

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

**THURSDAY, APRIL 2, 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**  
Michael Schrader

**CHIEF COUNSEL**  
Gary Crockett

**CLERK OF THE BOARD**  
Sharon Dwiars

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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, prior to the meeting.

*The Board Meeting Agenda and supporting materials are available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at [www.caloptima.org](http://www.caloptima.org). Board meeting audio is streamed live on the CalOptima website at [www.caloptima.org](http://www.caloptima.org).*

**To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:**

- 1) Listen to the live audio at +1 (213) 929-4232 Access Code: 706-895-210 or**
- 2) Participate via Webinar at <https://attendee.gotowebinar.com/register/3297131212788090379> rather than attending in person. Webinar instructions are provided below.**

## **CALL TO ORDER**

Pledge of Allegiance  
Establish Quorum

## **PRESENTATIONS/INTRODUCTIONS**

None.

## **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.*

## **MANAGEMENT REPORTS**

1. [Chief Executive Officer Report](#)
  - a. CalOptima Response to COVID-19

## **CONSENT CALENDAR**

2. [Minutes](#)
  - a. Approve Minutes of the March 5, 2020 Regular Meeting of the CalOptima Board of Directors; the Minutes of the March 12, 2020 Special Meeting of the CalOptima Board of Directors; the Minutes of the March 23, 2020 Special Meeting of the CalOptima Board of Directors
  - b. Receive and File Minutes of the August 8, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee; October 10, 2019 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee; Provider Advisory Committee, Whole-Child Model Family Advisory Committee; October 24, 2019 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

## **REPORT ITEMS**

3. [Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus \(COVID-19\) Pandemic](#)
4. [Consider Actions Related to Coronavirus \(COVID-19\) Pandemic](#)
5. [Consider Ratification of Coronavirus Disease \(COVID-19\) Mitigation Activities](#)
6. [Consider Authorizing Amendment to the County of Orange Public Healthcare Services Contract, for the Provision of Targeted Engagement and Housing Supportive Services](#)
7. [Consider Approval of CalOptima Medi-Cal Directed Payments Policy](#)
8. [Consider Authorizing a Contract with an Additional Community-Based Adult Service \(CBAS\) Provider to Serve as an Alternative Care Setting \(ACS\) for CalOptima Program of All-Inclusive Care for the Elderly \(PACE\) Members and Authorizing the Chief executive Officer to Negotiate Rates for ACS Contracts](#)
9. [Consider Authorizing an Amendment to the Contract with Program of All-Inclusive Care for the Elderly \(PACE\) Transportation Provider Secure Transportation to Extend the Contract](#)

10. Consider Actions Related to the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospital Contracts
11. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated with Children's Hospital of Orange County, the University of California, Irvine and St. Joseph Health and its Affiliates
12. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with the University of California, Irvine
13. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with St. Joseph Health and its Affiliates
14. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with Children's Hospital of Orange County
15. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated with the University of California, Irvine, or St. Joseph Healthcare and its Affiliates
16. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with the University of California, Irvine
17. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with St. Joseph Healthcare and its Affiliates
18. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates
19. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with St. Joseph Healthcare and its Affiliates
20. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with the University of California, Irvine
21. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts and contracts with MedImpact Healthcare Systems, Inc. and Vision Service Plan
22. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policy

23. Consider Approval of an Executive Employment Agreement for a Temporary (Interim) Chief Executive Officer
24. Consider Authorizing Contract with an Executive Search Firm for Chief Executive Officer Recruitment
25. Consider Recommended Appointment to the CalOptima Board of Directors' Member Advisory Committee
26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
27. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event

**ADVISORY COMMITTEE UPDATES**

28. Member Advisory Committee Update
29. Provider Advisory Committee Update
30. OneCare Connect Member Advisory Committee Update

**INFORMATION ITEMS**

31. COVID-19 Update
32. Introduction to the FY 2020-21 CalOptima Budget: Part 1
33. Whole Child Model Financial Update
34. February 2020 Financial Summary
35. Compliance Report
36. Federal and State Legislative Advocates Reports
37. CalOptima Community Outreach and Program Summary

**BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS**



**CLOSED SESSION**

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

CS-2 Pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS-3 Pursuant to Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS  
Agency Designated Representatives: (Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair)  
Unrepresented Employee: (Chief Executive Officer)

**ADJOURNMENT**

Webinar Instructions for Joining the Regular Meeting of the CalOptima Board of Directors  
April 2, 2020 at 2:00 p.m.

- 1. Please register for April Meeting of the CalOptima Board of Directors on April 2, 2020 2:00 PM PDT at:**

<https://attendee.gotowebinar.com/register/3297131212788090379>

- 2. After registering, you will receive a confirmation email containing a link to join the webinar at the specified time and date.**

*Note: This link should not be shared with others; it is unique to you.*

Before joining, be sure to [check system requirements](#) to avoid any connection issues.

- 3. Choose one of the following audio options:**

TO USE YOUR COMPUTER'S AUDIO:

When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

--OR--

TO USE YOUR TELEPHONE:

If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

United States: +1 (213) 929-4232

Access Code: 706-895-210

Audio PIN: Shown after joining the webinar

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## MEMORANDUM

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**DATE:** March 25, 2020

**TO:** CalOptima Board of Directors

**FROM:** Michael Schrader, CEO

**SUBJECT:** CEO Report — April 2, 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

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### **Orange County, CalOptima Responding to Community Spread of COVID-19**

The coronavirus disease 2019 (COVID-19) pandemic has dramatically and swiftly changed CalOptima’s daily operations. As we respond to the health care emergency declared at the national, state and local level, we are quickly adapting our usual approaches to address the needs of members, providers, employees and stakeholders. As of March 25, Orange County had 187 cases of COVID-19. Below are updates in key areas.

#### State Waiver Requests

On March 16, the Department of Health Care Services (DHCS) sent a Section 1135 Waiver [request](#) to the Centers for Medicare & Medicaid Services (CMS), asking for certain flexibilities that would support a more nimble response to COVID-19. The waiver addresses issues of provider participation, billing requirements and payment conditions to maintain beneficiary access and provider capacity; service authorization and utilization controls; state fair hearing requests and appeal deadlines; benefit flexibilities; telehealth/virtual visits; payment rates; eligibility flexibilities; and administrative activities. By Thursday, March 19, conditions had changed so rapidly that the state issued a second waiver [request](#) asking CMS for additional flexibilities. On March 23, CMS approved some of California’s requested changes, releasing a summary on its website [here](#). Unless otherwise specified, the waivers are effective March 1, 2020, and will end upon termination of the public health emergency. CMS also indicated it will continue to review the remaining requests.

#### Temporary Housing for Homeless Individuals

On March 24, CalOptima received a letter from 10 members of the Orange County State Legislative delegation requesting that CalOptima use Medi-Cal funds (revenue and/or reserves) to provide rent, temporary housing, shelter and related services for homeless individuals who are at high risk for, exhibiting symptoms of or ill with COVID-19. On March 25, Board of Directors Chair Paul Yost, M.D., and I hosted a call with approximately 20 staff representatives from Orange County’s state and federal legislative offices. During the call, CalOptima agreed to promptly send a letter from our Congressional delegation to the Acting Director of CMS, to implore CMS to approve the remaining elements of California’s Section 1135 Waiver requests, and in particular, the provision that would allow for Medi-Cal coverage and federal financial participation in expenditures related to temporary housing for the homeless as a result of the COVID-19 public health emergency.

### Legislation and Executive Actions

Local Health Plans of California has compiled a useful grid of the many legislative and executive actions that have passed or are pending as a result of COVID-19. These cover a range of activities affecting areas such as uninsured populations, Medi-Cal redeterminations, food assistance programs, housing protections, education, unemployment and paid leave. While the grid's information is fluid and subject to change, the March 24 edition follows my CEO Report.

### California Advancing and Innovating Medi-Cal (CalAIM)

Due to the pandemic, DHCS is postponing CalAIM regional meetings that had been scheduled between April 16 and May 4. The meetings were intended to provide technical assistance to health plans, counties and community-based organizations regarding the implementation of Enhanced Care Management and In Lieu of Services. However, the state did not announce that the January 1, 2021, proposed start date for those benefits was changing. But observers are beginning to question whether all the various CalAIM initiatives can follow the same timeframe given the current intense demands on health plans.

### Brown Act

As part of his emergency declaration, Gov. Gavin Newsom signed an Executive Order temporarily waiving the Brown Act provisions that require Board members participating in Board meetings to either be (a) physically present or (b) at an agendaized teleconference location. In other words, each Board member now has the option of participating in CalOptima Board meetings telephonically without listing their physical location on the agenda or making that location accessible to the public. The public will continue to have the option of attending Board meetings in person but minimizing physical attendance is encouraged to help control the spread of COVID-19. To that end, future Board meetings and advisory committee meetings will be live streamed and accessible via GotoWebinar, and instructions will be available on CalOptima's website.

### Providers and Health Networks

CalOptima is communicating frequently to contracted providers and health networks via website [updates](#) and fax blasts. Of note, we shared the new, more flexible rules that were just released regarding telephonic/telehealth visits during the national health emergency as well as information regarding COVID-19 testing availability, protocols and reimbursement codes. On March 19, CalOptima held the regularly scheduled monthly Health Network Forum via conference call. Chief Medical Officer David Ramirez, M.D., and Medical Director Miles Masatsugu, M.D., provided an extensive COVID-19 update. Our staff also detailed welcome changes that offer health networks some flexibility with reporting in light of staff demands in responding to the crisis.

### Hospital Payments

The California Hospital Association reached out asking for health plans to process the FY 2018–19 SB 239 Quality Assurance Fee (QAF) payments and Phase 2 FY 2017–18 directed payments, based on the growing pressure on safety net hospitals and concerns about shortages of supplies. In Orange County, QAF payments for the period are \$154 million and Phase 2 directed payments are \$91 million. CalOptima distributed the QAF payments on March 20 and will release the directed payments by March 31.

### Community-Based Adult Services (CBAS) Centers

CBAS centers are an essential element of the health care delivery system for frail seniors, yet hundreds of centers statewide have reported to DHCS that they are at risk of closing because of decreases in their daily census. In response to this emergency, DHCS included CBAS centers in the 1135 Waiver request, outlining alternative format services that the state proposed as eligible for continued reimbursement, including telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments; home-delivered meals in the absence of meals at the CBAS center; and physical therapy or occupational therapy in the home. To ensure that seniors continue to receive need care, CalOptima will be requesting Board approval on April 2 to implement the CBAS changes outlined by DHCS.

### Program of All-Inclusive Care for the Elderly (PACE)

As attendance at the CalOptima PACE center is limited by social distancing, participants are now receiving necessary services through alternative means in a “PACE Without Walls” model. Vans have been repurposed from transporting participants to delivering critical medical supplies, equipment and meals to participants’ homes. Our partner pharmacy is also delivering medications to homes. Home care providers are offering intervention and assistance with daily living tasks in the home. Most PACE staff have transitioned to telework, so they are making daily wellness calls to all 399 participants as well as participating in remote interdisciplinary team meetings. The PACE clinic remains open, and staff are on the front lines of patient care. Reflecting commitment and ingenuity, clinicians donned personal protective equipment to provide the first-ever drive-thru clinic visit in the PACE parking lot on March 20.

### Nurse Advice Line With Physician Consult

On March 19, DHCS asked that Medi-Cal plans immediately move to offer no-barriers access for members to their nurse advice lines with a warm handoff to a M.D. consult if needed. CalOptima’s nurse advice line is staffed by Carenet Health, which has a contractual relationship with MDLIVE. We immediately reached out to begin contract revisions to leverage its physician consult services. Because of the emergency nature of this mandated change, we will ask your Board to ratify this contract revision on May 7.

### Whole-Child Model (WCM)

Services for WCM members are changing with the closure of the school districts. The county announced that Medical Therapy Units, which are located on school campuses, are limiting services to medically urgent appointments.

### Health Homes Program (HHP)

DHCS has suspended the face-to-face requirement for HHP care coordination and health risk assessment, out of an abundance of caution for health plan staff.

### Clinical Field Teams (CFTs)

Two community health centers have suspended their CFT operations out of concern for staff and to limit community contact. Three other organizations remain available for dispatch, although the volume of referrals has decreased recently. CalOptima is continuing to support CFTs while being mindful of their safety. CalOptima has also taken steps to protect our Homeless Response Team (HRT) staff in the community by having them offer services remotely. The HRT telephone

referral lines and care coordination staff remain available to support the CFTs. CalOptima scheduled a March 25 conference call with CFT leaders and medical directors to ensure we can continue to coordinate our efforts to serve the vulnerable homeless population.

### Employees

CalOptima is exempted from the governor's Stay at Home Order based on our role in health care, which is one of the 16 essential critical infrastructure sectors. However, to respond to social distancing mandates, CalOptima is accelerating employees' transition to temporary telework and holding internal meetings via phone or webinar. As of March 25, and thanks to a rapid deployment process developed by our Information Services team, 82% of CalOptima's 1,355 employees are working from home. We also adjusted work duties for staff who typically have a role in the community. For example, our long-term care staff stopped visiting nursing homes and are approving all continuation requests through other means. Furthermore, CalOptima has clarified our expectations regarding reliably performing job duties while on temporary telework status, especially in cases where an employee's child may be home and off from school. Finally, CalOptima's building will remain open for employees who need to work here either because their home situation is incompatible with telework and/or they would have no job if the building is closed (i.e., Facilities staff). To ensure employees have current information, we increased the frequency of emails from executive leaders, held two all-staff informational webinars and activated our disaster hotline for employees to check for changes to building access.

### Media

Three media outlets — Orange County Register, Los Angeles Times and Voice of OC — have contacted CalOptima for comments on the pandemic's local impact. Based on the publication deadlines, we have arranged interviews with our medical leadership or provided a statement. In the Orange County Register, CalOptima's [statement](#) about what members should do if they are feeling unwell was included as part of a larger article about drive-thru test centers. The Voice of OC wrote an [article](#) about our changes at PACE. The Los Angeles Times article has not yet been published.

**Local Health Plans of California**  
**COVID-19: Summary of Federal and State Legislative & Executive Actions**  
*Updated as of March 24, 2020*

Topic	Provision	Funding	Source*	Date Issued/Signed
<b>General</b>				
Financial Resources for California's Response to COVID-19	The bill appropriates state general funds to respond to the COVID-19 emergency. Funding to be expended according to plans submitted by the Director of Finance.	\$500 million, up to \$1 billion in increments of \$50 million	<a href="#">AB/SB 89, amends the Budget Act of 2019</a>	3/16/20
Stay-at-Home Directive	Executive Order directing Californians to stay at home or in their place of residence except to maintain operations of federal critical infrastructure. Directs individuals to practice social distancing when they must leave their homes to purchase food, prescriptions, and receive health care. States that the directive is in effect until further notice.	N/A	<a href="#">Executive Order N-33-20</a>	3/19/20
			<a href="#">State Guidance on Essential Workers</a>	3/22/20
<b>Health Care Benefits/Coverage</b>				
Medicaid Coverage for COVID-19	Requires coverage of COVID-19 diagnostic testing, including visit to provider at no cost to the beneficiary.	N/A	<a href="#">H.R. 6201, Sec. 6004</a>	3/18/20
Uninsured Populations	Appropriates dollars for direct reimbursement to providers for claims related to COVID-19 for uninsured populations.	\$1 billion	<a href="#">H.R. 6201, Title V</a>	3/18/20
<b>Medicaid Eligibility</b>				
Medicaid Coverage for Uninsured Individuals	Provides states the option of covering uninsured individuals for COVID-19 diagnostic testing at 100% FMAP.	N/A	<a href="#">H.R. 6201, Sec. 6004</a>	3/18/20
Redeterminations	Suspends redeterminations for 90 days for Medi-Cal, CalFresh, CalWORKS, IHSS, and the Cash Assistant Program for Immigrants.	N/A	<a href="#">Executive Order N-29-20</a>	3/18/20
<b>Medicaid Reimbursement</b>				
Medicaid FMAP	Increases state base FMAP match rates by 6.2% from the first day of the federally declared emergency regarding	N/A	<a href="#">H.R. 6201, Sec. 6008</a>	3/18/20

\*State action includes Assembly Bills (AB), Senate Bills (SB), and Executive Orders  
 Federal action includes House of Representatives (H.R.) legislation

Topic	Provision	Funding	Source*	Date Issued/Signed
	COVID-19 through the last day of the calendar quarter in which the last day of the declared emergency occurs.			
<b>Health Facilities</b>				
Support for Facilities Serving Vulnerable Populations	Directs DSS and CDPH to identify health and community care facilities serving vulnerable populations and instructs them to redirect resources to these facilities.	N/A	<a href="#">Executive Order N-27-20</a>	3/16/20
Waivers of Licensing and Staffing Requirements	Authorizes the Director of CDPH to waive licensing and staffing requirements for clinics, adult day health care, hospice, and mobile clinics for the duration of the emergency. The order specifies that waivers may not be granted for any hospital or health facility, as defined in HSC Section 1250. Waivers shall include alternative measures to care for and protect the health of individuals served by these entities and protect public health and safety. All waivers shall be posted on the CDPH website.	N/A	<a href="#">Executive Order N-35-20</a>	3/21/20
State Hospitals	Authorizes the Director of the Department of State Hospitals to waive any applicable statutes related to the care, custody or treatment of individuals committed to state hospitals in order to ensure that patients can continue to receive the behavioral health care they need.	N/A	<a href="#">Executive Order N-35-20</a>	3/21/20
Department of Developmental Services	Authorizes the Director of the Department of Developmental Disabilities to waive any provision or requirement of the LPS Act, the CA Early Intervention Services Act. A directive may delegate to the regional centers any authority granted to the Department by law where the Director believes delegation is necessary for individuals to continue to receive services. Any waivers must be posted on the Department's website.	N/A	<a href="#">Executive Order N-25-20</a>	3/12/20
	Authorizes the Director of the Department of Developmental Services to deny admission or delay discharge of patients committed to facilities within its		<a href="#">Executive Order N-35-20</a>	3/21/20



Topic	Provision	Funding	Source*	Date Issued/Signed
	jurisdiction for up to 30 days in order to protect the individuals being served by the facility or the staff of the facility.			
<b>Food Assistance</b>				
SNAP and WIC Funding	Appropriates additional funding for SNAP and WIC programs through September 31, 2021.	\$500 million	<a href="#">H.R. 6201, Title I</a>	3/18/20
SNAP State Waivers	Authorizes states to request waivers to increase SNAP assistance to households up to the maximum monthly allotment.	N/A	<a href="#">H.R. 6201, Sec. 302</a>	3/18/20
Households with School-Aged Children	Authorizes additional food assistance for households with children whose schools are closed for at least five consecutive days due to COVID-19 and who otherwise would have received free or reduced school lunch. The assistance shall be provided through State agencies after submitting temporary emergency standards for eligibility and levels of benefits.	Amount determined necessary by the Secretary of Agriculture	<a href="#">H.R. 6201, Title I, Sec. 1101</a>	3/18/20
Emergency Food Assistance Program	Appropriates additional funding to food banks to purchase nutritious foods (\$300 million) and for the storage and distribution of food (\$100 million).	\$400 million	<a href="#">H.R. 6201, Title I</a>	3/18/20
Senior Nutrition Program	Appropriates additional funds to Aging and Disability Services Programs (grants to states), including for Home-Delivered Nutrition Services, Congregate Nutrition Services, and Nutrition Services for Native Americans. State matching requirements shall not apply to these funds.	\$250 million	<a href="#">H.R. 6201, Title V</a>	3/18/20
<b>Housing/Homelessness</b>				
Evictions Protections	Through May 31, 2020, suspends state laws that impose restrictions on local governments' authority to limit residential or commercial evictions related to decrease in income, non-payment of rent, or medical expenses related to COVID-19.	N/A	<a href="#">Executive Order N-28-20</a>	3/16/20
Housing Assistance Document Extensions	Requires public housing authorities to extend deadlines for housing assistance recipients to deliver records or	N/A	<a href="#">Executive Order N-28-20</a>	3/16/20

Topic	Provision	Funding	Source*	Date Issued/Signed
	documents related to eligibility for programs, to the extent deadlines are within the discretion of the housing authority.			
Homelessness Funding	<p>Governor directs \$150 million (pursuant AB/SB 89) to homelessness response efforts. Specifically, \$100 million to local governments – including cities, counties, and continuums of care – for shelter and emergency housing and \$50 million to purchase travel trailers and lease rooms in hotels, motels, etc. to provide immediate isolation for homeless individuals.</p> <p>Accompanying the funding, Exec Order lifts any statutory restrictions regarding the Homeless Emergency Aid Program and the Homeless Housing, Assistance, and Prevention Program that would prevent local agencies from preparing for or responding to COVID-19.</p>	\$150 million (of total funds appropriated pursuant AB/SB 89)	<a href="#">Funding Directive</a>  <a href="#">Allocation Amounts</a>  <a href="#">Executive Order N-32-20</a>	3/18/20
<b>Education</b>				
Activities During Closure	<p>If an LEA closes during COVID-19, it will still receive state funding to: provide distance learning, provide school meals, arrange for supervision for students during school hours, continuing to pay employees.</p> <p>Instructs CDE to develop guidance by 3/17 on implementing distance learning strategies, ensuring students with disabilities receive education consistent with their IEPs, providing meals.</p>	N/A	<a href="#">Executive Order N-26-20</a>	3/13/20
Funding for Schools	The bill ensures that funding available to schools is not impacted due to COVID-19 closures. It also appropriates state general funds to schools for purchase of personal protective equipment and supplies or labor costs for cleaning school facilities.	\$100 million	<a href="#">AB/SB 117, amends the Budget Act of 2019</a>	3/16/20
Academic Testing Requirements	Waives state statute which requires all students be administered academic assessments in math, English,	N/A	<a href="#">Executive Order N-30-20</a>	3/18/20

Topic	Provision	Funding	Source*	Date Issued/Signed
	language arts, and science for all schools for which the US Dept. of Ed. approves (via federal waiver) based on closures due to COVID-19.			
<b>Unemployment</b>				
Timelines for Filing Unemployment	Authorizes the Employment Development Department to waive the one-week waiting period in statute for disability insurance applicants who are unemployed and disabled as a result of COVID-19, and for unemployment insurance applicants who are unemployed due to COVID-19.	N/A	<a href="#">Executive Order N-25-20</a>	3/12/20
Federal Support for State Unemployment	Appropriates \$1 billion in emergency grants to states for payment of unemployment claims related to COVID-19. Of the total funds, \$500 million is for administrative or staffing costs associated with processing and paying unemployment claims, and \$500 million shall be reserved for states that have experienced a 10 percent or more increase in unemployment.	\$1 billion	<a href="#">H.R. 6201, Sec. 4102</a>	3/18/20
<b>Paid Leave</b>				
Sick Time	Requires employers with fewer than 500 employees to provide 80 hours of paid sick time, in addition to whatever sick leave the employer already provides, for employees that cannot work due to COVID-19. For part-time employees, the amount of sick time shall be equal to the number of hours the employee works, on average, over a two-week period.  The employee shall be paid at their normal rate of pay except if the leave is to care for a family member or child, in which case the pay shall be 2/3 the normal rate.	N/A	<a href="#">H.R. 6201, Sec. 5102</a>	3/18/20
FMLA	Requires employers with fewer than 500 employees to provide 12 weeks of job-protected leave to care for a child under the age of 18 if the child's school or if childcare is unavailable due to COVID-19. The first ten days of leave may be unpaid or the employee may elect to use any accrued	N/A	<a href="#">H.R. 6201, Sec. 110</a>	3/18/20

Topic	Provision	Funding	Source*	Date Issued/Signed
	<p>vacation, personal time, or sick time. After the first ten days, the employer must provide paid leave as follows:</p> <ul style="list-style-type: none"> <li>• At a rate no less than 2/3 what the employee would normally be paid, and the number of hours the employee would normally be scheduled to work.</li> <li>• Caps the employers' obligation for paid leave at \$200 per day or \$10,000 in aggregate.</li> </ul> <p>Authorizes the Secretary of Labor to exclude certain health care providers and emergency responders from the definition of eligible employee (for paid leave) and may also exempt small businesses with fewer than 50 employees.</p>			
Federal Paid Leave Program	Establishes a new federal emergency paid leave program administered by the SSA where qualifying workers may receive a benefit for up to three months in which they had to miss 14 or more days of leave due to COVID-19. Days for which workers receive pay from their employer do not count as leave days for the purposes of this program. The worker shall be paid 2/3 the amount of their average monthly earnings, up to \$4,000.	N/A	<a href="#">H.R. 6201, Sec. 602</a>	3/18/20
Employer Tax Credits	<p>Authorizes employer tax credits of 100% for qualified paid sick leave wages paid pursuant this bill. Caps tax credits at \$200/day per employee wages paid, with a maximum of 10 days.</p> <p>Authorizes additional tax credits (within certain parameters) for qualified health plan expenses, meaning the amount the employer occurs to maintain group health coverage to the extent those costs are excluded from the employee's gross income.</p>	N/A	<a href="#">H.R. 6201., Sec. 7001</a>	3/18/20

Topic	Provision	Funding	Source*	Date Issued/Signed
<b>Public Meetings</b>				
Convening Public Meetings	Authorizes flexibilities with regards to public meetings subject to the Bagley-Keene Act or Brown Act, including that meetings may be conducted by teleconference and may be made available to the public telephonically or virtually. It includes specific requirements for accessibility and noticing.	N/A	<a href="#">Executive Order N-29-20</a>	3/18/20
State or Local Legislative Bodies	Clarifies that local legislative bodies or state bodies to receive updates on COVID-19 and ask questions but prohibits them from taking action on items within their jurisdiction without complying with the Brown Act or Bagley-Keene Act. Clarifies that this Order does not impact the public meeting flexibilities granted under Executive Order N-29-20 (see above).	N/A	<a href="#">Executive Order N-35-20</a>	3/21/20

**MINUTES**  
**REGULAR MEETING**  
**OF THE**  
**CALOPTIMA BOARD OF DIRECTORS**

**March 5, 2020**

A Regular Meeting of the CalOptima Board of Directors was held on March 5, 2020 at CalOptima, 505 City Parkway West, Orange, California. Vice Chair Dr. Nikan Khatibi called the meeting to order at 2:01 p.m. Director Sanchez led the Pledge of Allegiance.

**ROLL CALL**

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

Members Absent: Paul Yost, M.D., Chair

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; Emily Fonda, M.D., Deputy Chief Medical Officer, Sharon Dwiers, Clerk of the Board

*Vice Chair Khatibi announced that he was reordering the agenda to hear Agenda Item S-1. Coronavirus (COVID-19) Update and Next Steps immediately following Agenda Item 1., Chief Executive Officer Report.*

**MANAGEMENT REPORTS**

**1. Chief Executive Officer Report**

Chief Executive Officer (CEO) Michael Schrader answered Board Member questions regarding his report.

**INFORMATION ITEM**

**S-1. Coronavirus (COVID-19) Update and Next Steps**

Supervisor Do noted that the County had declared a local emergency based on the Coronavirus pandemic. Dr. Nicole Quick, the County Health Officer, provided an update on the Coronavirus, including statistics on the outbreak worldwide and in Orange County, noting the differences between the regular influenza virus and the Coronavirus. Dr. Quick also provided the phone numbers (800-564-8448 live-person, health referral line) and website where providers and the public can get the latest information (ohealthinfo.com/novel/coronavirus.com), learn about best practices to prevent infections and prevent spreading the virus, and guidance on what to do if you think you are infected.

David Ramirez, M.D., Chief Medical Officer, and Miles Masatsugu, M.D., Medical Director, provided an update on CalOptima's response to the Coronavirus.

The Board directed staff to continue to collaborate with the Orange County Health Care Agency (HCA) to inform providers, including providing CalOptima's provider partners with the phone number(s) where the most up-to-date information on the Coronavirus is available, as well as specimen type needed for testing patients that may be infected.

### **PUBLIC COMMENTS**

1. Dr. Lindsay Fitzpatrick, Shanti Orange County – Oral re: Member access to mental health providers.

Staff was directed to work with this provider and refer the concerns raised to the provider network delivery system ad hoc.

2. Thomas Fielder, Housing is a Human Right Orange County – Oral re: California State University, Fullerton's *Annual Report on Conditions of Children in Orange County*.

### **CONSENT CALENDAR**

#### 2. Minutes

- a. Approve Minutes of the February 6, 2020 Regular Meeting of the CalOptima Board of Directors
- b. Receive and File Minutes of the November 15, 2019 Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the December 13, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the December 12, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

#### 4. Consider Approval of the Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology incorporating the Health Network Quality Rating Methodology

#### 5. Consider Approval of the Calendar Years 2020 and 2021 Health Network OneCare Connect Pay for Value Program Payment Methodology

#### 6. Consider Authorization of Proposed Budget Allocation Change in the CalOptima Fiscal Year 2019-20 Operating Budget for Translation Expenses

#### 7. Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating Budget for Claims Editing Solution and Recovery Services

#### 8. Consider Allocation of Intergovernmental Transfer (IGT) 9 Funds

#### 9. Consider Extension of Altruista Health Contract for Comprehensive Medical Management Systems

10. Consider Receiving and Filing 2019 CalOptima Quality Improvement Program Evaluation

11. Consider Approval of the CalOptima 2020 Quality Improvement Program and 2020 Quality Improvement Work Plan

12. Consider Receiving and Filing 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan Evaluation

13. Consider Approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Items 4, 5, 9 and 10 were pulled from the Consent Calendar for discussion.

**Action:** *On motion of Director Schoeffel, seconded and carried, the Board of Directors approved the balance of the Consent Calendar as presented. (Motion carried 8-0-0; Chair Yost absent)*

4. Consider Approval of the Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology incorporating the Health Network Quality Rating Methodology

5. Consider Approval of the Calendar Years 2020 and 2021 Health Network OneCare Connect Pay for Value Program Payment Methodology

Supervisor Do requested that these items be referred to the delivery system ad hoc for further study.

After discussion and clarification that any ad hoc recommendations could be brought back to the Board for further consideration, the Board agreed to approve Agenda Items 4 and 5 as presented.

**Action:** *On motion of Director DiLuigi, seconded and carried, the Board of Directors approved Agenda Items 4 and 5 as presented. (Motion carried 8-0-0; Chair Yost absent)*

9. Consider Extension of Altruista Health Contract for Comprehensive Medical Management Systems  
Supervisor Do pulled this item for discussion; however, his intent was to pull Consent Calendar Item 8.

**Action:** *On motion of Director Penrose, seconded and carried, the Board of Directors approved Agenda Item 9 as presented. (Motion carried 8-0-0; Chair Yost absent)*

8. Consider Allocation of Intergovernmental Transfer (IGT) 9 Funds

Supervisor Do made a motion to rescind the approval of Agenda Item 8 in order for this item to be discussed.

**Action:** *On motion of Supervisor Do, seconded and carried, the Board of Directors rescinded approval of Agenda Item 8 to allow for further consideration of the item. (Motion carried 8-0-0; Chair Yost absent)*



Supervisor Do questioned the staff recommendation to allocate IGT 9 funds to cover the Whole-Child Model program deficit.

Nancy Huang, Chief Financial Officer, explained that with Whole-Child Model (WCM) program being a new program, the rates CalOptima received from the state were based on limited data, and have proven to be inadequate. She noted that other health plans are similarly experiencing significant losses in administering the Whole-Child Model program in other counties.

Mr. Schrader added that in discussions with the state, plans have been told that this issue would be addressed prospectively. Mr. Schrader also noted that IGT 9 funds are now considered part of CalOptima's capitation, so applying these IGT dollars to offset this operating deficit is an appropriate use for the funds.

After extended discussion, the Board directed staff to conduct further study and return to the Board with more details on the WCM funding shortfall.

***Action: On motion of Supervisor Do, seconded and carried, the Board of Directors directed staff to bring this item back with a formal presentation and include a timeline and communications between CalOptima and the Department of Health Care Services for consideration at the April Board. (Motion carried 8-0-0; Chair Yost absent)***

10. Consider Receiving and Filing 2019 CalOptima Quality Improvement Program Evaluation

Dr. Khatibi pulled Agenda Item 10 for discussion and noted that, after the discussion on Agenda Items 4 and 5, he was comfortable with this item being approved as presented.

***Action: On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved Agenda Item 10 as presented. (Motion carried 8-0-0; Chair Yost absent)***

REPORTS

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

Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. 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 ratified 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, ratified the expenditure of up to \$1.75 million in IGT 6 and 7 funds for implementation. (Motion carried 6-0-1; Supervisor Do abstained; Director Schoeffel, Chair Yost absent)***

15. Consider Actions Related to Homeless Health Care Pilot Initiatives

Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. 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 1. Regarding the Clinical Field Team Pilot Program (CFTPP): a.) Extended the CFTPP through December 31, 2020 with operational changes as described herein; b.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend contracts to implement the described operational changes with Federally Qualified Health Centers (FQHCs) and FQHC Look-alikes providing services under CFTPP; and 2.) Regarding the Homeless Health Initiative (HHI): a.) Extended the HHI FQHC Expansion pilot through December 31, 2020 and continue to allow for reimbursement to participating FQHCs and FQHC Look-alikes directly for services provided to CalOptima Members via mobile health care units, in fixed locations at shelters, and at identified homeless hotspots; and b.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts/contract amendments with FQHCs and FQHC Look-alikes as necessary to implement such payments. (Motion carried 6-0-1; Supervisor Do abstained; Director Schoeffel, Chair Yost absent)*

16. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2020-21

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 Procurement and Renewal of Insurance Policies for Policy Year (PY) 2020-21 at a premium cost not to exceed \$2,850,000. (Motion carried 7-0-0; Director Schoeffel; Chair Yost absent)*

17. Consider Extension of Contracts Related to CalOptima's Key Operations

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

**Action:** *On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to: 1.) Extend the contracts with the following vendors as listed below through the dates indicated in the attached Tables 1 and 2: a.) Office Ally, Inc. (Claims Clearinghouse); b.) Change Healthcare Technologies, LLC (Claims Clearinghouse); c.) Health Management Systems, Inc. (HMS) (Medi-Cal Cost Containment); d.) Medecision, Inc. (CalOptima Link); e.) Star Medical Therapy Management*

*(MTM), LLC (Clinical Support Services); and 2.) Authorized payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1 and 2. (Motion carried 7-0-0; Director Schoeffel; Chair Yost absent)*

18. Receive Report from Grant Thornton on Compensation and Benefits Benchmarking and Analysis with Appendix; Consider Actions Related to Recommendations from Grant Thornton  
Eric Gonzaga, Principal of Grant Thornton, LLP, presented an overview of its analysis of CalOptima's compensation and benefits benchmarking and analysis and highlighted the organizations that were used in the salary comparisons.

***No Action Taken:*** After considerable discussion, Director Penrose made a motion to adopt the consultant's recommendation to: *1.) Receive Report from Grant Thornton on compensation and benefits benchmarking and analysis with Appendix: Custom Peer Groups; 2.) Adopt Resolution approving CalOptima's updated Human Resources Policies GA.8057: Compensation Program and GA.8058: Salary proposed implementation 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. The Motion was seconded, and a roll call vote was conducted. (Motion failed 3-5-0; Director DiLuigi, Director Nguyen, and Director Penrose voting yes; Director Berger, Supervisor Do, Vice Chair Khatibi, Director Schoeffel, and Supervisor Steel voting no; Chair Yost absent)*

19. Consider Recommended Appointment to the CalOptima Board of Directors' Provider Advisory Committee

***Action:*** *On motion of Supervisor Do, seconded and carried, the Board of Directors the Provider Advisory Committee (PAC) recommends: 1.) Appointment of the following agency-selected voting liaison representative to the Provider Advisory Committee effective upon Board Approval: a.) Andrew E. Inglis, M.D., Medical Director, Orange County Health Care Agency Representative (Motion carried 8-0-0; Chair Yost absent)*

20. Consider Reclassifying a Long-Term Services and Supports Seat and Renaming the Traditional/Safety Net Seat for CalOptima's Provider Advisory Committee and Amending CalOptima's Provider Advisory Committee Policy AA.1219b to Reflect the Proposed Changes

***Action:*** *On motion of Supervisor Do, seconded and carried, the Board of Directors 1) Adopted Resolution No. 20-0305-02, reclassifying a Long-Term Services and Supports seat as an Allied Health Services seat and renaming the Traditional/Safety Net seat to Safety Net Representative on the Board of Director' Provider Advisory Committee (PAC), effective upon Board approval*

*and 2.) Authorized updates to CalOptima Policy AA.1219b: Provider Advisory Committee to reflect the recommended changes. (Motion carried 8-0-0; Chair Yost absent)*

21. Consider Authorizing Vendor Contract Amendment and Additional Funding for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

**Action:** *On motion of Supervisor Do, seconded and carried, the Board of Directors 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's contract with Pacific Health Consulting Group (PHCG) to include additional work related to the evaluation of the CalOptima provider network delivery system; and 2.) Authorized additional expenditures on this engagement of unbudgeted funds in an amount not to exceed \$72,000.00 from reserves to fund the additional work covered by the proposed contract amendment. (Motion carried 8-0-0; Chair Yost absent)*

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

**Action:** *On motion of Director DiLuigi, seconded and carried, the Board of Directors 1.) Authorized expenditure for CalOptima's participation in the following community events: a.) Up to \$2,000 and staff participation at Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event in Santa Ana on April 5, 2020; b.) Up to \$2,000 and staff participation at the Arts Orange County's 8th Annual Dia del Nino Festival on Saturday and Sunday, April 18 and 19, 2020; c.) Up to \$2,500 and staff participation at Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event in Santa Ana on April 23, 2020; and 2.) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3.) Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 8-0-0; Chair Yost)*

**ADVISORY COMMITTEE UPDATES**

23. 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 noted that PAC Members are available to assist the Board Delivery System Ad Hoc.

**INFORMATION ITEMS**

Vice Chair Khatibi noted that staff has done a thorough job in preparing the information items and asked his fellow Board Members if they had any specific questions on any of the information items. Hearing none, the following agenda items were accepted as presented.

24. January 2020 Financial Summary

25. Compliance Report

26. Federal and State Legislative Advocates Reports

27. CalOptima Community Outreach and Program Summary

**BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS**

Director Sanchez announced that recruitment for positions on the CalOptima Board of Directors is still open, noting that the deadline to apply is March 20, 2020.

**CLOSED SESSION**

The Board of Directors adjourned to closed session at 4:50 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: (Dr. Nikan Khatibi, Richard Sanchez and Scott Schoeffel) Unrepresented Employee: (Chief Executive Officer).

The Board reconvened to open session at 5:16 p.m. with no reportable action.

**ADJOURNMENT**

Hearing no further business, the meeting was adjourned at 5:17 p.m.

/s/ Sharon Dwiars  
Sharon Dwiars  
Clerk of the Board

*Approved: April 2, 2020*

**MINUTES**  
**SPECIAL MEETING**  
**OF THE**  
**CALOPTIMA BOARD OF DIRECTORS**

**March 12, 2020**

A Special Meeting of the CalOptima Board of Directors was held on March 12, 2020 at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D. called the meeting to order at 1:03 p.m. Supervisor Steel led the Pledge of Allegiance.

**ROLL CALL**

Members Present: Paul Yost, M.D., Chair; Ria Berger; Ron DiLuigi; Supervisor Andrew Do; Lee Penrose; Richard Sanchez (non-voting); Scott Schoeffel (at 1:11 p.m.); Supervisor Michelle Steel

Members Absent: Dr. Nikan Khatibi, Vice Chair; Alexander Nguyen, M.D.

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

**PUBLIC COMMENTS**

There were no requests for public comment.

**REPORTS**

**1. Consider Modifications to CalOptima Policy GA.8042: Supplemental Compensation**

Dr. Yost introduced the item, noting that the rationale for the recommended action is to provide the CEO with greater flexibility to ensure stability in the organization during this time of transition as the Board begins the process of selecting a new CEO.

***Action: On motion of Supervisor Steel, seconded and carried, the Board of Directors agreed to continue this item until the April 2, 2020 Board Meeting. (Motion carried 7-0-0; Vice Chair Khatibi, Director Nguyen absent)***

**2. Consider Authorizing a Contract(s) with a Vendor or Vendors for Interim and Permanent CEO Recruitment Services and Related Expenditures**

***Action: On motion of Supervisor Do, seconded and carried, the Board of Directors directed staff to return on April 2, 2020 with additional background information on the vendors, and if possible, proposals from vendors and recommendations from staff, including details on: vendors' previous work completed; whether they have sued the County of Orange; if they will agree to execute CalOptima's standard contract***

***template without modification; and whether the vendor(s) is proposing to provide services related to the Interim CEO search or a Permanent CEO search, or both. (Motion carried 4-3-0; Director Berger, Supervisor Do, Director Schoeffel, and Supervisor Steel voting yes; Chair Yost, Director DiLuigi, and Director Penrose voting no; Vice Chair Khatibi, Director Nguyen absent)***

### **CLOSED SESSION**

The Board of Directors adjourned to closed session at 1:30 p.m. pursuant to: 1) Government Code section 54957, PUBLIC EMPLOYEE APPOINTMENT (Chief Executive Officer); 2) Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); and 3) Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D, Chair, Dr. Nikan Khatibi, Vice Chair) Unrepresented Employee: (Chief Executive Officer).

The Board reconvened to open session at 2:08 p.m. with no reportable action and continued the closed session meeting to March 23, 2020 at 1:00 p.m.

### **ADJOURNMENT**

Hearing no further business, Chair Yost adjourned at 2:10 p.m.

/s/ Sharon Dwiars  
Sharon Dwiars  
Clerk of the Board

*Approved: April 2, 2020*



**MINUTES**  
**SPECIAL MEETING**  
**OF THE**  
**CALOPTIMA BOARD OF DIRECTORS**

**March 23, 2020**

A Special Meeting of the CalOptima Board of Directors was held on March 23, 2020 at CalOptima, 505 City Parkway West, Orange, California and via Go-to-Webinar. Chair Paul Yost, M.D. called the meeting to order at 1:12 p.m. Director Penrose led the Pledge of Allegiance.

**ROLL CALL**

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

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer (CEO); Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Sharon Dwiers, Clerk of the Board

**PUBLIC COMMENTS**

There were no requests for public comment.

Director Sanchez noted his recusal for the Closed Session and stated he would not participate in the Closed Session discussion and vote.

**CLOSED SESSION**

The Board of Directors adjourned to closed session at 1:18 p.m. pursuant to: 1) Government Code section 54957, PUBLIC EMPLOYEE APPOINTMENT (Chief Executive Officer); 2) Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); and 3) Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D, Chair, Dr. Nikan Khatibi, Vice Chair) Unrepresented Employee: (Chief Executive Officer).

Following closed session, the Board reconvened to open session at 2:12 p.m. and the Chair reported out the following:

***Action:*** ***The Board of Directors has directed Chair Yost and Vice Chair Khatibi, labor negotiators, to work with Human Resources, to negotiate a contract with Richard Sanchez to serve as the temporary CEO for CalOptima, and bring the contract back to the April Board Meeting for final approval. (Votes: This action was taken by consensus of the Board, with no objection.)***



Minutes of the Special Meeting of the  
CalOptima Board of Directors  
March 23, 2020  
Page 2

**ADJOURNMENT**

Hearing no further business, Chair Yost adjourned the meeting at 2:14 p.m.

/s/ Sharon Dwiers

Sharon Dwiers  
Clerk of the Board

*Approved: April 2, 2020*

# MINUTES

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

August 8, 2019

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on August 8, 2019, at CalOptima, 505 City Parkway West, Orange, California.

### **CALL TO ORDER**

Chair Molnar called the meeting to order at 2:32 p.m. and led the Pledge of Allegiance.

### **ESTABLISH QUORUM**

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair (2:42 p.m.); Suzanne Butler; Sandra Finestone; Connie Gonzalez; Jaime Munoz; Ilia Rolon; Pamela Pimentel; Jacquelyn Ruddy; Mallory Vega (2:39 p.m.); Sr. Mary Therese Sweeney; Christine Tolbert.

Members Absent: Diana Cruz-Toro

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Belinda Abeyta, Interim Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Vy Nguyen, Manager Customer Service; Pallavi Patel, Director Process Excellence; Shamiq Hussain, Sr. Policy Advisor, Government Affairs; Rudy Huebner, Graphic Designer, Communications; Geoff Patino, Manager, Creative Branding, Communications; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Specialist

### **MINUTES**

#### **Approve the Minutes of the June 13, 2018 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee**

*Action: On motion of Member Sandy Finestone, seconded and carried, the MAC approved the minutes of the June 13, 2019 meeting. (8-0-0, Member Diana Cruz-Toro; Patty Mouton; Mallory Vega absent)*

### **PUBLIC COMMENT**

There were no public comments.

## **REPORTS**

### **Consider Recommendation of Chair and Vice Chair**

MAC received a letter of interest from Christine Tolbert, Members with Special Needs Representative for the Chair position. After no further nominations from the floor Chair Molnar requested a motion to recommend Member Tolbert as the MAC Chair for FY 2019-20.

***Action: On motion of Member Rolon, seconded and carried, the MAC approved the recommendation of Christine Tolbert for a one-year term as the MAC Chair (8-0-0, Member Diana Cruz-Toro absent)***

MAC also received letters of interest from Sally Molnar the Representative for Medically Indigent Persons and Pamela Pimentel the Children's Representative for the Vice Chair position. There were no further nominations from the floor. Chair Molnar requested that her name be removed from Vice Chair consideration and asked for a motion to recommend Pamela Pimentel as MAC Vice Chair for 2019-20.

***Action: On motion of Member Butler, seconded and carried, the MAC approved the recommendation of Pamela Pimentel for a one-year term as the MAC Vice Chair (8-0-0, Member Diana Cruz-Toro absent)***

## **CEO AND MANAGEMENT REPORTS**

### **Chief Executive Officer Update**

Michael Shrader, Chief Executive Officer, provided a verbal update on the Board of Directors' Strategic Planning Session being held at CalOptima August 9, 2019 to develop a 3-year Strategic Plan for 2020-2022. Mr. Schrader noted that Chapman Consulting would be presenting along with two other speakers. He also noted that the meeting would be held at CalOptima as a public meeting.

### **Chief Operating Officer Update**

Ladan Khamseh, Chief Operating Officer, provided an update on the implementation of the Whole-Child Model (WCM) which was implemented July 1, 2019. Ms. Khamseh noted the transition went well with the help of the providers and health networks. She noted that staff at CalOptima continue to hold daily huddles with California Children Services staff from the county, health networks and the providers to ensure all the member needs were being met. CalOptima also participates in daily status call with the Department of Health Care Services (DHCS) to provide an update on the transition. . CalOptima continues to communicate to the members and to the providers the benefits of the program and continues to reach out to non-contracted providers for contracting opportunities.

### **Chief Medical Officer Update**

David Ramirez, M.D., Chief Medical Officer, discussed quality measures, and member experience. Dr. Ramirez announced that CalOptima is reviewing the opportunity for CalOptima to provide texting services to CalOptima members. Dr. Ramirez noted that DHCS is also in the process of releasing Tele Health guidelines which will contribute to the member experience.

## **INFORMATION ITEMS**

### **Health Home Program Update**

Pallavi Patel, Director, Process Excellence, presented an update on the Health Homes Program. (HHP). Ms. Patel noted that CalOptima's anticipated launch date is January 1, 2020 for members with chronic conditions and July 1, 2020 is for those with serious mental illness, with or without a chronic condition. Ms. Patel provided feedback from DHCS along with their recommended objectives and goals for HHP.

### **Annual Healthcare Effectiveness Data and Information Set (HEDIS) Report**

Irma Munoz, Lead Project Manager Quality Analytics, presented the updated HEDIS 2019 results for Medi-Cal, OneCare, and OneCare Connect. Ms. Munoz noted CalOptima's Medi-Cal results for all DHCS Minimum Performance Levels (MPLs) have been met for OneCare and that 44% of the measures performed higher than in 2018. For OneCare Connect she noted that 60% of the measures were higher than the 2018 results and noted that there are opportunities for additional improvement in each category.

### **Health Network Report Card for Members**

Marsha Choo, Manager, Quality Analytics, presented an updated on CalOptima's Health Network Quality Performance Report Card. Ms. Choo provided feedback to the MAC on the quality of care and member satisfaction surveys.

### **Provider Overcapacity Notification**

Marsha Choo, Manager, Quality Analytics, provided an updated on CalOptima's Medi-Cal Primary Care Providers (PCPs) Member Assignment goals and actions. Ms. Choo noted that the DHCS goals are to ensure PCPs do not have more than 2,000 CalOptima members assigned a PCP. CalOptima notifies the PCPs when they are approaching 2,000 or more members. Ms. Choo also mentioned that doctors with over 2,000 members will no longer be assigned new members. The PCP will have to wait three consecutive months before being assigned new members and must be below 2,000 members limit.

### **New CalOptima Website Demonstration**

Geoff Patino, Manager, Creative Branding, and Rudy Huebner, Graphic Designer, Communications, provided a comprehensive demonstration on the new CalOptima Website.

### **Federal & State Budget Update**

Shamiq Hussain, Sr. Policy Advisory, Government Affairs, provided a verbal update on the Federal & State Budget. Mr. Hussain noted the Proposition 56's (Tobacco tax) new proposed supplemental payments will stay in their current form and current payment levels until December 1, 2021. Mr. Hussain also discussed the expansion of the full scope Medi-Cal to the undocumented population starting with ages 19-25. This expansion is anticipated to go into effect no sooner than January 1, 2020. The California Legislature anticipates that there will be 90,000 new Medi-Cal enrollees across the state due to this expansion. Mr. Hussain also discussed the status of the Pharmacy carve-out which was initiated through Governor Newsom's Executive Order in January 2019.

**MAC Member Updates**

Chair Molnar updated the MAC on an Intergovernmental Transfer Funds (IGT) item discussed at the August 1, 2019 Board meeting. Ms. Molnar also reminded the MAC of the recruitment for the current Long-Term Services and Supports Representative and noted that recruitment would remain open until a candidate was identified.

**ADJOURNMENT**

Chair Molnar announced the next meeting will be a Special Joint Advisory Committee Meeting scheduled for Thursday, October 10, 2019 at 8:00 a.m.

Hearing no further business, Chair Molnar adjourned the meeting at 4:42 p.m.

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

*Approved: February 25, 2020*

# MINUTES

**SPECIAL JOINT MEETING OF THE  
CALOPTIMA BOARD OF DIRECTORS'  
MEMBER ADVISORY COMMITTEE,  
ONECARE CONNECT  
CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN)  
MEMBER ADVISORY COMMITTEE,  
PROVIDER ADVISORY COMMITTEE AND  
WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE**

**October 10, 2019**

A Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and Whole-Child Model Advisory Committee (WCM FAC), was held on Thursday, November 8, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

## **CALL TO ORDER**

PAC Chair Nishimoto called the meeting to order at 8:12 a.m., and WCM FAC Chair Byron led the Pledge of Allegiance.

## **ESTABLISH QUORUM**

### **Member Advisory Committee**

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Diana Cruz-Toro; Connie Gonzalez; Sally Molnar; Patty Mouton; Jamie Munoz (8:50 A.M.); Ilia Rolon; Sr. Mary Therese Sweeney

Members Absent: Sandy Finestone, Jacqueline Ruddy, Mallory Vega

### **OneCare Connect Member Advisory Committee**

Members Present: Patty Mouton, Chair; Jyothi Atluri (non-voting); Josefina Diaz; Keiko Gamez (9:10 AM); Sara Lee; Mario Parada; Donald Stukes

Members Absent: Gio Corzo; George Crits (non-voting); Sandy Finestone; Erin Ulibarri (non-voting)

### **Provider Advisory Committee**

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Donald Bruhns; Jena Jensen; John Kelly, M.D.; Junie Lazo-Pearson Ph.D.; Craig Myers; Jacob Sweidan M.D.; Loc Tran, Pharm.D.

Members Absent: Anja Batra, M.D., Tina Bloomer, WHNP, Pat Patton, MSN, RN

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Dr. David Ramirez, M.D. Chief Medical Officer; Len Rosignoli, Chief Information Officer, Candice Gomez, Executive Director, Program Implementation; Albert Cardenas, Director, OneCare Connect Customer Service; Tracy Hitzeman, Executive Director Clinical Operations; Thanh-Tam Nguyen, M.D., Medical Director, Medical Management; Dr. Emily Fonda, Medical Director, Medical Management; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Assistant, Customer Service

### **Whole-Child Model Family Advisory Committee**

Members Present: Maura Byron, Chair; Pam Patterson, Vice Chair (8:58 AM); Sandra Cortez; Brenda Deeley, Kristen Rogers (8:39 AM); Malissa Watson

Members Absent: Cathleen Collins, Kathleen Lear  
*WCM FAC did not achieve a quorum.*

### **PUBLIC COMMENT**

There were no requests for public comment.

Michael Schrader, Chief Executive Officer, welcomed all the four Board Advisory Committee members and provided a brief background of the strategic plan formulation and introduced Athena Chapman and Caroline Davis of Chapman Consulting who would be presenting the draft plan.

### **INFORMATION ITEMS**

#### **CalOptima Strategic Plan Update**

Athena Chapman and Caroline Davis of Chapman Consulting provided a comprehensive presentation regarding CalOptima's 2020-2022 Strategic Plan. Mrs. Davis reviewed CalOptima's goals and strategic plan development process with the Members. This process included interviews with CalOptima Board Members, Executive Staff, and the Board Advisory Committees' Chairs and Vice Chairs. Mrs. Chapman discussed the five priorities and objectives for the 2020-2022 Strategic Plan and provided the members with three key discussion questions to solicit feedback. The feedback received by the Advisory Committee Members will be included in the draft presentation at the November 7, 2019 CalOptima Board of Director's Meeting for approval.

**Health Homes Program Whole Person Care Program Comparison**

MAC Chair Tolbert introduced Melissa Tober- Beers from the Orange County Health Care Agency (OCHCA) along with CalOptima's Candice Gomez, Executive Director, Program Implementation and Tracey Hitzeman, Executive Director, Clinical Operations. Ms. Tober-Beers, Ms. Gomez, and Ms. Hitzeman jointly presented on the Whole Person Care (WPC) and Health Homes Program (HHP) providing details on the comparisons and contrasts of each of these programs.

**ADJOURNMENT**

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

/s/ Cheryl Simmons

Cheryl Simmons

Staff to the Advisory Committees

*Approved by PAC: December 12, 2019*

*Approved by MAC: February 25, 2020*

*Approved by OCC MAC: February 27, 2020*



# MINUTES

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

October 24, 2019

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on October 24, 2019 at CalOptima, 505 City Parkway West, Orange, California.

### **CALL TO ORDER**

Chair Patty Mouton called the meeting to order at 3:07 p.m. and led the Pledge of Allegiance.

### **ESTABLISH QUORUM**

Members Present: Patty Mouton, Chair; Josefina Diaz; Sandy Finestone; Keiko Gamez (3:20 p.m.); Sara Lee; Mario Parada; Donald Stukes; Erin Ulibarri (non-voting)

Members Absent: Gio Corzo, Vice Chair; Adam Crits, M.D. (non-voting), Jyothi Atluri (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Emily Fonda, M.D., Deputy Chief Medical Officer; Belinda Abeyta, Interim Executive Director, Operations; Candice Gomez, Executive Director, Program Implementation; Shamiq Hussain, Sr. Policy Advisor, Government Affairs; Albert Cardenas, Director, Customer Service (Medicare); Andrew Tse, Manager, OneCare Connect Customer Service; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant, Customer Service.

### **MINUTES**

#### **Approve the Minutes of the August 22, 2019 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee**

*Action: On motion of Member Sandy Finestone, seconded and carried, the Committee approved the minutes of the August 22, 2019 meeting. (Motion carried 6-0-0; Members Corzo and Gamez absent)*

### **PUBLIC COMMENT**

There were no requests for public comment

## **CEO AND MANAGEMENT REPORTS**

### **Chief Executive Officer Update**

Michael Schrader, Chief Executive Officer, provided a verbal update on CalOptima's NCQA Rating and noted that this year we tied with four other public plans with a 4.0 rating. Goal for next year is to achieve a 4.5 rating. Mr. Schrader also discussed the 2020-2022 Strategic Plan that is being formulated by Chapman Consulting. He noted that a draft proposal will be discussed at the November 7, 2019 Board meeting and based on feedback received by the Board the consultants will come back in December for final approval of the Strategic Plan. Mr. Schrader also discussed the Delivery System evaluation that is being prepared by Pacific Health Group (PHG) who is working with Milliman to determine a new delivery model. He noted that providers had requested individual meetings prior to a decision by the Board before they present a draft recommendation at the December 5, 2019 Board meeting and a possible final decision at the February 6, 2020 Board meeting.

Mr. Schrader also discussed a new Department of Health Care Services (DHCS) program called California Advancing and Innovating Medi-Cal (CalAIM). CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes for Medi-Cal members by implementing a broad delivery system, program and payment reform across the Medi-Cal program. He noted that DHCS will formally release the CalAIM proposal on October 29, 2019 and he would keep the OCC MAC updated as information becomes available.

### **Chief Operating Officer Update**

Ladan Khamseh, Chief Operating Officer discussed the Qualified Medicare Beneficiary (QMB) Program. The QMB program is one of four Medicare savings program that allows members to get help from DHCS to pay their Medicare premiums with help paying for Part A premiums, Part B premiums and deductibles, coinsurance as well as copayments. She noted that working in conjunction with the Orange County Social Services Agency (SSA) outreach has begun to members who were eligible for Medicare Part A through Social Services. Ms. Khamseh notified the committee that a vacancy exists for a Consumer Representative on the Member Advisory Committee (MAC) and asked the members to notify Cheryl Simmons, Staff to the Advisory Committees if they knew of a Medi-Cal member who might be interested in applying for the Consumer Representative seat on the MAC.

### **Chief Medical Officer Update**

David Ramirez, M.D., Chief Medical Officer, announced that Emily Fonda, M.D., had been promoted to Deputy Chief Medical Officer. Dr. Ramirez also discussed the initiative to become a 4.5 quality rated health plan.

## **INFORMATION ITEMS**

### **Homeless Health Update**

Marie Jeannis, Enterprise Analytics Manager, presented an update on the Homeless Health Initiative. Ms. Jeannis gave a comprehensive overview of CalOptima's homeless identification methods and homeless disparities, which were identified as diagnoses of behavioral health, chronic conditions, homeless utilization metrics, and cost comparisons. Ms. Jeannis provided a detailed disparities summary regarding CalOptima members who are homeless in comparison to those who aren't

homeless. Ms. Jeannis also noted that CalOptima is in alignment with partnering organizations such as, the Orange County Health Care Agency (OCHCA) who provides data from the DHCS and the Sheriff's and Coroner's office of the deceased members.

### **Ombudsman Update**

Member Sara Lee, Legal Aid Society of Orange County (LASOC), reported that the Ombudsman Service Program (OSP) at LASOC continues to assist members with OneCare Connect (OCC) enrollment issues, potential OCC disenrollment, and to help bridge services for members who have been terminated from OCC. Other services include assistance to those dual eligible members with Share of Cost issues and education of members on their OCC benefits, the role of the Personal Care Coordinator and care coordination. Ms. Lee noted that the phone number for members to contact Legal Aid has recently been changed and asked that CalOptima update their records so that the correct phone number is given to the member. Ms. Lee will provide CalOptima's OCC Customer Service with the new number.

### **Federal & State Legislative Update**

Shamiq Hussain, Sr. Policy Analyst, Government Affairs provided a verbal update on the Federal and State Budgets. Mr. Hussain reported on the State of California's health policy to date and gave a preview of the 2020 State health policy agenda, which includes CalAIM and Healthy California for All. Mr. Hussain noted SB 29 bill which offers expanded full-scope Medi-Cal to the undocumented individuals of the senior population, which will be highlighted in Governor Newsom's 2020 Health policy agenda. Mr. Hussain also discussed the SB 503 and AB 1642 bills which highlight the Medi-Cal Managed Care Plans.

### **OCC MAC Member Updates**

Chair Mouton reminded the members that their compliances courses were due by November 8, 2019 and if they needed assistance to contact Cheryl Simmons, Staff to the Advisory Committees. Chair Mouton also discussed the Recruitment Ad Hoc Committee that was formed with members from MAC and PAC. She noted that the first ad hoc meeting was held on October 16, 2019 and the first meeting was spent reviewing seat descriptions. Chair Mouton suggested that members form a similar ad hoc to review seat descriptions for the OCC MAC. Sandy Finestone, Keiko Gamez and Chair Mouton agreed to be part of the OCC MAC recruitment ad hoc.

### **ADJOURNMENT**

Chair Mouton announced that the next regular meeting would be held on Thursday, December 19, 2019 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 4:46 p.m.

/s/ Cheryl Simmons

Cheryl Simmons  
Staff to the Advisory Committees

*Approved: February 27, 2020*

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

## Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

### Report Item

3. Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic

### Contact

Candice Gomez, Executive Director Program Implementation, (714) 246-8400  
Brigette Gibb, Executive Director Human Resources, (714) 246-8400

### Recommended Actions

1. Ratify the implementation of mitigation strategies to slow the transmission of COVID-19 through temporary telework for CalOptima employees; and
2. Ratify unbudgeted expenditures from existing reserves for emergency purchases to support these mitigation strategies, including CalOptima's Temporary Telework process in the amount not to exceed \$915,000

### Background

On January 31, 2020, the Secretary of U.S. Department of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On February 27, 2020, Orange County declared a local health emergency. The Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside of a list of "essential activities."

### Discussion

Along with federal, state, and local agencies, CalOptima management has been actively engaged in efforts to evaluate business needs and protect the health and safety of CalOptima employees, members, providers, and our community, and mitigate the spread and limit exposure to the disease. CalOptima management has been closely monitoring this public health emergency and taking preventive actions based on information and guidelines provided by federal, state, and local agencies including, but not limited to, the Centers for Disease Control and Prevention (CDC), the California Department of Public Health, and the Orange County Health Care Agency.

The health and safety of CalOptima employees is critical to ensuring business continuity and access to health care services for CalOptima members. CalOptima has considered the following objectives in evaluating the organization's response to the pandemic as the current situation constantly evolves:

- Maintaining continuity of essential services and business functions while maintaining a safe work environment for CalOptima employees;

- Maximizing social distancing and limiting group meetings and interactions that might spread COVID-19;
- Developing flexible work arrangements for employees as appropriate;
- Maintaining a unified response consistent with actions taken by state and local government; and
- Ensuring that CalOptima is transparent in its processes and communications to its employees, providers and members.

CalOptima's operations are considered part of the critical infrastructure in both the healthcare/public health sector as well as the government sector. As an essential business, CalOptima's operations must continue to be fully functioning and effective. As part of business continuity and emergency planning, CalOptima management has evaluated job functions, and categorized CalOptima staff according to the following five categories:

1. Job duties cannot be performed remotely;
2. Job duties can be performed remotely;
3. Job duties support essential functions in the 505 City Parkway West building:
  - Facility support
  - Building security
  - Building management
  - Information Services 3<sup>rd</sup> Shift
  - Information Services Help Desk
  - Mail room
  - Member enrollment and reconciliation
  - Finance accounts payable;
4. Job duties support essential functions in the PACE Center, 13300 Garden Grove Blvd:
  - PACE clinic, transportation, and reception staff
  - PACE records management; and
5. Job duties can be performed remotely, but employee's home environment is not conducive to working remotely.

To protect employees during the pandemic, CalOptima management has been implementing infection control and social distancing measures as these are released by the CDC or other regulatory agencies. Based on the guidelines provided by regulatory agencies, on March 13, 2020, CalOptima management has moved forward with its business continuity and emergency plan, and initiated temporary telework for CalOptima staff whose job duties can be performed remotely. In order to institute an orderly process for temporary telework, CalOptima management implemented phases for deployment. This process was made voluntary to employees and only applied to those with job duties that meet the requirements for temporary telework.

Phase 1: Employees identified in the high risk categories (as defined by CDC guidelines as of March 13, 2020), including those eligible for leave under the Family Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA), or those requiring a reasonable accommodation under the Americans with Disabilities Act (ADA).

Phase 2: Employees who had already been issued the necessary equipment to work remotely.

Phase 3: Employees who had not previously been issued the necessary equipment to work remotely have been and will continue to be deployed when fully equipped and according to job function with the following priority:

- a. Employees with direct member interaction (e.g., talk to Members);
- b. Employees whose job duties result in an organizational decisions or determinations (e.g., approval, denial, or appeal of medical service authorization requests);
- c. All other staff as equipment needs are met.

The temporary telework process was not contemplated as part of CalOptima Policy GA. 8044: Telework Program, and the number of employees on temporary telework exceeds the Board-authorized number of teleworkers (1/3 of CalOptima staff). Currently, approximately 82% of CalOptima employees are working remotely, and management anticipates that this number may increase to as many as 85-90%. Management is seeking Board ratification of the actions taken to respond to the COVID-19 pandemic and implement mitigation strategies by placing employees on temporary telework, which:

- (1) Reduces the number of employees present in the administration building and facilitates social distancing measures to mitigate the spread of COVID-19;
- (2) Ensures business continuity while employees are working remotely;
- (3) Protects the health and safety of CalOptima employees; and
- (4) Ensures that CalOptima is continuing to carry out its essential operations by meeting the needs of members and being responsive to providers.

To support temporary telework, CalOptima staff also recommends ratification of unbudgeted expenditures in the amount of \$915,000 for equipment and mobile ready software to allow CalOptima employees to work remotely. Expenditures also include replenishment of back-up laptop inventory plus additional laptops for urgent and unforeseeable needs due to COVID-19. The recommended amount of unbudgeted expenditures is based on estimated costs and approximately 10% contingency for unanticipated costs. Estimated itemized costs are as follows:

<b>Item</b>	<b>Amount</b>
RSA Tokens to allow connectivity outside of building	\$43,911
VPN Licenses to allow connectivity to the CalOptima network	\$76,600
IP Softphone Licenses to allow connectivity to the phone system	\$259,893
Power Cords	\$4,505
Headsets and Headset Adapters	\$42,185
Surge Protectors	\$10,532
Cables and Soundbars for Computer Monitors	\$28,458

ACD License to support phone system	\$38,510
Bluecoat Web Security Service (WSS)	\$21,970
Computer Monitors	\$184,145
Cat6 Patch Cables for Computer Parts	\$759
Back-up Laptops	\$121,879
Contingency	\$81,653
<b>Estimated Costs</b>	<b>\$915,000</b>

For employees remaining in the two CalOptima buildings, additional space planning efforts have been implemented to promote social distancing practices. Additional planning is also being evaluated should it be necessary through local, state, or federal action that employees remain locked-down at home and all essential work functions must be performed remotely. CalOptima staff will return to the CalOptima Board of Directors for consideration of future actions as appropriate.

**Fiscal Impact**

The recommended action to ratify unbudgeted expenditures for emergency purchases to support CalOptima’s response to the public health emergency and implementation of temporary telework is unbudgeted. An allocation of up to \$915,000 from existing reserves will fund this action.

**Rationale for Recommendation**

Implementing temporary telework ensures that CalOptima takes appropriate action to not only protect the health and safety of our employees and community during the COVID-19 pandemic, but also ensure that CalOptima members and providers are able to access covered, medically necessary health care services during this pandemic.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Temporary Telework Agreement
2. CalOptima Policy GG.8044 Telework Program

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**







### **Participation:**

CalOptima plays a vital role in the community as a resource for care, information, and support. Our focus is to enable our employees to manage the community response and to serve the needs of CalOptima members, while also taking care of our own employees. Employee recognizes that the temporary telework option is voluntary and at the Employee's discretion. This work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Approval of the temporary telework arrangement will be made based on an evaluation of the appropriateness of your position to work from home, the resources available to enable you to work, business priorities, and staffing concerns. Business continuity for critical areas is our utmost priority to ensure CalOptima is providing excellent services to our members and responding in a timely manner to all inquiries and regulatory requirements.

### **Application of CalOptima Policies, Procedures and Rules:**

- a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA. 8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI-security of CalOptima assets, dependent care, etc.
- b. Employee understands and agrees that the temporary telework arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

**Technological Capabilities:** When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

**Safety and Security:** Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site, with particular sensitivity to any protected health information in written or oral form. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

### **Confirmation of Agreement:**

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for temporary telework as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

CalOptima may terminate this agreement at any time, with or without notice.

**Employee:**

_____	_____	_____
Print Name	Signature	Date

**Immediate Supervisor:**

_____	_____	_____
Print Name	Signature	Date

**APPROVED BY HUMAN RESOURCES:**

_____	_____	_____
Print Name	Signature	Date

Policy #: GA.8044  
Title: **Telework Program**  
Department: Human Resources  
Section: Not Applicable  
CEO Approval: Michael Schrader MS

Effective Date: 03/01/12  
Last Review Date: 02/01/18  
Last Revised Date: 02/01/18

Board Approved Policy

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**I. PURPOSE**

This policy describes guidelines for a work structure that: 1) permits an employee to perform their work from a Remote Work Location, unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

**II. POLICY**

- A. Telework is a workplace arrangement in which an eligible employee works his or her entire work schedule away from the Central Worksite at a Remote Work Location, unless business needs require otherwise.
  - 1. A partial teleworking arrangement is not allowed. A Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location.
- B. Telework is not a universal employee benefit or entitlement, but rather, an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the telework program based on business needs.
- C. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.
- D. The total number of employees in telework positions at any point in time may equal but not exceed the maximum number telework positions as directed by the CalOptima Board of Directors.
- E. Telework positions may be identified as follows:
  - 1. Human Resources (HR) may designate a position as a telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework.
  - 2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.
  - 3. A department leader may designate one (1) or more positions as suitable for teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite.

- F. Remote Work exception to the Telework policy: When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a Remote Work Location on an occasional basis.
1. Occasional is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position.
  2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, establishing a Remote Work Location, security of CalOptima assets, inspection, etc.
  3. Furthermore, for departments which permit employees to work from a Remote Work Location, to be eligible to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.
- G. Terms of Employment
1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.
  2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.
  3. Telework will be voluntary unless specifically stated as a condition of employment.
  4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged.
- H. Teleworker Selection
1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:
    - a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

- b. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) regulations.
  - c. The nature of the work and the employee's job responsibilities do not require daily face-to-face contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.
  - d. The nature of the work is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.
2. To be eligible for telework, the following considerations will be evaluated:
- a. Employee must be in good standing, with no prior disciplinary action in the last year or on a Performance Improvement Plan, and may be scheduled for full-time or part-time and/or may be exempt or non-exempt (hourly).
  - b. Based on business considerations and management discretion, supervisors and managers may be approved for telework only if their entire team teleworks.
  - c. If supervisors and managers have staff that does not telework and/or are not eligible for telework, they must be present in the office to supervise their non-telework staff.
  - d. Telework is not available for senior manager level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Operating Officer.
3. To participate in the telework program, an employee must meet additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.
4. To be eligible to work from a Remote Work Location the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

#### I. Termination of Telework Arrangement

1. A Teleworker may elect at any time to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.
  - a. The Teleworker must notify and discuss the change with his or her manager and receive approval.
  - b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.
  - a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.
3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

#### J. Work Schedule and Accessibility

1. A Teleworker's schedule of work hours, including breaks, overtime, and deviations from regular work hours, should be approved by the Teleworker's manager.
  - a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, or the progress of individual or team assignments.
  - b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to: meetings, consultations, presentations and conferences.
  - c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate manager supervision and communication.
2. The number of hours normally scheduled to work by an employee shall not change because of telework.
3. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.
4. Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance.
5. An exempt Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.
6. Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.
7. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.
8. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers or members.

9. When visiting the Central Worksite, a Teleworker will notify their direct supervisor or alternate of their presence in office building, including their physical location and tentative length of stay.
10. A Teleworker will attend job-related meetings, training sessions, and conferences, as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.
11. During telework hours, a Teleworker must be reachable via telephone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.
12. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.

#### K. Dependent Care

1. A Teleworker will **not** act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make dependent care arrangements to permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

#### L. Deployment Preparation

1. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Understanding the policies and procedures of telework is an important determinant of success in the telework program. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

#### M. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.
  - a. A Teleworker must set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.
  - b. Preferably, this workspace will be a separate room that is designated as a home office.
  - c. The home office location and specified workstation and internet access must be in compliance with the EH&S standards and the safety checklists.

- d. The employee must sign and submit the CalOptima Teleworking Agreement, along with all other required documentation to HR within the required period of time.
2. A Teleworker will not hold face-to-face business meetings with providers, Members, or professional colleagues at the Home Office.
3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.
  - a. CalOptima will provide advanced notice of any delivery.
  - b. The Teleworker must allow access to the Home Office at the designated day and time.
4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.
5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.
  - a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office Locations of Teleworkers.
6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.
  - a. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils).
  - b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.
7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.
8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker.

#### N. Teleworker Performance Management

1. The manager and Teleworker will develop and agree upon any relevant goals and performance guidelines, as well as the frequency of performance discussions.
2. The manager of the Teleworker shall:
  - a. Monitor the Teleworker's productivity and performance consistently and as business needs require.
  - b. Provide timely and specific feedback to the Teleworker on a regular basis.



- c. Plan for and use multiple channels to keep the Teleworker informed and up-to-date about departmental and CalOptima activities.
- d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

O. Program Reporting and Evaluation

- 1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.
- 2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards and outcomes for the Teleworkers to HR upon request.

P. Liability

- 1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.
- 2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.
- 3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.
- 4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.
- 5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.
- 6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.
  - a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work.
- 7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.
- 8. CalOptima is not responsible for any loss or damage to:
  - a. A Teleworker's property;

- b. Personal property owned by a Teleworker or any of the Teleworker's family members; or
  - c. Property of others in the custody of a Teleworker.
9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.
- Q. Compliance: Handling PHI from a Remote Work Location
- 1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location.
  - 2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.
    - a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.
  - 3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite through the use of:
    - a. Binders; or
    - b. Folders or other protective cover.
  - 4. Upon their disposal, a Teleworker shall shred all PHI documents or files. A Teleworker shall transport PHI documents that are taken to the Remote Work Location and ready for destruction back to the Central Worksite for shredding.
  - 5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.
- R. Use of Computer from Remote Work Location
- 1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.
  - 2. A Teleworker shall adhere to the following information security procedures:
    - a. Maintain the confidentiality of his or her user sign-on identification code and password;
    - b. Keep the PC or laptop secure at all times;

- c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;
    - d. Ensure that passwords or operating instructions are not stored with the computer; and
    - e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.
  3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:
    - a. Loss of a PC or laptop;
    - b. Software irregularities indicating possible virus infection; and
    - c. Access by unauthorized persons.
  4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include disciplinary action up to and including termination of employment.
  5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.
- S. Use of electronic mail with PHI
  1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.
  2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.
- T. Use of printer from Remote Work Location
  1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite. On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.
- U. Security of CalOptima Assets
  1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must only be used by the Teleworker and may not be used by other guests or individuals for personal use.
3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.
4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.
5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:
  - a. Not returned at the conclusion of employment; or
  - b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.
6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

#### V. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into **the Central Worksite** from a local Remote Worksite Location.
2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.
3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.
4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

#### W. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

#### X. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in: termination of the employee's telework arrangement and/or disciplinary action, up to and including termination of the employee. Certain violations of this Policy, other

applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

### III. PROCEDURE

Not Applicable

### IV. ATTACHMENTS

- A. CalOptima Telework Agreement
- B. CalOptima Occasional Off-site Work Agreement

### V. REFERENCES

- A. CalOptima Employee Handbook
- B. CalOptima Policy GA.5004: Travel Policy
- C. CalOptima Policy GA.8000: Glossary of Terms
- D. CalOptima Policy GA.8020: 9/80 Work Schedule
- E. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

### VI. REGULATORY AGENCY APPROVALS

None to Date

### VII. BOARD ACTIONS

- A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
- B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
- C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
- D. 06/06/13: Regular Meeting of the CalOptima Board of Directors
- E. 03/01/12: Regular Meeting of the CalOptima Board of Directors

### VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	03/01/2012	GA.8044	Telework Program	Administrative
Revised	06/06/2013	GA.8044	Telework Program	Administrative
Revised	05/01/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative

**IX. GLOSSARY**

<b>Term</b>	<b>Definition</b>
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee’s regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima’s primary physical location of business applicable to the employee, which is either CalOptima’s administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A designated workspace within the Teleworker’ residence.
Protected Health Information (PHI)	<p>Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.</p> <p>This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:</p> <ol style="list-style-type: none"> <li>1. The past, present, or future physical or mental health or condition of a Member;</li> <li>2. The provision of health care to a Member; or</li> <li>3. Past, present, or future Payment for the provision of health care to a Member.</li> </ol>
Remote Work Location	The Employee’s Home Office or designated pre-approved work location.
Teleworker	An employee who meets CalOptima’s Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

#### Report Item

4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

#### Contact

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

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

#### Recommended Actions

1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;
2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;
3. Authorize unbudgeted expenditures from existing reserves of up to \$14 million to provide funding for rates adjustments for Health Network capitation rates;
4. ~~Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ | Amended 4/2/20
5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
  - a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
  - b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

#### Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

### **Discussion**

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

#### **Medi-Cal Rate Enhancement for Health Networks**

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately \$4.4 million.
2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

#### **Special Reimbursement to CBAS providers**

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members. On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.
2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
  - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
  - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
  - Provide physical therapy or occupational therapy in the home
3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.



Interim Medi-Cal Rate for Coronavirus Testing

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~

Amended  
4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~

Amended  
4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately \$4.4 million. An allocation of up to \$14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~

Amended  
4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**



BRADLEY P. GILBERT, MD, MPP  
DIRECTOR

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



GAVIN NEWSOM  
GOVERNOR

March 19, 2020

Jackie Glaze  
CMS Acting Director  
Medicaid & CHIP Operations Group Center for Medicaid & CHIP  
Services 7500 Security Boulevard  
Baltimore, MD 21244  
Jackie.Glaze@cms.hhs.gov

**REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES  
RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL  
EMERGENCY/PUBLIC HEALTH EMERGENCY**

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

**1. Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.
- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.
- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
  - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
  - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
  - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
  - Flexibility to allow following services to be provided at a beneficiary's home:
    - Physical Therapy
    - Occupational Therapy
  - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
  - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

**2. Eligibility Flexibilities**, including but not necessarily limited to:

- Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

**3. Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

- Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.
- Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

**4. Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

- Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.
- Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.
- Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

#### **5. Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the [Certified Public Expenditure \(CPE\) protocol](#) approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.
- Waiver of the interim rate setting methodology described on page 5 and 6 of the [Drug Medi-Cal Organized Delivery System \(DMC ODS\) Certified Public Expenditure protocol](#) approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.
- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

#### **6. Clarification of Previous Requests:**

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.
- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

## **7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):**




- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided *in* jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.
- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

Jackie Glaze  
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March 19, 2020

additional beds. Evaluation of less restrictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,  
Original Signed By: 

Jacey Cooper     
Chief Deputy Director  
Health Care Programs  
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP  
Director  
Department of Health Care Services

Erika Sperbeck  
Chief Deputy Director  
Policy & Program Support  
Department of Health Care



## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

#### **Report Item**

5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

#### **Contact**

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400

Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

#### **Recommended Actions**

1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of \$20,000 from the Professional Fees budget to fund the contracts with medical consultants.

#### **Background/Discussion**

##### ***Telehealth Policies and Procedures (P&Ps)***

One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services during the COVID-19 crisis.



Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

### ***Medi-Cal Telehealth Policy***

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;
- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;
- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;
- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;
- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.
- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.
- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.
- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

### ***Medicare Telehealth Policy***

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.
- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:
  - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).
  - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.
  - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.
  - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.
- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.
- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

### ***Virtual Care Expert Consultant***

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

### **PAYMENT SCHEDULE**

<b>Milestone</b>	<b>Completion Date</b>	<b>Fee</b>
Review Past Telehealth Attempts	March 30, 2020	\$3,500
Assessment of Virtual Care Strategy	April 17, 2020	\$10,500
Gap Analysis	May 1, 2020	\$21,000

Provide Recommendations	May 15, 2020	\$21,000
Vet Recommendations to Stakeholders	May 15, 2020	\$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	\$3,500
Develop Implementation Workplan	June 30,2020	\$14,350
<b>TOTAL</b>		<b>\$94,850</b>

***Medical Consultants in Response to COVID-19 Situation***

On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California’s governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima’s Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima’s PACE members who are considered the highest risk population. Therefore, the Plan’s executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership’s considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

## **PAYMENT INFORMATION**

- \$10,000 for each medical consultant
- Total: \$20,000

### **Fiscal Impact**

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of \$100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed \$20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to \$20,000.

### **Rationale for Recommendation**

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachment**

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

**ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children’s Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

Policy: GG.1665  
Title: Telehealth and Other Technology-Enabled Services  
Department: Medical Management  
Section: Population Health Management

CEO Approval:

Effective Date: 03/01/2020  
Revised Date: Not applicable

Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect
- PACE
- Administrative - Internal
- Administrative – External

## I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

## II. POLICY

- A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.
- B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.
- C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:
  - 1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;
  - 2. Comply with all state and federal laws regarding the confidentiality of health care information;
  - 3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;
  - 4. Document treatment outcomes appropriately; and
  - 5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member’s treatment.

- D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.
- E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.
- F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.
- G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.
- H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.
- I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.
- J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.
- K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

### **III. PROCEDURE**

#### **A. Member Consent to Telehealth Modality**

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.
2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.
3. Qualified Providers must document consent as provided in Section III.D.

#### **B. Qualifying Provider Requirements**

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:
  - a. The Qualified Provider meets the following licensure requirements:



- i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or
  - ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.
2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).
3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

#### C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:
  - a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;
  - b. The Member has provided verbal or written consent in accordance with this Policy;
  - c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;
  - d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and
  - e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.
  - f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:
    - i. In an operating room;
    - ii. While the Member is under anesthesia;
    - iii. Where direct visualization or instrumentation of bodily structures is required; or
    - iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

#### D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.
2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.
3. CalOptima and its Health Networks shall not require providers to:
  - a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or
  - b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.
4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.
5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

#### E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member
  - a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,
  - b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,
  - c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.
2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.
2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

- a. E-consults are permissible only between Qualified Providers.
- b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.
- c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

- a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).
- b. Virtual/Telephonic Communications are classified as follows:
  - i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.
  - ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.
  - a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.
  - b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.
  - I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.
  - J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and 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. ATTACHMENT(S)**

- A. COVID-19 Emergency Provisions Addendum

#### **V. REFERENCE(S)**

- A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
- C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
- D. CalOptima Policy GG.1510: Appeals Process
- E. CalOptima Policy GG.1603: Medical Records Maintenance
- F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
- G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
- H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

- I. 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
- J. CalOptima Policy HH.1102: Member Grievance
- K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
- L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
- M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
- N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
- O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
- P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

**VI. REGULATORY AGENCY APPROVAL(S)**

Date	Regulatory Agency

**VII. BOARD ACTION(S)**

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

**VIII. REVISION HISTORY**

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

**IX. GLOSSARY**

<b>Term</b>	<b>Definition</b>
Asynchronous Store and Forward	The transmission of a Member’s medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children’s Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima’s Medi-Cal 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), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member’s treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member’s health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 202001



Term	Definition
FQHC/RHC Established Member	<p>A Medi-Cal eligible recipient who meets one or more of the following conditions:</p> <ul style="list-style-type: none"> <li>• The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years.</li> <li>• The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented.</li> <li>• The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.</li> </ul>
Federally Qualified Health Centers (FQHC)	<p>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.</p>
Health Network	<p>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.</p>
HIS-MOA Clinics	<p>Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details</p>
Medically Necessary or Medical Necessity	<p>Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.</p>
Medical Record	<p>A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.</p>

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.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 2020040



Attachment A  
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding “new” and “established” patients, “face-to-face”/in-person, and “four walls” requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
  - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
  - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

<https://www.dhcs.ca.gov/>

Policy: MA.2100  
 Title: Telehealth and Other Technology-Enabled Services  
 Department: Medical Management  
 Section: Population Health Management

*CEO Approval:*

Effective Date: 03/01/2020  
 Revised Date: Not applicable

Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect
- PACE
- Administrative - Internal
- Administrative – External

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**I. PURPOSE**

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

**II. POLICY**

- A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).
- B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.
- C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.
- D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.
- E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.
- F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

- 1 G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed  
2 for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS  
3 guidance and this Policy.  
4
- 5 H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver  
6 Covered Services comply with applicable laws, regulations, guidance addressing coverage and  
7 reimbursement of Covered Services provided via Telehealth.  
8
- 9 I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and  
10 Remote Monitoring Services that are commonly furnished remotely using telecommunications  
11 technology without the same restrictions that apply to Medicare Telehealth Covered Services may  
12 also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the  
13 requirements set forth in this Policy.  
14
- 15 J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise  
16 modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum  
17 attached to this Policy for information related to health-related national emergency waivers.  
18

### 19 **III. PROCEDURE**

#### 20 **A. Member Consent to Telehealth Modality**

- 21
- 22
- 23 1. Members must consent to the provision of virtual Covered Services that are provided via secure  
24 electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-  
25 Visits, which consent shall be documented in the Member's medical records.  
26

#### 27 **B. Provision of Covered Services through Telehealth**

- 28
- 29 1. A Qualified Provider may provide Covered Services to an established Member via Telehealth  
30 when all of the following criteria are met:  
31
- 32 a. The Member is seen in an Originating Site;  
33
- 34 b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA)  
35 or in a county outside of a Metropolitan Statistical Area (MSA);  
36
- 37 c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified  
38 Provider;  
39
- 40 d. The Telehealth Covered Services encounter must be provided through Interactive Audio  
41 and Video telecommunication that provides real-time communication between the Member  
42 and the Qualified Provider (store and forward is limited to certain demonstration projects).  
43 See Section III.C. of this Policy for other Technology-Enabled services that are not  
44 considered to be Telehealth, and which may be provided using other modalities; and  
45
- 46 e. The type of Telehealth Covered Services fall within those identified in the CMS List of  
47 Services (available at [https://www.cms.gov/Medicare/Medicare-General-  
48 Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes)).  
49
- 50 f. The Qualified Provider must be licensed under the state law of the state in which the Distant  
51 Site is located, and the Telehealth Covered Service must be within the Qualified Provider's  
52 scope of practice under that state's law.  
53
- 54 2. The Originating Site for Telehealth Covered Services may be any of the following:

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- a. The office of a physician or practitioner;
  - b. A hospital (inpatient or outpatient);
  - c. A critical access hospital (CAH);
  - d. A rural health clinic (RHC);
  - e. A Federally Qualified Health Center (FQHC);
  - f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);
  - g. A skilled nursing facility (SNF); or
  - h. A community mental health center (CMHC).
3. Telehealth Service Requirements and Electronic Security
- a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.
    - i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.
    - ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
    - iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.
4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:
- a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.
  - b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.
5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

1 C. Other Technology-Enabled Services

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3 1. Virtual Check-In Services

- 4  
5 a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In  
6 Services to connect with Members outside of the Qualified Provider's office if all of the  
7 following criteria are met:  
8  
9 i. The Virtual Check-In Services are initiated by the Member;  
10  
11 ii. The Member has an established relationship with the Qualified Provider where the  
12 communication is not related to a medical visit within the previous seven (7) days and  
13 does not lead to a medical visit within the next twenty-four (24) hours (or soonest  
14 appointment available);  
15  
16 iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;  
17  
18 iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate  
19 Members on the availability of the service prior to the Member's consent to such  
20 services); and  
21  
22 v. The Member verbally consents to Virtual Check-In Services and the verbal consent is  
23 documented in the medical record prior to the Member using such services.  
24  
25 b. Live interactive audio, video or data telecommunications, Asynchronous Store and  
26 Forward, and telephone may be used for Virtual Check-In Services subject to compliance  
27 with Section III.D below.  
28  
29 c. Qualified Providers may bill for Virtual Check-In Services furnished through secured  
30 communication technology modalities, such as telephone (HCPCS code G2012) or captured  
31 video or image (HCPCS code G2010).  
32

33 2. E-Visits

- 34  
35 a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a  
36 secure online patient portal if all of the following criteria are met:  
37  
38 i. The Member has an established relationship with a Qualified Provider;  
39  
40 ii. The provider furnishing the E-Visit is a Qualified Provider; and  
41  
42 iii. The Members generates the initial inquiry (communications can occur over a seven (7)-  
43 day period).  
44  
45 b. Live interactive audio, video, or data telecommunications, Asynchronous Store and  
46 Forward, and telephone may be used for Virtual Check-In Services subject to compliance  
47 with Section III.D. of this Policy.  
48  
49 c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as  
50 applicable, for E-Visits.  
51

52 3. E-Consults

1 a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone,  
2 internet and Electronic Health Record modalities are permitted where such consult services  
3 meet the requirements in applicable billing codes, including time requirements.  
4

5 b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452  
6 for E-Consults.  
7

8 4. Remote Monitoring Services  
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10 a. Remote Monitoring Services are not considered Telehealth Covered Services and include  
11 Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring  
12 and Principle Care Management services.  
13

14 b. Remote Monitoring Services must meet the requirements established in applicable billing  
15 codes.  
16

17 D. The Qualified Provider must comply with all applicable laws and regulations governing the security  
18 and confidentiality of the electronic transmission. Qualified Providers may not use popular  
19 applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat,  
20 Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and  
21 federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when  
22 so permitted, they may only be used for the time period such applications are allowed. In such  
23 public emergency circumstances, Qualified Providers are encouraged to notify Members that these  
24 third-party applications potentially introduce privacy risks. Qualified Providers should also enable  
25 all available encryption and privacy modes when using such applications. Under no circumstances,  
26 are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video  
27 communication applications) permissible for Telehealth.  
28

29 E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima  
30 Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004:  
31 Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and  
32 MA.9004: Expedited Service Appeal.  
33

34 F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in  
35 accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by  
36 this Policy shall be made in accordance with all applicable CMS requirements and guidance.  
37

38 **IV. ATTACHMENT(S)**  
39

40 A. COVID-19 Emergency Provisions Addendum  
41

42 **V. REFERENCE(S)**  
43

44 A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the  
45 Department of Health Care Services (DHCS) for Cal MediConnect

46 B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare  
47 Advantage

48 C. CalOptima Contract for Health Care Services

49 D. CalOptima Policy CMC.9002: Member Grievance Process

50 E. CalOptima Policy CMC.9003: Standard Appeal

51 F. CalOptima Policy CMC.9004: Expedited Appeal

52 G. CalOptima Policy MA.9002: Member Grievance Process

53 H. CalOptima Policy MA.9003: Standard Service Appeal

- I. CalOptima Policy MA.9004: Expedited Service Appeal
- J. Title 42 United States Code § 1395m(m)
- K. Title 42 CFR §§ 410.78 and 414.65
- L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

**VI. REGULATORY AGENCY APPROVAL(S)**

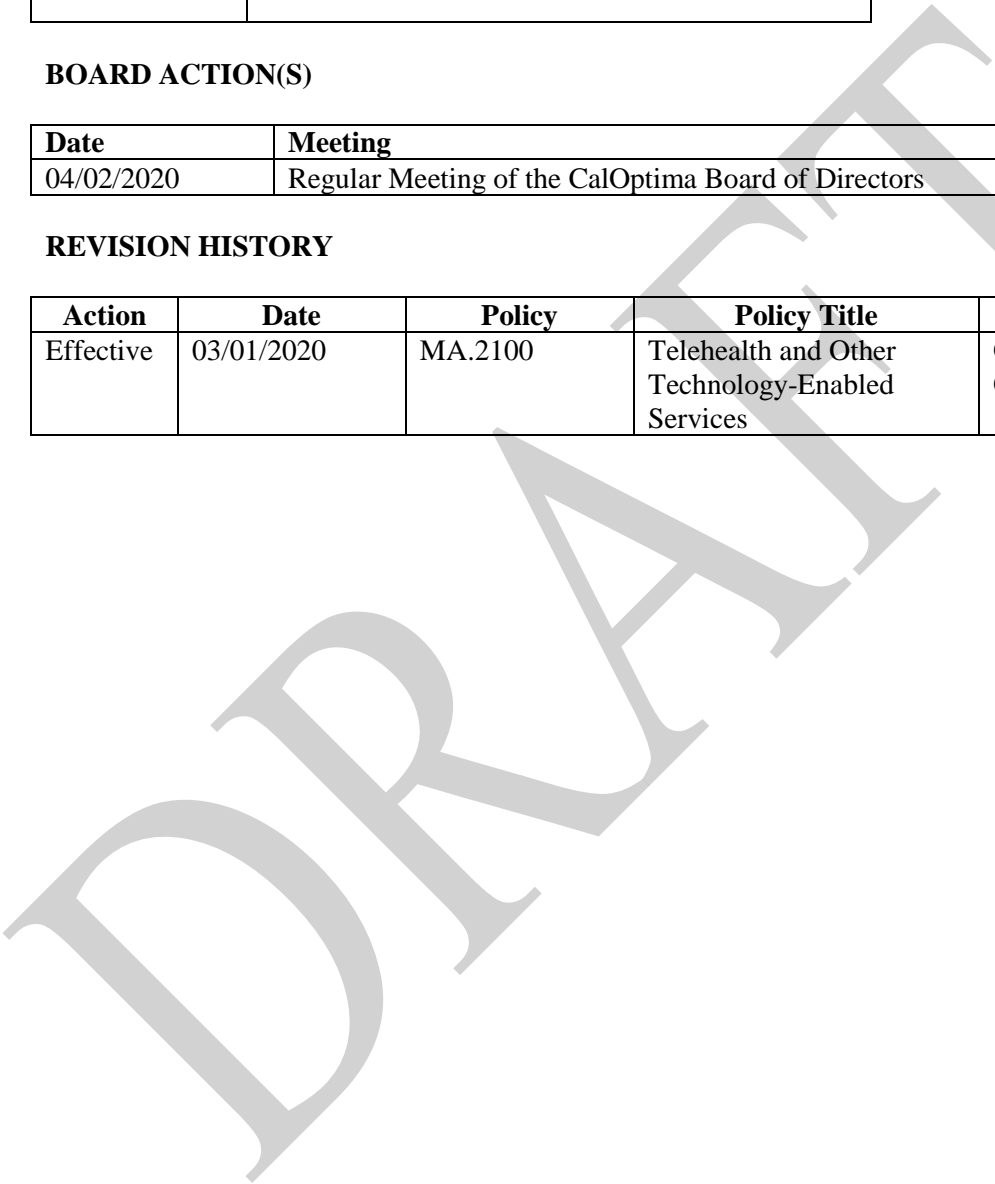
Date	Regulatory Agency

**VII. BOARD ACTION(S)**

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

**VIII. REVISION HISTORY**

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect





1 IX. GLOSSARY  
2

Term	Definition
Asynchronous Store and Forward	The transmission of a Member’s medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS’ list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at <a href="https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes">https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</a> .
Covered Services	<p>OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare &amp; Medicaid Services (CMS) Contract.</p> <p>OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare &amp; Medicaid Services (CMS) Contract.</p>
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member’s treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member’s health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	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.
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.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
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.



<b>Term</b>	<b>Definition</b>
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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RICHARD FIGUEROA  
ACTING DIRECTOR

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



GAVIN NEWSOM  
GOVERNOR

**DATE:** October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** TELEHEALTH SERVICES POLICY

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.<sup>1</sup> This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.<sup>2</sup> *Revised text is found in italics.*

**BACKGROUND:**

The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),<sup>3</sup> codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,<sup>4</sup> Health and Safety Code (HSC) Section 1374.13,<sup>5</sup> and Welfare and Institutions Code (WIC) Sections 14132.72<sup>6</sup> and 14132.725.<sup>7</sup> For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

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<sup>1</sup> The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: [https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele\\_m01o03.doc](https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc)

<sup>2</sup> More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: <https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx>

<sup>3</sup> AB 415 is available at:

[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201120120AB415](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415)

<sup>4</sup> BPC Section 2290.5 is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC)

<sup>5</sup> HSC Section 1374.13 is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC)

<sup>6</sup> WIC Section 14132.72 is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC)

<sup>7</sup> WIC Section 14132.725 is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC)

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

**POLICY:**

Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4<sup>th</sup> Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.<sup>8</sup>

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.

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



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



BRADLEY P. GILBERT, MD, MPP  
DIRECTOR

GAVIN NEWSOM  
GOVERNOR

**DATE:** March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

**PURPOSE:**

In response to the COVID-19 pandemic, it is imperative that members practice “social distancing.” However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

**REQUIREMENTS:**

Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:<sup>1</sup>

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim. For example, if an MCP reimburses a provider \$100 for an in-person visit, the MCP must reimburse the provider \$100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services’ guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

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<sup>1</sup> Government Code section 8550, et seq.

SUPPLEMENT TO ALL PLAN LETTER 19-009  
Page 2

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division

## **SