81,749	80,096	79,714	492,568	508,986	(16,418)
WCM	1 732	1 706	1 620	1 598	1 581	1 593	9 830	11 802	(1 972)
Total	**189,144**	**187,219**	**179,572**	**181,034**	**178,041**	**175,852**	**1,090,862**	**1,126,324**	**(35,462)**
Fee for Service (Dual)									
Aged	51,730	52,454	52,097	52,050	52,649	51,770	312,750	312,411	339
BCCTP	15	18	17	18	19	20	107	108	(1)
Disabled	20,752	20,053	20,586	20,577	20,781	20,848	123,597	123,224	373
TANF Child		19	1	1	1	1	23		23
TANF Adult	964	1,923	949	941	963	938	6,678	5,389	1,289
LTC	3,044	3,097	3,061	3,161	3,204	2,971	18,538	18,294	244
MCE	2,116	2,171	1,935	1,717	1,737	2,255	11,931	12,390	(459)
WCM	15	15	15	16	15	16	92	96	(4)
Total	**78,636**	**79,750**	**78,661**	**78,481**	**79,369**	**78,819**	**473,716**	**471,912**	**1,804**
Fee for Service (Non-Dual)									
Aged	4,682	4,211	4,370	4,583	4,890	3,841	26,577	26,956	(379)
BCCTP	550	542	484	532	525	518	3,151	3,576	(425)
Disabled	4,928	5,692	4,374	4,930	5,428	8,670	34,022	26,737	7,285
TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	150,205	132,932	17,273
TANF Adult	19,658	19,951	19,512	19,854	23,011	22,542	124,528	114,522	10,006
LTC	328	326	331	347	364	302	1,998	2,112	(114)
MCE	40,680	41,152	40,342	41,308	48,994	48,138	260,614	250,847	9,767
WCM	843	960	978	1,008	1,079	874	5,742	5,460	282
Total	**97,240**	**104,940**	**86,516**	**97,857**	**114,205**	**106,079**	**606,837**	**563,142**	**43,695**
Grand Totals									
Aged	65,252	65,468	65,215	65,497	66,470	64,297	392,199	393,102	(903)
BCCTP	566	561	503	552	545	540	3,267	3,690	(423)
Disabled	44,910	45,085	43,999	44,722	45,542	48,677	272,935	262,672	10,263
TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	1,698,963	1,704,859	(5,896)
TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	528,640	521,380	7,260
LTC	3,375	3,427	3,399	3,513	3,572	3,279	20,565	20,424	141
MCE	233,874	233,801	230,582	230,692	235,916	235,071	1,399,936	1,411,571	(11,635)
WCM	11 825	12 044	11 855	11 760	11 751	11 501	70 736	77 640	(6 904)
Total MediCal MM	**739,771**	**746,052**	**711,968**	**727,437**	**739,601**	**722,413**	**4,387,242**	**4,395,338**	**(8,096)**
OneCare Connect	**14,257**	**14,090**	**14,186**	**14,093**	**14,065**	**14,264**	**84,955**	**84,692**	**263**
OneCare	**1,530**	**1,545**	**1,564**	**1,567**	**1,498**	**1,465**	**9,169**	**8,998**	**171**
PACE	**335**	**345**	**356**	**368**	**375**	**393**	**2,172**	**2,154**	**18**
Grand Total	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**	**738,535**	**4,483,538**	**4,491,182**	**(7,644)**

ENROLLMENT:

Overall December enrollment was 738,535

- Unfavorable to budget 5,736 or 0.8%
- Decreased 17,004 or 2.3% from prior month (PM) (November 2019)
- Decreased 27,659 or 3.6% from prior year (PY) (December 2018)

Medi-Cal enrollment was 722,413

- Unfavorable to budget 5,959 or 0.8%
  - Temporary Assistance for Needy Families (TANF) unfavorable 7,347
  - Whole Child Model (WCM) unfavorable 1,439
  - Medi-Cal Expansion (MCE) unfavorable 410
  - Long-Term Care (LTC) unfavorable 125
  - Seniors and Persons with Disabilities (SPD) favorable 3,361
- Decreased 17,188 from PM

OneCare Connect enrollment was 14,264

- Favorable to budget 249 or 1.8%
- Increased 199 from PM

OneCare enrollment was 1,465

- Unfavorable to budget 41 or 2.7%
- Decreased 33 from PM

PACE enrollment was 393

- Favorable to budget 15 or 4.0%
- Increased 18 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
722,413	**728,372**	**(5,959)**	**(0.8%)**	**Member Months**	**4,387,242**	**4,395,338**	**(8,096)**	**(0.2%)**
				Revenues				
275,967,740	268,400,817	7,566,924	2 8%	Capitation Revenue	1,744,576,305	1,614,129,315	130,446,991	8 1%
-	-	-	0 0%	Other Income	-	-	-	0 0%
275,967,740	**268,400,817**	**7,566,924**	**2.8%**	**Total Operating Revenue**	**1,744,576,305**	**1,614,129,315**	**130,446,991**	**8.1%**
				Medical Expenses				
96,346,837	94,788,872	(1,557,965)	(1 6%)	Provider Capitation	573,560,302	570,873,746	(2,686,556)	(0 5%)
60,112,967	48,878,808	(11,234,159)	(23 0%)	Facilities Claims	318,530,989	289,978,856	(28,552,134)	(9 8%)
24,420,537	23,486,089	(934,448)	(4 0%)	Professional Claims	157,722,137	138,736,994	(18,985,144)	(13 7%)
42,690,532	44,503,249	1,812,717	4 1%	Prescription Drugs	263,277,225	264,278,714	1,001,489	0 4%
39,481,647	37,649,494	(1,832,153)	(4 9%)	MLTSS	236,695,964	222,814,257	(13,881,706)	(6 2%)
3,564,666	4,674,658	1,109,992	23 7%	Medical Management	21,555,204	27,060,670	5,505,466	20 3%
2,731,563	3,209,424	477,861	14 9%	Reinsurance & Other	115,164,870	19,183,208	(95,981,662)	(500 3%)
269,348,748	**257,190,594**	**(12,158,154)**	**(4.7%)**	**Total Medical Expenses**	**1,686,506,692**	**1,532,926,445**	**(153,580,247)**	**(10.0%)**
6,618,992	**11,210,223**	**(4,591,230)**	**(41.0%)**	**Gross Margin**	**58,069,613**	**81,202,870**	**(23,133,256)**	**(28.5%)**
				Administrative Expenses				
6,661,257	7,099,305	438,048	6 2%	Salaries, Wages & Employee Benefits	38,403,113	42,622,769	4,219,656	9 9%
259,364	374,540	115,176	30 8%	Professional Fees	1,225,966	2,223,652	997,686	44 9%
716,263	954,254	237,991	24 9%	Purchased Services	4,476,824	5,725,520	1,248,696	21 8%
380,057	442,912	62,855	14 2%	Printing and Postage	1,760,331	2,664,104	903,773	33 9%
296,109	455,750	159,641	35 0%	Depreciation & Amortization	2,157,878	2,734,500	576,622	21 1%
1,342,959	1,645,292	302,333	18 4%	Other Operating Expenses	8,826,484	9,893,142	1,066,658	10 8%
(461,735)	(177,947)	283,788	159 5%	Indirect Cost Allocation, Occupancy Expense	(1,452,138)	(1,050,353)	401,785	38 3%
9,194,275	**10,794,106**	**1,599,831**	**14.8%**	**Total Administrative Expenses**	**55,398,457**	**64,813,334**	**9,414,877**	**14.5%**
				Operating Tax				
83,763,850	11,230,877	72,532,973	645 8%	Tax Revenue	83,763,850	67,765,618	15,998,232	23 6%
83,763,850	11,230,877	(72,532,973)	(645 8%)	Premium Tax Expense	83,763,850	67,765,618	(15,998,232)	(23 6%)
-	-	-	0 0%	Sales Tax Expense	-	-	-	0 0%
0	-	(0)	**0.0%**	**Total Net Operating Tax**	0	-	(0)	**0.0%**
				Grant Income				
27,648	-	27,648	0 0%	Grant Revenue	46,651	-	46,651	0 0%
11,767	-	(11,767)	0 0%	Grant expense - Service Partner	(8,713)	-	8,713	0 0%
11,898	-	(11,898)	0 0%	Grant expense - Administrative	58,460	-	(58,460)	0 0%
3,983	-	3,983	**0.0%**	**Total Grant Income**	(3,096)	-	(3,096)	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**(0)**	**-**	**(0)**	**0.0%**
197	**-**	**197**	**0.0%**	**Other income**	**374**	**-**	**374**	**0.0%**
(2,571,103)	**416,117**	**(2,987,220)**	**(717.9%)**	**Change in Net Assets**	**2,668,435**	**16,389,536**	**(13,721,101)**	**(83.7%)**
97.6%	***95.8%***	***(1.8%)***	***(1.9%)***	***Medical Loss Ratio***	***96.7%***	***95.0%***	***(1.7%)***	***(1.8%)***
3.3%	***4.0%***	***0.7%***	***17.2%***	***Admin Loss Ratio***	***3.2%***	***4.0%***	***0.8%***	***20.9%***

MEDI-CAL INCOME STATEMENT - DECEMBER MONTH:

REVENUES of $276.0 million are favorable to budget $7.6 million driven by:

- Unfavorable volume related variance of $2.2 million
- Favorable price related variance of $9.8 million due to:
  - $6.4 million of Coordinated Care Initiative (CCI) revenue, $2.0 million from prior year
  - $3.0 million of FY 2020 revenue due to Department of Health Care Services (DHCS) acuity rate adjustment
  - $2.8 million of FY 2020 LTC revenue from non-LTC members
  - Offset by $3.3 million of WCM revenue

MEDICAL EXPENSES of $269.3 million are unfavorable to budget $12.2 million driven by:

- Favorable volume related variance of $2.1 million
- Unfavorable price variance of $14.3 million due to:
  - Facilities Claims unfavorable variance of $11.6 million due to WCM
  - Provider Capitation unfavorable variance of $2.3 million due to Proposition 56

ADMINISTRATIVE EXPENSES of $9.2 million are favorable to budget $1.6 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.4 million
- Other Non-Salary expenses are favorable to budget $1.2 million

CHANGE IN NET ASSETS is ($2.6) million for the month, unfavorable to budget $3.0 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Six Months Ending December 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,264	**14,015**	**249**	**1.8%**	**Member Months**	**84,955**	**84,692**	**263**	**0.3%**
				Revenues				
2,428,984	2,757,701	(328,717)	(11 9%)	Medi-Cal Capitation Revenue	14,582,097	16,720,314	(2,138,217)	(12 8%)
16,907,270	15,980,441	926,829	5 8%	Medicare Capitation Revenue Part C	100,916,331	97,074,161	3,842,170	4 0%
6,298,670	4,756,087	1,542,583	32 4%	Medicare Capitation Revenue Part D	32,036,583	28,693,807	3,342,776	11 6%
-	-	-	0 0%	Other Income	-	-	-	0 0%
25,634,924	**23,494,229**	**2,140,695**	**9.1%**	**Total Operating Revenue**	**147,535,011**	**142,488,282**	**5,046,729**	**3.5%**
				Medical Expenses				
11,462,319	10,731,329	(730,990)	(6 8%)	Provider Capitation	67,703,583	65,321,049	(2,382,534)	(3 6%)
4,128,273	3,516,949	(611,324)	(17 4%)	Facilities Claims	22,677,741	20,942,326	(1,735,415)	(8 3%)
787,781	694,005	(93,776)	(13 5%)	Ancillary	4,113,802	4,090,189	(23,613)	(0 6%)
1,445,842	1,557,141	111,299	7 1%	MLTSS	8,277,637	9,333,910	1,056,273	11 3%
5,510,016	5,466,446	(43,570)	(0 8%)	Prescription Drugs	33,831,602	32,455,657	(1,375,945)	(4 2%)
1,095,695	1,138,158	42,463	3 7%	Medical Management	6,212,580	6,634,486	421,906	6 4%
175,380	219,433	44,053	20 1%	Other Medical Expenses	1,126,793	1,304,674	177,881	13 6%
24,605,306	**23,323,461**	**(1,281,845)**	**(5.5%)**	**Total Medical Expenses**	**143,943,738**	**140,082,291**	**(3,861,447)**	**(2.8%)**
1,029,618	**170,768**	**858,850**	**502.9%**	**Gross Margin**	**3,591,273**	**2,405,991**	**1,185,282**	**49.3%**
				Administrative Expenses				
684,801	825,634	140,833	17 1%	Salaries, Wages & Employee Benefits	4,228,209	4,907,785	679,576	13 8%
4,000	77,795	73,795	94 9%	Professional Fees	448,486	466,775	18,289	3 9%
133,352	242,988	109,636	45 1%	Purchased Services	975,351	1,457,932	482,581	33 1%
22,212	95,861	73,649	76 8%	Printing and Postage	319,482	575,162	255,680	44 5%
-	-	-	0 0%	Depreciation & Amortization	-	-	-	0 0%
30,781	71,889	41,108	57 2%	Other Operating Expenses	106,988	431,330	324,342	75 2%
693,393	519,792	(173,601)	(33 4%)	Indirect Cost Allocation	3,351,109	3,118,752	(232,357)	(7 5%)
1,568,539	**1,833,959**	**265,420**	**14.5%**	**Total Administrative Expenses**	**9,429,625**	**10,957,736**	**1,528,111**	**13.9%**
				Operating Tax				
-	-	-	0 0%	Tax Revenue	-	-	-	0 0%
-	-	-	0 0%	Premium Tax Expense	-	-	-	0 0%
-	-	-	0 0%	Sales Tax Expense	-	-	-	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
(538,921)	**(1,663,191)**	**1,124,270**	**67.6%**	**Change in Net Assets**	**(5,838,352)**	**(8,551,745)**	**2,713,393**	**31.7%**
96.0%	***99.3%***	***3.3%***	***3.3%***	***Medical Loss Ratio***	***97.6%***	***98.3%***	***0.7%***	***0.8%***
6.1%	***7.8%***	***1.7%***	***21.6%***	***Admin Loss Ratio***	***6.4%***	***7.7%***	***1.3%***	***16.9%***

ONECARE CONNECT INCOME STATEMENT - DECEMBER MONTH:

REVENUES of $25.6 million are favorable to budget $2.1 million driven by:

- Favorable volume related variance of $0.4 million
- Favorable price related variance of $1.7 million

MEDICAL EXPENSES of $24.6 million are unfavorable to budget $1.3 million

- Unfavorable volume related variance of $0.4 million
- Unfavorable price related variance of $0.9 million

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million

CHANGE IN NET ASSETS is ($0.5) million, favorable to budget $1.1 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,465	**1,506**	**(41)**	**(2.7%)**	**Member Months**	**9,169**	**8,998**	**171**	**1.9%**
				Revenues				
1,255,303	1,086,743	168,560	15 5%	Medicare Part C revenue	7,333,988	6,637,209	696,779	10 5%
603,072	519,092	83,980	16 2%	Medicare Part D revenue	3,360,603	3,107,438	253,165	8 1%
1,858,375	**1,605,835**	**252,540**	**15.7%**	**Total Operating Revenue**	**10,694,591**	**9,744,647**	**949,944**	**9.7%**
				Medical Expenses				
464,784	430,945	(33,839)	(7 9%)	Provider capitation	2,846,557	2,630,477	(216,080)	(8 2%)
458,684	513,200	54,516	10 6%	Inpatient	2,374,608	3,032,777	658,169	21 7%
27,660	56,033	28,373	50 6%	Ancillary	268,765	331,243	62,478	18 9%
(7,830)	46,040	53,870	117 0%	Skilled nursing facilities	52,163	272,118	219,955	80 8%
606,397	506,425	(99,972)	(19 7%)	Prescription drugs	3,182,671	3,002,539	(180,132)	(6 0%)
55,690	47,734	(7,956)	(16 7%)	Medical Management	235,585	287,496	51,911	18 1%
-	10,870	10,870	100 0%	Other medical expenses	-	64,943	64,943	100 0%
1,605,384	**1,611,247**	**5,863**	**0.4%**	**Total Medical Expenses**	**8,960,348**	**9,621,593**	**661,245**	**6.9%**
252,991	**(5,412)**	**258,403**	**4774.6%**	**Gross Margin**	**1,734,242**	**123,054**	**1,611,188**	**1309.3%**
				Administrative Expenses				
68,915	51,102	(17,813)	(34 9%)	Salaries, wages & employee benefits	367,735	309,086	(58,649)	(19 0%)
15,000	21,480	6,480	30 2%	Professional fees	129,371	128,880	(491)	(0 4%)
13,555	17,063	3,508	20 6%	Purchased services	92,360	102,378	10,018	9 8%
40,781	16,667	(24,114)	(144 7%)	Printing and postage	61,433	100,002	38,569	38 6%
(0)	4,738	4,738	100 0%	Other operating expenses	1,427	28,428	27,001	95 0%
51,701	35,589	(16,112)	(45 3%)	Indirect cost allocation, occupancy expens	242,917	213,534	(29,383)	(13 8%)
189,951	**146,639**	**(43,312)**	**(29.5%)**	**Total Administrative Expenses**	**895,242**	**882,308**	**(12,934)**	**(1.5%)**
63,040	**(152,051)**	**215,091**	**141.5%**	**Change in Net Assets**	**839,000**	**(759,254)**	**1,598,254**	**210.5%**
86.4%	***100.3%***	***14.0%***	***13.9%***	***Medical Loss Ratio***	***83.8%***	***98.7%***	***15.0%***	***15.1%***
10.2%	***9.1%***	***(1.1%)***	***(11.9%)***	***Admin Loss Ratio***	***8.4%***	***9.1%***	***0.7%***	***7.5%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
393	**378**	**15**	**4.0%**	**Member Months**	**2,172**	**2,154**	**18**	**0.8%**
				Revenues				
2,432,327	2,273,074	159,253	7 0%	Medi-Cal Capitation Revenue	13,464,975	12,950,172	514,803	4 0%
508,501	521,583	(13,082)	(2 5%)	Medicare Part C Revenue	2,834,326	2,999,312	(164,986)	(5 5%)
178,222	139,351	38,871	27 9%	Medicare Part D Revenue	819,585	794,645	24,940	3 1%
3,119,050	**2,934,008**	**185,042**	**6.3%**	**Total Operating Revenue**	**17,118,886**	**16,744,129**	**374,757**	**2.2%**
				Medical Expenses				
768,467	876,083	107,616	12 3%	Medical Management	4,216,291	5,237,141	1,020,850	19 5%
596,149	562,615	(33,534)	(6 0%)	Facilities Claims	4,078,511	3,157,355	(921,156)	(29 2%)
465,224	616,049	150,825	24 5%	Professional claims	3,298,005	3,463,194	165,189	4 8%
24,733	249,252	224,519	90 1%	Patient transportation	1,181,331	1,377,328	195,997	14 2%
258,988	234,600	(24,388)	(10 4%)	Prescription drugs	1,378,992	1,316,676	(62,316)	(4 7%)
35,723	29,018	(6,705)	(23 1%)	MLTSS	210,796	141,869	(68,927)	(48 6%)
127,935	6,666	(121,269)	(1819 2%)	Other Expenses	150,534	40,000	(110,534)	(276 3%)
2,277,218	**2,574,283**	**297,065**	**11.5%**	**Total Medical Expenses**	**14,514,459**	**14,733,563**	**219,104**	**1.5%**
841,832	**359,725**	**482,107**	**134.0%**	**Gross Margin**	**2,604,428**	**2,010,566**	**593,862**	**29.5%**
				Administrative Expenses				
119,464	141,889	22,425	15 8%	Salaries, wages & employee benefits	830,522	855,723	25,201	2 9%
123	153	30	19 4%	Professional fees	1,136	918	(218)	(23 7%)
4,847	18,971	14,124	74 4%	Purchased services	50,631	113,826	63,195	55 5%
7,066	10,533	3,467	32 9%	Printing and postage	61,270	63,198	1,928	3 1%
2,087	2,116	29	1 4%	Depreciation & amortization	12,541	12,696	155	1 2%
4,175	4,136	(39)	(0 9%)	Other operating expenses	22,841	24,815	1,974	8 0%
46,518	4,098	(42,420)	(1035 1%)	Indirect Cost Allocation, Occupancy Expense	84,014	23,893	(60,121)	(251 6%)
184,280	**181,896**	**(2,384)**	**(1.3%)**	**Total Administrative Expenses**	**1,062,954**	**1,095,069**	**32,115**	**2.9%**
				Operating Tax				
5,832	-	5,832	0 0%	Tax Revenue	32,232	-	32,232	0 0%
5,832	-	(5,832)	0 0%	Premium Tax Expense	32,232	-	(32,232)	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
657,552	**177,829**	**479,723**	**269.8%**	**Change in Net Assets**	**1,541,473**	**915,497**	**625,976**	**68.4%**
73.0%	***87.7%***	***14.7%***	***16.8%***	***Medical Loss Ratio***	***84.8%***	***88.0%***	***3.2%***	***3.6%***
5.9%	***6.2%***	***0.3%***	***4.7%***	***Admin Loss Ratio***	***6.2%***	***6.5%***	***0.3%***	***5.1%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Six Months Ending December 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				
47,933	23,102	(24,831)	(107.5%)	Purchase services	287,666	138,607	(149,059)	(107.5%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	986,963	1,048,350	61,387	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	104,859	95,196	(9,663)	(10.2%)
83,911	140,162	56,251	40.1%	Repair and maintenance	635,647	840,972	205,325	24.4%
23,494	46,432	22,938	49.4%	Other Operating Expense	288,091	278,592	(9,499)	(3.4%)
(337,309)	(400,287)	(62,978)	(15.7%)	Indirect allocation, Occupancy	(2,303,226)	(2,401,717)	(98,491)	(4.1%)
(0)	**-**	**0**	**0.0%**	**Total Administrative Expenses**	**0**	**-**	**(0)**	**0.0%**
0	**-**	**0**	**0.0%**	**Change in Net Assets**	**(0)**	**-**	**(0)**	**0.0%**

OTHER INCOME STATEMENTS – DECEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $63.0 thousand, favorable to budget $215.1 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $657.6 thousand, favorable to budget $479.7 thousand

CalOptima
Balance Sheet
December 31, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$465,465,756	Accounts Payable	$89,098,516
Investments	456,122,997	Medical Claims liability	753,310,433
Capitation receivable	383,024,805	Accrued Payroll Liabilities	11,421,423
Receivables - Other	30,875,068	Deferred Revenue	32,885,838
Prepaid expenses	7,065,129	Deferred Lease Obligations	6,359
		Capitation and Withholds	131,892,675
Total Current Assets	**1,342,553,755**	**Total Current Liabilities**	**1,018,615,245**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,574,782		
505 City Parkway West	50,489,717		
	98,150,864		
Less: accumulated depreciation	(49,943,873)		
Capital assets, net	48,206,991	Other (than pensions) post	
		employment benefits liability	25,440,671
Other Assets		Net Pension Liabilities	23,671,930
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,067,727,846**
Cash and Cash Equivalents	8,236,462		
Long-term Investments	558,844,370	Deferred Inflows	
Total Board-designated Assets	567,080,832	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	625,579,745	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,016,340,491**	TNE	95,518,594
		Funds in Excess of TNE	856,777,665
Deferred Outflows		**TOTAL NET POSITION**	952,296,259
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	**2,027,430,940**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,027,430,940**

CalOptima
Board Designated Reserve and TNE Analysis
as of December 31, 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	155,430,553				
	Tier 1 - Logan Circle	154,299,315				
	Tier 1 - Wells Capital	154,707,630				
Board-designated Reserve		464,437,498	316,285,764	492,773,346	148,151,734	(28,335,848)
TNE Requirement	Tier 2 - Logan Circle	102,643,334	95,518,594	95,518,594	7,124,740	7,124,740
	Consolidated:	**567,080,832**	**411,804,358**	**588,291,940**	**155,276,474**	**(21,211,108)**
	Current reserve level	*1.93*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
December 31, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	354,699	16,753,389
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	462,689	3,157,382
Changes in assets and liabilities:		
Prepaid expenses and other	(1,102,553)	(1,277,388)
Catastrophic reserves		
Capitation receivable	(94,415,296)	(61,958,106)
Medical claims liability	(8,902,224)	999,481
Deferred revenue	(28,289,534)	(18,148,925)
Payable to health networks	(26,651,825)	22,989,535
Accounts payable	83,427,458	46,431,790
Accrued payroll	906,731	1,219,488
Other accrued liabilities	(6,359)	(38,153)
Net cash provided by/(used in) operating activities	(74,216,214)	10,128,494
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	24,189,229	117,583,300
Change in Property and Equipment	(148,171)	(4,739,484)
Change in Board designated reserves	(1,234,534)	(6,935,425)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	22,806,524	107,709,478
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(51,409,691)	117,837,972
CASH AND CASH EQUIVALENTS, beginning of period	516,875,446	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**465,465,756**	**465,465,756**

BALANCE SHEET - DECEMBER MONTH:

ASSETS of $2.0 billion increased $20.8 million from November or 1.0%

- Capitation Receivables increased $91.8 million due to FY 2020 Managed Care Organization (MCO) tax and timing of capitation received
- Operating Cash decreased $51.4 million due to timing of capitation received and shared risk payments
- Investments decreased $24.2 million due timing of capitation received and shared risk payments

LIABILITIES of $1.1 billion increased $20.5 million from November or 2.0%

- Accounts Payable increased $83.4 million due to the state's retroactive reinstatement of MCO tax for FY 2020 year-to-date
- Deferred Revenue decreased $28.3 million due to prepayment from Centers for Medicare & Medicaid Services (CMS) in prior month
- Capitation and Withhold decreased $26.7 million due to payout of shared risk pool
- Medical Claims Liability decreased $8.9 million due to timing of claim payments

NET ASSETS total $952.3 million

Homeless Health Initiative and Allocated Funds
as of December 31, 2019

		Amount
Program Commitment		**$ 100,000,000**
Funds Allocation, approved initiatives:		
Be Well OC	$	11,400,000
Recuperative Care		8,500,000
Housing Supportive Services		2,500,000
Clinical Field Team Start-Up & Federally Qualified Health Center (FQHC)		1,600,000
Homeless Response Team (CalOptima)		6,000,000
Homeless Coordination at Hospitals		10,000,000
CalOptima 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 December 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 (Human 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
December	Medi-Cal	IS Infrastructure - Maintenance HW/SW - Microsoft True-Up	IS Infrastructure - Maintenance HW/SW - Network Connectivity - Extreme Networks	$53,000	Repurpose $53,000 from Microsoft True-Up to Network Connectivity - Extreme Networks.	2020
December	Medi-Cal	Facilities - 6th Floor Lunchroom Remodel	Facilities - Replace Conference Room AV Equipment	$13,000	To reallocate $13,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910	2020
December	Medi-Cal	Facilities - Conference Room 910 Upgrades	Facilities - Replace Conference Room AV Equipment	$17,000	To reallocate $17,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	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
February 6, 2020

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

- Timeliness Monitoring Project:

  On October 8, 2019, the Centers for Medicare & Medicaid Services (CMS) announced that it will conduct an industry-wide monitoring project in 2020, to evaluate the timeliness of processing of Medicare Advantage (Part C) organization determinations and reconsiderations and Medicare Prescription Drug (Part D) coverage determinations and redeterminations. The requested review period for this monitoring efforts is February 1, 2019 – April 30, 2019. Findings from this monitoring effort may result in compliance actions, if necessary, and may have implications for the Star Ratings data integrity reviews for the four (4) appeals measures. On January 6, 2020, CalOptima was formally notified of its selection for this monitoring effort, and is currently working internally to collect and review the ODAG/CDAG universes that will be due to CMS on January 28, 2020. CMS has not scheduled the webinar validations yet.

- Calendar Year (CY) 2015 Medicare Part C National Risk Adjustment Data Validation (RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On December 5, 2019, CMS hosted a training call for the plans selected regarding the audit process. Additional training on the submission of selected medical records will be held on January 9, 2020, and the submission window for medical records opened on January 10, 2020.

- National Contract Year 2017 Risk Adjustment Data Validation (RADV) Audit – Final Findings Report:

  On December 19, 2019, CMS provided the final report for the 2017 National RADV audit. The report indicates that three (3) of the six (6) hierarchical condition categories

(HCCs) reviewed could not be confirmed by CMS. CalOptima is awaiting notification of financial impact from CMS on the HCCs that could not be verified.

- 2020 CMS Readiness Checklist (applicable to OneCare and OneCare Connect):

  On October 3, 2019, CMS released the 2020 Readiness Checklist for Medicare Advantage organizations and Medicare-Medicaid Plans. Plans are expected to fulfill key operational requirements summarized in the Readiness Checklist for the 2020 benefit year. CalOptima's Office of Compliance completed its validation review of the requirements in the 2020 Readiness Checklist with all impacted departments. No deficiencies were identified.

- Medicare Data Validation Audit (applicable to OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. A kick-off call with CalOptima's independent contractor, Advent, was held on January 6, 2020. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2020. The validation audit is expected to take place starting in March and conclude in June 2020. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (IDUR) Controls

2. OneCare Connect

- CY 2020 Monitoring of Posted Comprehensive Formularies:

  On October 29, 2019, CMS announced it will be conducting a review to compare the formularies posted on the health plan's websites for CY 2020 with their approved formularies effective on January 1, 2020. On October 31, 2019, CMS notified CalOptima that its OneCare Connect program had been selected for this monitoring effort. On November 22, 2019, CMS notified CalOptima that it did not identify any potential discrepancies within the review sample; therefore, no action is required by CalOptima at this time.

- Performance Measure Validation (PMV):

  On 12/11/19, CMS' contractor, Health Services Advisory Group (HSAG), provided the draft report for the Performance Measure Validation (PMV) activity that was held in September 2019 for the following two (2) Medicare-Medicaid Plan (MMP) reporting measures:

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.

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- Core 2.1: *Members with an Assessment Completed within 90 Days of Enrollment*
- Core 3.2: *Members with a Care Plan Completed within 90 Days of Enrollment*

On January 8, 2020, CalOptima received the final report, which indicated that all measure data were compliant with CMS' specifications and data, as reported, were valid.

- Medicare Part D Prescription Drug Event Validation (PEPV) Audit – Final Findings Report:

  By way of background, on January 10, 2019, CMS informed CalOptima that its OneCare Connect program had been selected to participate in the CY 2017 Medicare PEPV audit. Through the PEPV audit, CMS validated the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2017 payments. On December 4, 2019, CMS issued the final report, which indicated that all four (4) PDEs selected for audit were successfully validated and compliant.

- CY 2018 National Risk Adjustment Data Validation (RADV) Audit

  On January 9, 2020, CMS notified CalOptima that one or more enrollees in its OneCare Connect program has been selected for the CY 2018 Medicare Part C Improper Payment Measure, known as the National Risk Adjustment Data Validation (RADV) activity or "NATl8 RADV." CMS will use the results of this review to calculate a program wide improper payment rate for Medicare Part C. CalOptima will be required to submit medical records for selected contracts to support the validation of risk adjustment data. CMS will host a training teleconference prior to the RADV medical record submission start date, which has not been set yet.

- Compliance Program Effectiveness (CPE) Audit (OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit of its compliance program on an annual basis. As such, CalOptima has engaged an independent auditor to ensure that its compliance program is administering all elements of an effective compliance program, as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The onsite audit took place the week of September 23 – 26, 2019, and covered all aspects of CalOptima's Compliance program, including but not limited to, delegation oversight, internal oversight, FWA, compliance training, policies and procedures, and other general compliance activities. On December 17, 2019, CalOptima received the final report. Overall, the independent auditor determined that CalOptima demonstrated an effective compliance program. The auditor identified two (2) conditions and one (1) observation, which are summarized below:

  - CalOptima did not demonstrate screening of employees, temporary employees, volunteers, consultants, governing body members and/or FDRs against the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists prior to hiring or contracting and monthly thereafter for two (2) of the twenty-two (22) sample files reviewed. This condition was the result of CalOptima's Human Resources (HR) department not screening a governing body member until one day after his appointment to the CalOptima Board of Directors and using an incorrect

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.

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last name for screening a temporary employee. The HR department has already implemented a correction plan to address these areas to mitigate the risk of this issue recurring.

- CalOptima did not undertake timely corrective actions in response to potential noncompliance and/or fraud, waste and abuse (FWA). This condition was the result of CalOptima's Office of Compliance lacking timely follow-through on corrective actions for issues that are considered low risk in two (2) of the files selected. CalOptima's Office of Compliance is taking steps to enhance its corrective action process to more timely address issues.

3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

  On November 7, 2019, DHCS sent CalOptima an engagement notice for a medical audit of CalOptima's Medi-Cal and OneCare Connect programs. The onsite audit will take place from January 27, 2019 to February 7, 2019. The audit will cover the review period of February 1, 2019 to January 31, 2020. The audit will cover CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) members, Medi-Cal services for SPDs, as well as Medicaid-based services in OneCare Connect.

  The DHCS will evaluate CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, member rights, quality management, and administrative and organizational capacity.

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which focuses on the accuracy and completeness of CY 2017 Medi-Cal RDT encounter 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 near future. 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 reviewed CalOptima's fiscal and administrative affairs and included an examination of CalOptima's financial reports.

  On January 9, 2020, the DMHC provided CalOptima with a draft audit report. The DMHC report noted CalOptima was in compliance in all areas, and no deficiencies were identified. CalOptima has ten (10) calendar days to review the report before the final report is published on the DMHC's website.

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.

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- 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.

B. Regulatory Notices of Non-Compliance

On December 20, 2019, CalOptima received a Notice of Deficiency from the DHCS. In the notice, the DHCS identified two (2) instances in October 2019 where CalOptima failed to timely notify the DHCS of changes in the availability or location of covered services, including termination of network providers and subcontractors. CalOptima's Regulatory Affairs & Compliance department is currently working with responsible business owners to address the deficiency. CalOptima submitted a timely response to the DHCS on January 17, 2020.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Policy and Procedure Reviews

   - During the September 2019 file review of Medi-Cal, OneCare, OneCare Connect, and PACE claims and provider dispute resolutions (PDRs), CalOptima's Claims department received a compliance score of 100% based on a focused review of the department's policies and procedures.

   - During the July-September 2019 file review of Medi-Cal, OneCare, and OneCare Connect call inquiries and exempt/oral grievances, CalOptima's Customer Service department received a compliance score of 100% for a focused audit of the department's policies and procedures.

2. Internal Monitoring: Medi-Cal [a\]

   - Behavioral Health Integration: Prior Authorizations (PA) Requests

Month	Timeliness for Routine	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Score for Denials
January-June 2019	100%	0%	N/A	100%

   - For the January-June 2019 file review of Medi-Cal behavioral health prior authorizations, CalOptima's Behavioral Health Integration department received a

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.

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compliance score of 67% based on a focused review of twelve (12) prior authorization requests selected for review.

- The lower compliance score of 0% for timeliness for denials for January - June 2019 was due to one (1) untimely prior authorization request.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of behavioral health prior authorization requests. The A&O department continues to work with the Behavioral Health Integration 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 authorizations.

- Behavioral Health Integration: Behavioral Health Services

Month	Reporting Universe Generation and Validation Processes	Behavioral Health Services Document Review	Behavioral Health Treatment Plan Case Review	Behavioral Health Turn Around Times (TAT) for Services
January-June 2019	100%	100%	100%	25%

- For the January-June 2019 file review of Medi-Cal behavioral health services, CalOptima's Behavioral Health Integration department received a compliance score of 81% based on a focused review of the department's policies and procedures, as well as twenty-four (24) behavioral health treatment plans selected for review.

- The lower compliance score of 25% for behavioral health turnaround times (TAT) for services for January-June 2019 was due to nine (9) untimely behavioral health treatment plans.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of behavioral health treatment plans. The A&O department continues to work with the Behavioral Health Integration 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 documentation of behavioral health treatment plans.

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.

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- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy	Policy and Procedure Review
August 2019	100%	100%	100%	100%	N/A
September 2019	100%	100%	100%	97%	100%
October 2019	100%	100%	100%	100%	N/A

  - For the September 2019 file review of Medi-Cal claims, CalOptima's Claims department received a compliance score of 99% based on a focused review of sixty (60) claims and a compliance score of 99% for timeliness based on the overall universe of professional claims.

  - For the October 2019 file review of Medi-Cal claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of sixty (60) claims and a compliance score of 99% for timeliness based on the overall universe of professional 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
August 2019	100%	100%	95%	98%	100%
September 2019	100%	100%	90%	100%	100%
October 2019	100%	100%	93%	100%	50%

  - For the September 2019 file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 98% based on a focused review of forty (40) claims and a compliance score of 99% for timeliness based on the overall universe of PDRs.

  - The lower compliance score of 90% for accurate PDR determinations for September 2019 was due to inaccurate PDR determinations.

  - For the October 2019 file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 89% for a focused review of forty (40) claims and a compliance score of 99% for timeliness based on the overall universe of PDRs.

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- The lower compliance score of 93% for accurate PDR determinations for October 2019 was due to inaccurate PDR determinations.
- Out of six (6) claims, the lower compliance score of 50% for clear and specific PDR resolution language for October 2019 was due to three (3) untimely and inaccurate interest payments.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate and timely processing of PDRs within regulatory requirements.

- Medi-Cal Customer Service: Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe Review
July – September 2019	100%	100%	100%

➢ For the July-September 2019 file review of Medi-Cal inquiries, CalOptima's Customer Service department received a compliance score of 100% based on a focused review of nine (9) inquiry calls selected for review.

- 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
July – September 2019	100%	0%	100%	100%	100%	100%

➢ For the July – September 2019 file review of Medi-Cal exempt grievances, CalOptima's Customer Service department received a compliance score of 100% based on the overall universe of exempt grievances.

➢ Based on a focused review of ten (10) exempt grievances, the lower compliance score of 0% was due to incorrect resolution dates in the universe.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of exempt grievances. The A&O department continues to work with the Customer Service

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department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate universe submissions.

3. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2019	100%	100%	100%	100%
September 2019	100%	100%	100%	100%
October 2019	100%	100%	100%	100%

➢ For the September 2019 file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of twenty (20) claims and a compliance score of 99% for timeliness based on the overall universe of paid and denied claims.

➢ For the October 2019 file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of twenty (20) claims and a compliance score of 99% for timeliness based on the overall universe of paid and denied claims.

- OneCare Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
July - September 2019	100%	100%	100%

➢ For the July - September 2019 file review of OneCare Part C inquiries, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) inquiry calls selected for review.

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- OneCare Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
July - September 2019	100%	100%	100%

  - For the July - September 2019 file review of OneCare Part D inquiries, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
July - September 2019	100%	100%	100%

  - For the July - September 2019 file review of OneCare oral grievances, CalOptima's Customer Service department received a compliance score of 100% based on a focused review of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2019	100%	90%	100%	100%
September 2019	90%	100%	100%	100%
October 2019	100%	100%	100%	90%

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- For the September 2019 file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 98% based on a focused review of twenty (20) paid and denied claims selected for review and a compliance score of 99% for timeliness based on the overall universe of professional claims.

- For the October 2019 file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 98% based on a focused review of twenty (20) paid and denied claims selected for review and a compliance 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
August 2019	100%	88%	100%
September 2019	100%	100%	N/A
October 2019	100%	100%	100%

- For the September 2019 file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 100% based on a focused review of one (1) PDR selected for review and a compliance score of 99% for timeliness based on the overall universe of PDRs.

- For the October 2019 file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 100% based on a focused review of five (5) PDRs selected for review and a compliance score of 100% for timeliness based on the overall universe of PDRs.

- OneCare Connect Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
July - September 2019	100%	100%	100%

- For the July - September 2019 file review of OneCare Connect Part C inquiries, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) inquiry calls selected for review.

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- OneCare Connect Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
July - September 2019	100%	100%	100%

  - For the July - September 2019 file review of OneCare Connect Part D inquiries, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) inquiry calls selected for review.

- OneCare Connect Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
July - September 2019	100%	100%	100%

  - For the July - September 2019 file review of OneCare Connect oral grievances, CalOptima's Customer Service department received a score of 100% based on a focused review of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances.

5. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
August 2019	100%	100%	100%	100%
September 2019	100%	100%	90%	100%
October 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.

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- For the September 2019 file review of PACE claims, CalOptima's Claims department received a compliance score of 98% based on a focused review of twenty (20) paid and denied claims selected for review.

- The lower compliance score of 90% for denied claims accuracy for September 2019 was due to one (1) inaccurate claim.

- For the October 2019 file review of PACE claims, CalOptima's Claims department received a score of 100% based on a focused review of twenty (20) claims selected for review.

- CalOptima's Audit & Oversight (A&O) department issued a request for a 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
August 2019	100%	100%	100%	N/A
September 2019	100%	100%	100%	100%
October 2019	100%	100%	100%	N/A

- For the September 2019 file review of PACE PDRs, CalOptima's Claims department received a score of 100% based on a focused review of one (1) PDR selected for review.

- For the October 2019 file review of PACE PDRs, CalOptima's Claims department received a score of 100% based on a focused review of twenty (20) PDRs selected for review.

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- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
August 2019	100%	100%
September 2019	100%	100%
October 2019	100%	100%

➢ For the September 2019 file review of PACE SDRs, CalOptima's PACE department received a score of 100% based on a focused review of eight (8) SDRs selected for review and compliance score of 100% for timeliness based on the overall universe of SDRs.

➢ For the October 2019 file review of PACE SDRs, CalOptima's PACE department received a score of 100% based on a focused review of nine (9) SDRs selected for review and compliance score of 100% for timeliness based on the overall universe of SDRs.

6. Health Network Monitoring: Medi-Cal [a\]

- 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
August 2019	55%	86%	93%	59%	59%	92%	92%	80%	92%	91%	67%	89%	67%
September 2019	45%	89%	96%	68%	77%	77%	93%	86%	77%	94%	75%	67%	88%
October 2019	69%	80%	90%	67%	72%	83%	97%	71%	83%	92%	100%	84%	96%

➢ Based on a focused review of select files, seven (7) health networks drove the lower compliance score for timeliness. Seventeen (17) of the twenty-five (25) files received from the seven (7) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
  – Failure to meet timeframe for decision (Urgent -72 hours, Routine – 5 business days)

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  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- Based on a focused review of select files, five (5) health network drove the lower compliance score for clinical decision making. Five (5) files of the eight (8) files received from the five (5) health networks were deficient. Deficiencies for the lower scores for clinical decision making include the following:
  - Failure to obtain appropriate professional to make decision
  - Failure to cite criteria for decision

- Based on a focused review of select files, six (6) health networks drove the lower compliance score for letter score. Nine (9) of the fourteen (14) files received from the six (6) health networks were deficient. Deficiencies for the lower letter scores 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
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify

- Based on the overall universe of Medi-Cal authorizations for September 2019, CalOptima's health networks received an aggregate compliance score of 99% for timely processing of routine authorization requests and a compliance score of 98% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2019	94%	88%	95%	92%
September 2019	95%	95%	88%	79%
October 2019	89%	93%	94%	92%

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.

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- Based on a focused review of select paid claims, three (3) health networks drove the decreased compliance score from 95% in September 2019 to 89% in October 2019 for untimely processing of multiple claims. Three (3) of the eight (8) files received were deficient for timeliness.

- Based on a focused review of paid claims, two (2) health networks drove the decreased compliance score from 95% in September 2019 to 93% in October 2019 due to missing documents that are required for processing accurate payment on claims. Three (3) of the eight (8) files received were deficient.

- Based on the overall universe of Medi-Cal claims for September 2019, CalOptima's health networks received an overall compliance score of 93% 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.

7. Health Network Monitoring: OneCare [a\]

- 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
August 2019	92%	100%	100%	100%	93%	100%	83%	99%
September 2019	70%	100%	100%	94%	94%	100%	84%	96%
October 2019	100%	100%	100%	93%	97%	100%	84%	96%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. One (1) out of the two (2) files received was deficient. Deficiencies for the lower score for timeliness include the following:
  - Failure to meet timeframe for decision (expedited)
  - Failure to meet timeframe for member oral notification (expedited)
  - Failure to meet timeframe for provider notification (expedited)

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.

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- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for September 2019, CalOptima's health networks received an overall compliance score of 99% for timely processing of standard Part C authorization requests and 81% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2019	94%	100%	94%	94%
September 2019	100%	100%	94%	88%
October 2019	100%	100%	96%	82%

- Based on a focused review of select files, two (2) health networks drove the decreased compliance score from 88% in September 2019 to 82% in October 2019 for denied claims accuracy decreased due to missing documents that are required for processing accurate payment on claims. Three (3) of the six (6) files received were deficient for denied claims accuracy.

- Based on the overall universe of OneCare claims for CalOptima's health networks for September 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 79% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 95% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the 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

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policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

8. Health Network Monitoring: OneCare Connect [a\]

- 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
August 2019	85%	100%	92%	68%	87%	**70%**	77%	88%	90%	90%	93%
September 2019	72%	100%	98%	86%	86%	**93%**	74%	92%	100%	83%	96%
October 2019	88%	100%	99%	90%	92%	**70%**	60%	73%	100%	89%	95%

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for clinical decision making. Five (5) of the eight (8) files received from the five (5) health networks were deficient. Deficiencies for the lower scores for clinical decision making 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 a focused review of select files, two (2) health networks drove the lower compliance letter score. All four (4) files received from the two (2) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member's preferred language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for September 2019, CalOptima's health networks received an overall compliance score of 99% for timely processing of routine authorization requests and 99% 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

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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
August 2019	90%	95%	96%	95%
September 2019	83%	92%	98%	93%
October 2019	88%	88%	94%	85%

- Based on a focused review of select files, three (3) health networks drove the decreased compliance score from 92% in September 2019 to 88% in October 2019 for paid claims accuracy due to missing documents that are required for processing accurate payment on claims. Three (3) of the six (6) files received were deficient for paid claims accuracy.

- Based on a focused review of select files, two (2) health networks drove the decreased compliance score from 98% in September 2019 to 94% in October 2019 for denied claims timeliness due to untimely processing of multiple claims. Three (3) of the ten (10) files received were deficient for timeliness.

- Based on a focused review of select files, two (2) health networks drove the decreased compliance score from 93% in September 2019 to 85% in October 2019 for denied claims accuracy due to missing documents that are required for processing accurate claims. Six (6) of the ten (10) files received were deficient for denied claims accuracy.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for September 2019, CalOptima's health networks received the following overall compliance scores:
  - 98% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 99% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 99% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of

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claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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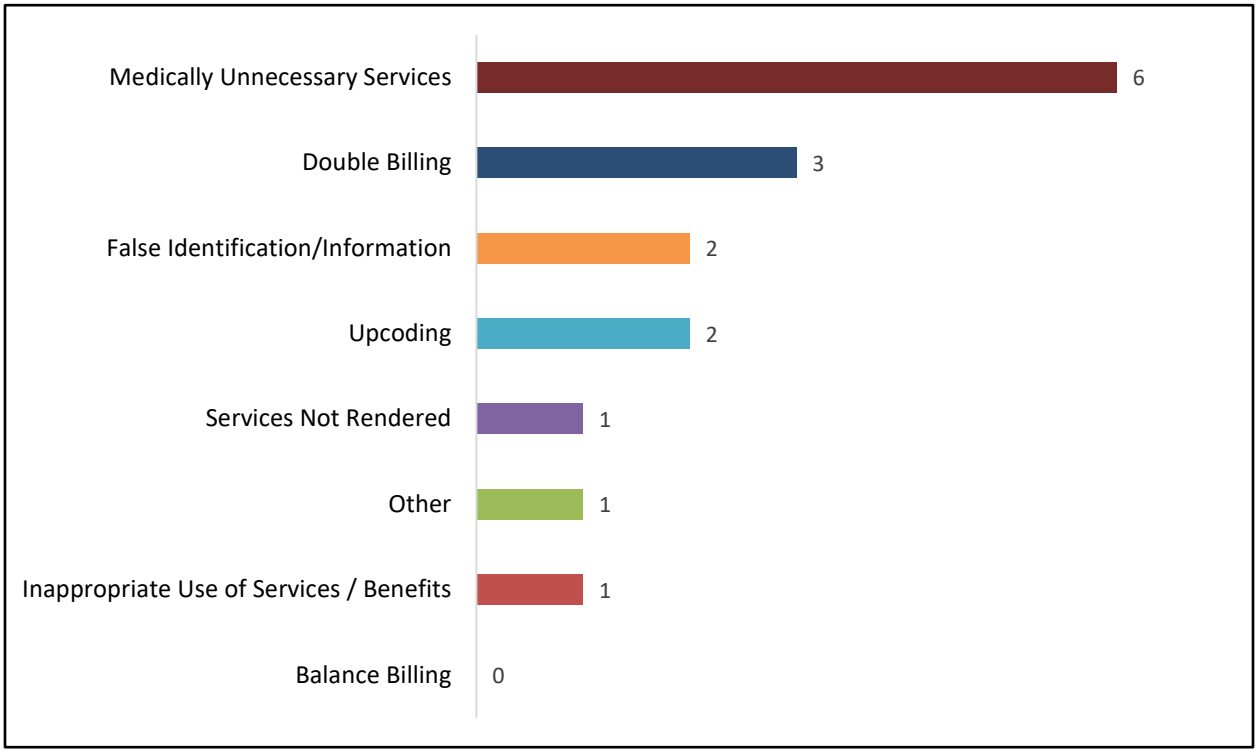
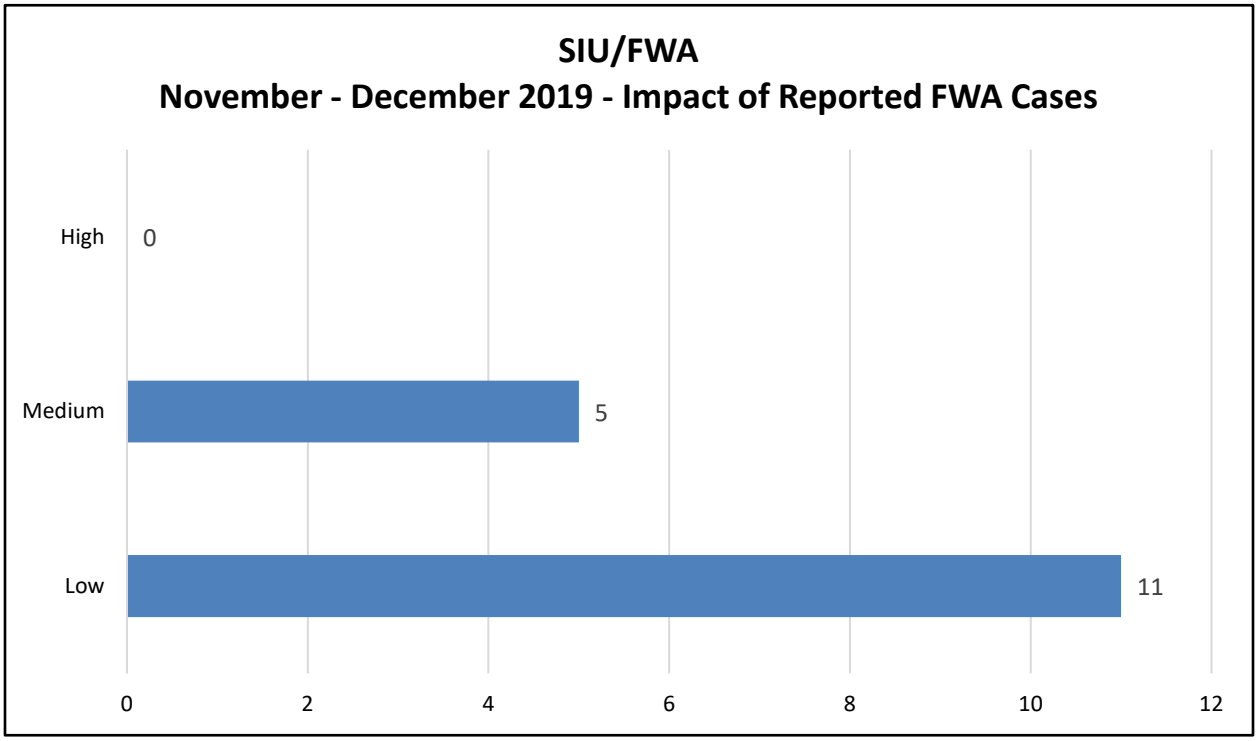
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in November and December 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.

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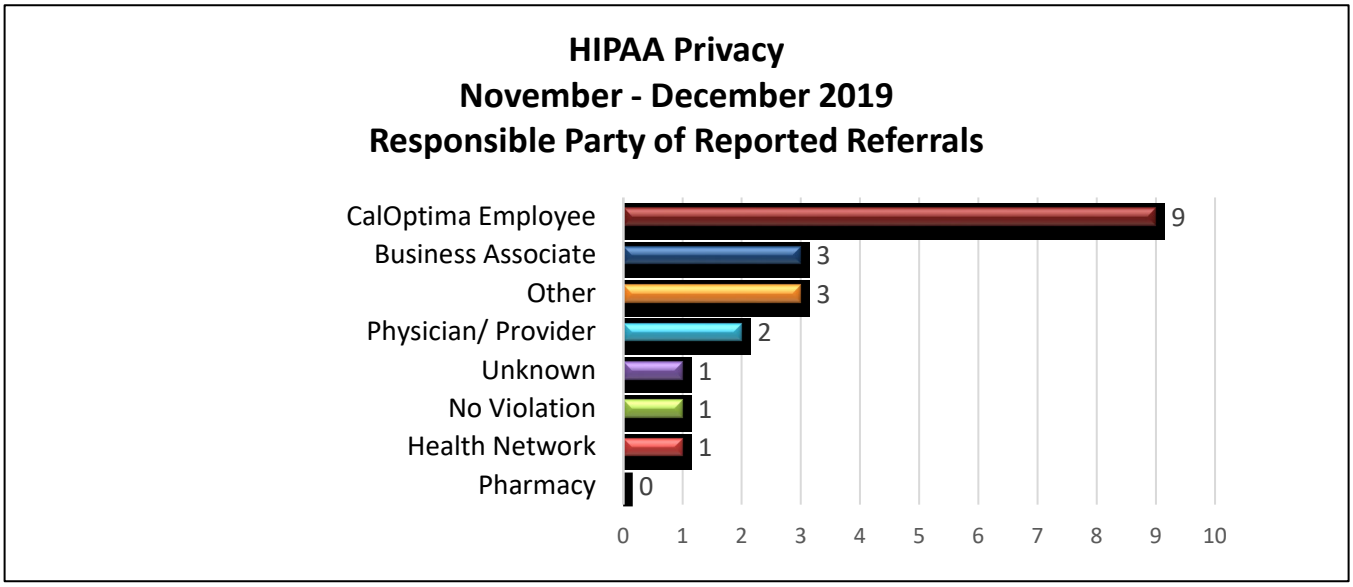
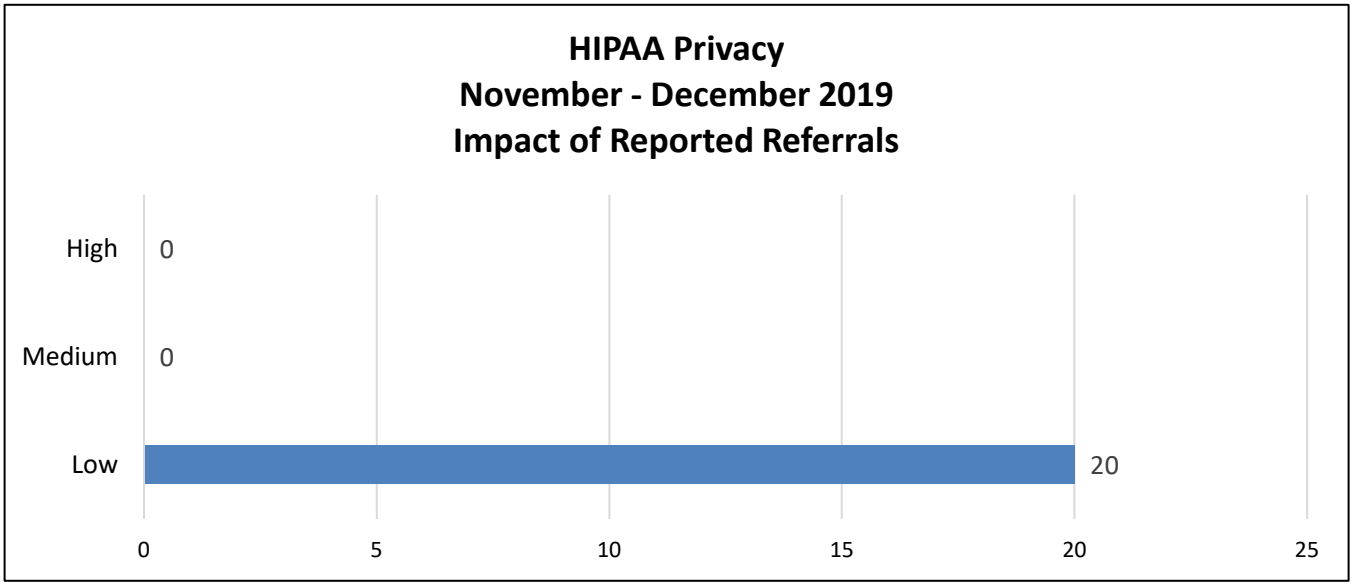
E. Privacy Update (November and December 2019)





Total Number of Referrals Reported to DHCS (State)	20
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**20**

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.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

January 13, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: January Board of Directors Report

Congress reached a major spending deal to close out 2019, wrapping up fiscal 2020 appropriations and extending a number of expiring health care programs until May. Legislative action on both surprise medical billing and drug pricing stalled but is expected to resume this year, testing the conventional wisdom that major legislation is difficult to pass in an election year. This report provides an update on activity through January 13, 2020.

Budget Deal and Extenders

On December 16, 2019, congressional appropriators released a $1.4 trillion Fiscal Year (FY) 2020 spending deal in two "minibuses." The first minibus (H.R. 1158) included the Defense, Homeland Security, Commerce-Justice-Science, and Financial Services appropriations bills. The second minibus (H.R. 1865) included the Agriculture-FDA, Labor-HHS-Education, Energy-Water, Interior-Environment, State-Foreign Operations, Transportation-HUD, Military Construction-VA, and Legislative Branch spending measures. The FY 2020 appropriations packages were signed into law by President Trump on December 20.

The Labor-HHS portion of the package included $94.4 billion in discretionary funding for the Department of Health and Human Services (HHS), an increase of $4.4 billion. This includes a $2.6 billion increase for the National Institutes of Health (NIH). Notably, the deal permanently repealed three major Affordable Care Act (ACA) taxes: the Cadillac tax on high-cost health plans, the medical device excise tax, and the health insurance tax. H.R. 1865 also extended a number of expiring health care programs and provisions through May 22, 2020, including: extension of the work geographic practice cost index floor; extension of funding for community health centers, the National Health Service Corps, and the teaching hospital graduate medical education program; and other public health programs.

The package delayed the Medicaid disproportionate share hospital (DSH) payment reductions until May 23 and extended several other Medicaid provisions, including:

- Money Follows the Person Rebalancing Demonstration (extension through May 22).

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- Community Mental Health Services Demonstration Program (extension through May 22).
- Protection for Medicaid Recipients of Home and Community-Based Services against Spousal Impoverishment (extension of spousal impoverishment protections through May 22).
- Medicaid Funding for the Territories (two years of Medicaid funding (FY 2021 and 2022) for Puerto Rico and other territories).

None of the surprise billing or comprehensive drug pricing proposals made it into the year-end packages to wrap up FY 2020 spending. However, the new May 22 deadline for Congress to extend certain expiring health care provisions provides a potential opportunity and legislative vehicle for Members to address bipartisan policy priorities, including surprise billing and drug pricing, prior to the 2020 Presidential election. Surprise billing and drug pricing are both likely to score as cost-savers and could be used to help offset the cost of longer-term health care "extenders" as well as individual health care bills already moving through the legislative process related to specific medical conditions and targeted health care benefits.

Meanwhile, the White House announced that the President's Budget Request will be sent to Congress on February 10, 2020, officially kicking off the FY 2021 appropriations process. The two-year budget caps deal reached by congressional appropriators and the White House in July should assist House and Senate Appropriations subcommittees with their allocations, and the House expects to debate many of the 12 spending bills in June. A final spending deal is not likely to be inked until after the election, however.

Drug Pricing Legislation

House Democrats voted in December to approve the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), but Senate Majority Leader Mitch McConnell (R-KY) has refused to take up the bill, which relies on government price negotiation and international reference pricing. The bill passed on a near-party line vote with two House Republicans supporting the measure.

Leader McConnell also has not committed to bring the Senate Finance Committee-passed Prescription Drug Pricing Reduction Act (S. 2543) to the floor, given opposition from many Republican senators, particularly with regard to the bill's penalties for manufacturers who increase the price of certain drugs above inflation. The Finance package initially passed out of Committee in July 2019 with a majority of Republicans on the panel voting against it. Finance Committee Chairman Chuck Grassley (R-IA) has criticized competing drug pricing legislation proposed by House Energy & Commerce Committee Republicans, arguing that it does not do enough to counter price increases by manufacturers.

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The year-end appropriations legislation did include the CREATES Act, which aims to stop abuse of Risk Evaluation and Mitigation Strategies (REMS) that prevent manufacturers from obtaining samples of a brand drug to create a generic version.

On December 18, the Administration announced a proposed rule to allow for importation of certain drugs from Canada and a draft guidance to enable drug manufacturers to import Food and Drug Administration (FDA)-approved drugs and biologics manufactured abroad. The comment period on the proposal closes in March. However, the Administration has not yet released its much-awaited International Pricing Index (IPI) Model proposed rule, which would tie reimbursement for certain Medicare Part B drugs to international prices, not unlike the core provision of H.R. 3. Strong congressional opposition to the proposal could result in legislative action to modify or overturn the rule, while prompting renewed consideration of alternatives to reduce prices.

Surprise Medical Billing

Bipartisan leaders of the Energy & Commerce Committee and Senate Health, Education, Labor and Pensions (HELP) Committee Chair Lamar Alexander (R-TN) announced a bicameral agreement on surprise medical billing in early December that relies on a benchmark payment rate for out-of-network bills along with a "baseball-style" arbitration process that parties have recourse to if the median in-network payment is above $750. HELP Committee Ranking Member Patty Murray (D-WA) did not endorse this plan, however, and other senators including Sens. Bill Cassidy (R-LA) and Maggie Hassan (D-NH) took issue with the benchmark payment approach.

The bipartisan leaders of the House Ways & Means Committee subsequently announced they were developing their own proposal for a "robust reconciliation process" that is expected to deviate from the benchmark approach. The Ways & Means Committee is expected to release legislative text and mark up its proposal in January. The Committee is also expected to take up the Improving Seniors' Timely Access to Care Act (H.R. 3107) to reform prior authorization practices within the Medicare Advantage program. Depending on what is produced by the Ways & Means Committee, substantial work is likely to be necessary to craft a compromise bill that can be included as part of the health extenders package in May.

Energy and Commerce Hearing

On January 8, the House Energy & Commerce Health Subcommittee held a hearing to consider several pieces of legislation to improve Americans' health care coverage and outcomes, including proposals related to sudden unexpected infant death, infant mortality, childhood asthma,

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congenital abnormalities, coverage of immunosuppressive drugs, and the Medicare Part B enrollment process. The Committee also examined H.R. 3935, the Protecting Patients Transportation to Care Act, introduced by Rep. Buddy Carter (R-GA). The legislation would codify existing regulations to include non-emergency medical transportation (NEMT) in the list of mandatory Medicaid benefits. The bill also would require state Medicaid programs to have in place a prior authorization or utilization management process for the benefit.

The bills before the Subcommittee are bipartisan and fairly noncontroversial, making them candidates for possible inclusion in a May extenders package. Stakeholders are pressing the committees of jurisdiction to take up other health care legislation for inclusion in the package as well. For example, a group of hospitals, health care providers, insurers and beneficiary advocates sent a letter to Energy & Commerce leaders urging consideration of Social Determinants of Health Accelerator Act (H.R. 4004), which would award grants to states and local entities to develop and implement Medicaid interventions that better address social determinants of health.

Affordable Care Act Litigation

The future of the ACA could come down to a crucial Supreme Court decision in 2020. On December 18, the Fifth Circuit Court of Appeals ruled that the ACA's individual mandate is unconstitutional because it can no longer be considered a tax after the Tax Cuts and Jobs Act of 2017 reduced the individual mandate penalty to $0. With regard to the severability of the law, the Fifth Circuit remanded the case back to the district court for further consideration of the issue. On January 3, 2020, the defendant states in *Texas v. United States* filed a petition with the U.S. Supreme Court seeking immediate review of the ruling. On January 10, the plaintiff states and the U.S. Department of Justice filed briefs asking the Supreme Court to deny the motion for expedited review. If expedited review is granted, a final decision on the constitutionality of the ACA could come before the end of the year and potentially prompt a legislative response by Congress. Otherwise, the case is likely to carry out for several additional years.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

CalOptima
Legislative Update
By Don Gilbert and Trent Smith
January 14, 2020

The Legislature has returned to Sacramento to begin the second year of the two-year session. Legislative hearings necessary to dispense with bills introduced last year have begun. Bills introduced in 2019 must pass out of their "house or origin" by January 31. Meanwhile, legislators have until February 21 to introduce new bills.

On January 10, Governor Newsom released the proposed 2020-2021 State Budget. The $222.2 billion budget, the largest State Budget in California's history, projects a $5.6 billion surplus and total reserves of $21 billion. Of interest to CalOptima, the Budget includes $167.9 billion ($47.4 billion General Fund and $120.5 billion other funds) for all health and human services programs. The Medi-Cal budget is proposed at $105.2 billion ($23.6 billion General Fund) in 2019-2020 and $107.4 billion ($26.4 billion General Fund) in 2020-2021. The Budget assumes that caseload will decrease approximately 1.3 percent from 2018-2019 to 2019-2020 and increase approximately 0.4 percent from 2019-2020 to 2020-2021. Medi-Cal is projected to cover approximately 12.9 million Californians, approximately one-third of the state's population, in 2020-2021.

The Governor's Budget places a great emphasis on making health care more affordable and accessible. Consistent with this theme is the Medi-Cal Healthier California for All initiative (formerly known as CalAIM, or the California Advancing and Innovating Medi-Cal initiative). The Governor's Budget summary explains that Medi-Cal has significantly expanded and changed over the last 10 years. Since implementing the Affordable Care Act, the Department of Health Care Services (DHCS) has undertaken many initiatives and adopted demonstration projects to improve care under the Medi-Cal program. Some of those demonstration programs include, Whole Person Care, the Coordinated Care Initiative, Health Homes, and public hospital system delivery transformation. The Medi-Cal Healthier California for All initiative (MCHCA) seeks to build upon the successes of these programs.

The Budget summary further explains that Medi-Cal enrollees may receive care from many different delivery systems including managed care, fee-for-service, mental health, substance use disorder, dental, developmental, and/or In-Home Supportive Services. The Administration argues that better coordination of health care delivery systems will improve clinical outcomes and assist beneficiaries with navigating the complex system. MCHCA will better coordinate between and integrate these delivery systems.

Additional goals of the MCHCA are to identify and manage member risk and need through whole person care approaches and addressing social determinants of health. In summary, placing more health services under the control of one administrator allows for better coordination and integration of care and will allow enrollees to receive better preventive care, live healthier lives, and ultimately save the state money. These goals seem to mirror the principles by which County Organized Health Systems operate.

To implement the MCHCA initiative effective January 1, 2021, the Budget includes $695 million ($348 million General Fund), growing to $1.4 billion ($695 million General Fund) in 2021-2022 and 2022-2023.

Responding to the requests of many Democratic legislators, the Budget also includes a plan to extend Medi-Cal to income-eligible young adults, regardless of immigration status, and expanding eligibility for no-cost Medi-Cal for persons aged 65 and older, and persons with disabilities up to 138 percent of the federal poverty level.

Another proposal outlined in the Governor's Budget is his plan to address the high costs of prescription drugs. As part of the Governor's Executive Order issued in January 2019, DHCS began to transition pharmacy services from Medi-Cal managed care to a fee-for-service system. This transition is intended to standardize the Medi-Cal pharmacy benefit statewide, improve the availability of pharmacy services with a pharmacy network that includes approximately 94 percent of the state's pharmacies, and strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers. The Administration estimates that centralizing the purchasing of prescription drugs will result in hundreds of millions of dollars in annual General Fund savings by fiscal year 2022-2023. Potential cost savings aside, some have questioned how the Governor rationalizes combining more health care services under one provider, as proposed in the MCHCA, while simultaneously carving out prescription drug benefits from Medi-Cal managed care.

In his press conference, the Governor announced that he will dedicate state funding to offset losses incurred by clinics and hospitals participating in the 340B program. This concern has been a major criticism of the Governor's Golden State Drug Program, as many clinics and hospitals rely on the funding they generate under the 340 program to supplement their operating budgets.

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A new approach to controlling prescription drug prices was also presented in the Budget. The Governor is proposing the new Generic Contracting Program, whereby the Administration will negotiate partnerships to establish the state's own generic drug label.

The state would contract with one or more generic drug manufacturers to manufacture certain generic drugs on behalf of the state and participating entities. The Governor argues that this proposal will increase competition in the generic market, resulting in lower generic drug prices for all purchasers.

Also included in the Medi-Cal portion of the Budget is the restorations of some optional benefits and expanding preventative services with a specific focus on screening for adverse childhood experiences. The Governor also wants to increase Medi-Cal provider rates and reward providers who agree to serve Medi-Cal patients. One specific proposal he has put forth is repaying loans for doctors and dentists who agree to serve Medi-Cal patients in under-resourced parts of the state.

As part of his effort to make health care more affordable, the Governor is proposing several new government offices and task forces. The Office of Health Care Affordability will be established in the Spring of 2020 and is charged with increasing price and quality transparency, developing specific strategies and cost targets for the different sectors of the health care industry, and financial consequences for entities that fail to meet these targets. Ultimately, the goal of this Office is to create savings for consumers who are directly impacted by increasing health care costs.

In addition, the Office of Health Care Affordability is tasked with creating specific strategies to address hospital cost trends by region, with a particular focus on cost increases driven by delivery system consolidation. The Office will also work to establish standards to advance evidence-based and value-based payments to physicians, physician groups, and hospitals as well as to advance administrative simplification.

The Budget also proposes establishing a Center for Data Insights and Innovation within the Health and Human Resources Agency. The Center will focus on leveraging data to develop knowledge and insights to improve program delivery and drive system transformation across health and human services.

The Center will integrate the Office of Innovation, the Office of the Patient Advocate, and the Office of the Health Information Integrity. Among its goals, this new Office hopes to improve the operational use and quality of integrated data for program

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planning, policy development, and rigorous research and evaluation. The Office will also strive to increase the state's ability to create evidence-based programs and maximize federal reimbursements. They also want to enhance the capacity of state staff to use linked data to inform policy and decision making.

In the area of behavioral health, the Administration is establishing the Behavioral Health Task Force at the Health and Human Services Agency. The Task Force will bring together relevant state departments, counties, consumers, health plans, providers, and other stakeholders. The Task Force will review existing policies and programs to improve the quality of care, and coordinate system transformation efforts to better prevent and respond to the impacts of mental illness and substance use disorders in California's communities. One of the goals of this task force is to develop better solutions to assist homeless individuals who suffer from mental health issues.

Also, the Budget proposes instituting a state individual mandate to stabilize the health insurance market. In addition, the Governor is proposing augmenting premium assistance for Covered California enrollees.

Finally, the Governor is assuming the Federal Government will approve California’s waiver application establishing a three-and-a-half year Managed Care Organization (MCO) provider tax. The Budget reflects these projected revenues beginning in 2021-2022, but not in the current budget year.

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2019–20 Legislative Tracking Matrix

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/17/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 385 Calderon	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Performance Outcome System:** Would require the Department of Health Care Service (DHCS) to improve existing performance outcome systems measuring the outcomes of EPSDT services.	**05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/05/2019** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services (IHSS).	**07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program (CHIP), is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment.	**05/16/2019** Committee on Appropriations; Hearing postponed at the request of the Committee **04/02/2019** Passed Committee on Health **02/15/2019** Introduced	CalOptima: Watch
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. The financial costs for In-Home Supportive Services (IHSS) is estimated to cost $13 million General Fund.	**09/13/2019** Held in Assembly **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
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

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 563 Quirk-Silva	**Mental Health Funding for the North Orange County Public Safety Task Force:** Would establish a two-year pilot program in Orange County with the appropriation of $16 million from the General Fund to support those experiencing a mental health crisis. Funds to be allocated to the North Orange County Public Safety Task Force: $8 million by January 1, 2020 and $8 million by January 1, 2021. Funds would establish programs such as urgent and nonurgent telephone lines, case management, and a mobile response team.	**05/16/2019** Committee on Appropriations; Held under submission **04/24/19** Passed Committee on Health **02/13/2019** Introduced	CalOptima: Watch Orange County Board of Supervisors: Support

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 852 Pan	**California Generic Prescription Drugs:** Would authorize the State of California to manufacture and manage their own generic prescription drugs.	**01/13/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 741 Kalra	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Provider Training:** Would expand provider training, for those providing EPSDT services, to include universal trauma screenings. Training would include how to administer and use the new trauma screening tool, providing care, proper diagnosis and referrals for patients who have tested positive in trauma screenings, and connecting patients to proper resources and care.	**05/16/2019** Committee on Appropriations; Held Under Submission **04/24/2019** Passed Committee on Health **02/19/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners:** Would permit nurse practitioners to open and operate their own private practice. Would also permit a board-certified nurse practitioner to perform specific functions, without supervision by a physician and surgeon, in settings such as clinics, medical group practices, and health care agencies.	**05/16/2019** Hearing postponed at the request of the Appropriations Committee **05/15/2019** Committee on Appropriations; Suspense file **04/11/2019** Passed Committee on Business and Professions **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

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** Carry-over bill; Moved to inactive filed 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: Co-Sponsor, Support
AB 316 Ramos/Rivas	**Medi-Cal Dental Services:** Would increase the fee-for-service reimbursement rate for Denti-Cal providers that provide services to individuals with special needs. Pending approval from the Centers for Medicare & Medicaid Services (CMS), the increase in reimbursement rates to Denti-Cal providers would allow the provider to be reimbursed for the additional time and resources required to treat a patient with special needs. Providers are currently not receiving additional funds if a patient with specials needs uses more time and resources than originally allocated. Would allow the member four dental visits within a twelve-month period. The reimbursement rate would increase from $100 per visit to $140 per visit with support from Proposition 56 dollars.	**05/17/2019** Committee on Appropriations; Held Under Submission **04/10/2019** Passed Committee on Health **01/30/2019** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support

*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: January 15, 2020

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
April 24	Last day for policy committees to hear and report bills to fiscal committees
May 1	Last day for policy committees to hear and report non-fiscal bills to the floor
May 15	Last day for fiscal committees to report fiscal bills to the floor
May 26–29	Floor session only
May 29	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 2–August 3	Summer recess
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 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).

CalOptima Board of Directors Legislative Update

FEBRUARY 6, 2020

BY TRENT SMITH

EDELSTEIN GILBERT ROBSON & SMITH LLC

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Legislative Overview

State Senate

29 Democrats

10 Republicans

1 Vacancy

State Assembly

61 Democrats

19 Republicans

1 No Party Preference

Governor Newsom - Year 2

- Remember Governor Brown?

EDELSTEIN GILBERT ROBSON & SMITH LLC

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State Budget Timeline

January – Governor releases state budget

March- May – Legislative Budget Sub-Committees review budget

May – Governor releases revised budget reflecting updates revenues

May-June – Legislative Budget Sub-Committees debate revised budget and pass committee reports on to full budget committees

Early June- Budget Committees in each house adopt budgets and pass to respective floors

Early June – Each house adopts own budget. Differences between the houses are resolved in a Joint Budget Conference Committee. Legislative leadership and Governor meet to resolve major differences in spending and policy priorities

June 15 – Both Senate and Assembly pass final budget to the Governor

July 1 – New fiscal year begins. Budget must be signed by the Governor before July 1

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Legislative Perspective of the Governor's Budget

- Still early – No Sub-Committee hearings
- Budget Committees have hosted a Budget Overview provided by the Department of Finance and Legislative Analyst Office (LAO)
  - Mostly positive comments from legislators

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Legislative Perspective on Medi-Cal Healthier California for All (Formerly CalAIM)

- Coordinated and Integrated Care – Sound familiar?
- Legislators seem supportive but will have questions when heard in budget committees
- Interested parties will weigh in
- Aggressive timeline for implementation
- Put all services under one umbrella – but carve out pharmacy?

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Healthy California for All Commission

- Created to respond to Single Payer legislative proposals
- Politically charged issue
- Commission will identify costs and hurdles associated with a possible California Single Payer program.

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Questions?

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Board of Directors Meeting
February 6, 2020

CalOptima Community Outreach Summary — December 2019 and January 2020

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 and 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
According to the lunar calendar and the Chinese zodiac, this year's Lunar New Year begins on Saturday, January 25, 2020, and is the Year of the Metal Rat. To welcome the Lunar New Year, Community Relations collaborated with various internal departments to host a resource table at two festivals — one held in Costa Mesa and one held in Fountain Valley. CalOptima participated in these festivals on Saturday, January 25, and Sunday, January 26, 2020, from 10 a.m. to 5 p.m. Staff handed out fliers and brochures about CalOptima's programs and services to thousands of attendees at both festivals and the concert. At the festivals, attendees tested their luck by spinning a prize wheel to win various giveaways.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
As of December 30, 2019, CalOptima expected to participate in 64 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

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Date	Events/Meetings
12/02/19	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
12/03/19	• Collaborative to Assist Motel Families
12/04/19	• Orange County Aging Services Collaborative General Meeting • Anaheim Human Services Network Meeting • Orange County Healthy Aging Initiative Meeting • Vietnamese American Service Providers Network Meeting
12/05/19	• Orange County Women's Health Project Advisory Board Meeting
12/06/19	• Covered Orange County General Meeting
12/09/19	• Stanton Collaborative Meeting • Fullerton Collaborative Meeting
12/11/19	• Orange County Communications Workgroup
12/12/19	• Kid Healthy Community Advisory Committee Meeting
12/18/19	• Orange County Diabetes Coalition • Covered Orange County Steering Committee • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting
12/19/19	• Garden Grove Community Collaborative Meeting • Orange County Care Coordination Collaborative for Kids Meeting • Orange County Children's Partnership Committee Meeting
12/23/19	• Community Health Research and Exchange
12/24/19	• Orange County Senior Roundtable Meeting
01/06/20	• Orange County Health Care Agency's Mental Health Services Act Steering Committee Meeting • Fullerton Collaborative Meeting
01/07/20	• Collaborative to Assist Motel Families
01/08/20	• Anaheim Homeless Collaborative • Mental Health Care Task Force Meeting • Orange County Communication Workgroup Meeting

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01/09/20	• Cal State Fullerton Center for Healthy Neighborhoods Community Advisory Board Meeting • Kid Healthy Community Advisory Committee Meeting • Buena Park Collaborative Meeting • Garden Grove Community Collaborative Advisory Committee Meeting • State Council on Developmental Disabilities Regional Advisory Committee Meeting
1/10/20	• Senior Citizens Advisory Committee Board Meeting • Orange County Diabetes Collaborative Meeting
1/13/20	• Orange County Veterans and Military Families Collaborative — Children and Family Workgroup Meeting • Fullerton Collaborative Meeting
1/14/30	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • San Clemente Youth Wellness and Prevention Coalition Meeting
1/15/20	• Orange County Communications Workgroup Meeting • La Habra Community Collaborative Meeting • Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable
1/16/20	• Orange County Disability Coalition • Garden Grove Community Collaborative Meeting • Orange County Children's Partnership Meeting
1/21/20	• Orange County Cancer Coalition Meeting • Placentia Collaborative Meeting • North Orange County Senior Collaborative All Members Meeting
1/22/20	• Santa Ana Unified School District Wellness Center Meeting
1/23/20	• Orange County Care Coordination for Kids Meeting
1/27/20	• Stanton Collaborative Meeting • Orange County Strategic Plan for Aging — Leadership Council Meeting
1/28/20	• Orange County Senior Roundtable

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TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff/ Volunteer to Attend	Events/Meetings
12/03/19	2	• Elder Abuse Town Hall — Trends in Elder Abuse: Protecting Yourself from Financial Vulnerability, hosted by Orange County Social Services Agency and the Office of Orange County Supervisor Donald P. Wagner
12/07/19	1	• Resource Expo hosted by Anaheim Elementary School District, Abraham Lincoln Elementary
12/08/19	3	• Public Health Awareness Seminar hosted by Iranian American Medical Association in collaboration with Society of Iranian Psychiatrists of North America and OMID Multicultural Institute for Development (Registration Fee: $300 included one resource table for outreach and speaking opportunity at the event)
12/11/19	1	• Family Holiday Celebration hosted by Delhi Community Center
12/14/19	4	• Breakfast with Santa hosted by Orange County Autism Foundation (Sponsorship Fee: $1,000 included one resource table for outreach)
	1	• Resource Health Fair hosted by Bridge Church
12/21/19	2	• Annual Community Breakfast with Santa hosted by the Cambodian Family Community Center (Sponsorship Fee: $500 included agency's logo on event fliers, Facebook page and one resource booth for outreach at event)
01/21/20	2	• Senior Event hosted by Board of Supervisor Donald P. Wagner and Orange County Social Services Agency
01/25/20	16	• Tet Festival 2020 hosted by Vietnamese Community of Southern California (Sponsorship Fee: $10,000 included booth in prime location at the festival, three display banners at the event, 20 mentions on stage, 25 radio impressions, 15 television impressions, full-size ad on 10,000 fliers and two backdrops on stage)
	16	• Annual Union of Vietnamese Student Association (UVSA) Tet Festival hosted by USVA (Sponsorship Fee: $10,000 included booth in prime location at the festival, agency's logo and link on event website, 45 admission tickets, two 3-day admission badges, seven 3-day parking hang tags, two display banners near main entrance, full-page ad in event program, logo on event ad in Vietnamese newspapers, social media impression appreciation post and graphic ad impressions on main stage)
01/30/20	2	• Choose Wellness Event hosted by Garden Grove Unified School District

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As of December 30, 2019, CalOptima expected to organize or convene the following 13 community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
12/09/19	• CalOptima's Info Series — Topic: Health Homes Program: Strengthening Care Coordination for At-Risk Members
12/10/19	• CalOptima's Homeless Stakeholder Engagement Strategy Session
12/12/19	• Population Health Management Workshop — Topic: Transcending Principles of Street Medicine and Their Clinical Application
01/08/20	• Community Alliance Forum — Topic: Leading with Gratitude
01/14/20	• Population Health Management Workshop — Topic: Reporting Child Abuse and Neglect
01/16/20	• CalOptima's Health Network Forum
01/22/20	• In-Home Supportive Services Electronic Rollout Workshop
01/29/20	• Cafecito: Latino Community Collaborative Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
12/03/19	• Community-Based Organization Presentation to Cal State Fullerton students in Nursing Program — Topic: Medi-Cal in Orange County
12/06/19	• County Community Service Center Health Seminar — Topic: Mindfulness-Based Stress Reduction Overview (Vietnamese)
12/13/19	• Community-Based Organization Presentation to Boat People SOS-CA — Topic: Medi-Cal in Orange County (Vietnamese) • Community-Based Organization Presentation to Saahas for Cause — Topic: Medi-Cal in Orange County
12/17/19	• County Community Service Center Health Seminar — Topic: Getting a Good Night's Sleep without Medication (Vietnamese)
01/30/20	• Community-Based Organization Presentation for the Choose Wellness Event hosted by Garden Grove Unified School District — Topic: Medi-Cal in Orange County

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CalOptima provided two endorsements consistent with CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, during this reporting period (e.g., letters of support, program/ public activity events with support or use of name/logo).

1. Letter of Support for Share Our Selves' Service Area Competition application to the Health Resources and Services Administration to renew its designation and funding as a Federally Qualified Health Center.
2. Letter of Support for Southland Integrated Services, Inc. Service Area Competition application to the Health Resources and Services Administration to renew its designation and funding as a Federally Qualified Health Center.

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CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
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We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

February

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Saturday, 2/1 10 a.m.–4 p.m.	+ Orange County Heritage Council Orange County Black History Parade & Cultural Faire	Health/Resource Fair Open to the Public	2 Staff	Downtown Anaheim Street Promenade 205 W. Center St. Anaheim

Monday, 2/3 1–4 p.m.	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	505 E. Central Santa Ana
Monday, 2/3 2:30–3:30 p.m.	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 2/4 9:30–11 a.m.	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 2/5 9–10:30 a.m.	++ OC Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 2/5 10 a.m.–12 p.m.	++ Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 2/5 10:30 a.m.–12 p.m.	++Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Thursday, 2/6 9–11 a.m.	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church Andrew's Hall 1855 Orange Olive Rd. Orange
Thursday, 2/6 11 a.m.–1 p.m.	+Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Courtyard Center 12732 Main Garden Grove
Friday, 2/7 9–10:30 a.m.	++Covered Orange County General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Friday, 2/7 10–11 a.m.	++ Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 2/8 10 a.m.–1 p.m.	+Clinic in the Park Family Health Expo	Health/Resource Fair Open to the Public	1 Staff	Higher Ground Youth and Family Services 1535 E. Broadway Anaheim

Saturday, 2/8 10:30-1 pm	+PACE Senior Health and Wellness Event	Health/Resource Fair Open to the Public	3 Staff	13300 Garden Grove Blvd. Garden Grove
Monday, 2/10 1-2:30 pm	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N Cabrillo Park Dr. Santa Ana
Tuesday, 2/11 9-10:30 am	++ Orange County Strategic Plan for Aging - Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 2/11 10-11:30 am	++ Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 2/11 3:30-5:30 pm	++ San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 2/12 12-1:30 pm	++ Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 2/12 3:30-4:30 pm	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Various locations
Thursday, 2/13 10-11:30 am	++ Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 2/13 12:30-1:30 pm	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC Building C 1901 E. Fourth St. Santa Ana
Tuesday, 2/18 11am-12pm	++ Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Library Community Room 411 Chapman Ave. Placentia
Wednesday, 2/19 9:15-11 am	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 2/19 11am-1pm	++ Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	1300 McFadden Ave., Rm. 13 Santa Ana
Wednesday, 2/19 1-4 pm	++ Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 2/20 7am- 1:30 pm	+ UCI Paul Merage School of Business 2020 Health Care Forecast Conference	Health/Resource Fair Open to the Public	Sponsorship $1,000 2 Staff	Arnold and Mabel Beckman Center 100 Academy Way

				Irvine
Thursday, 2/20 8:30-10 am	++ Orange County Children's Partnership Committee (OCCP)	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 2/20 11:30-1 pm	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 2/20 1-2:30 pm	++ 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
Monday, 2/24 9-11am	++ Community Health Research and Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St., Santa Ana
Monday, 2/24 12:30-1:30 pm	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 2/25 7:30-9 am	++ OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 2/25 2:30-4:30 pm	++ Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village in Santa Ana 1505 E. 17th St. Santa Ana
Thursday, 2/27 1:30-3:30 pm	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana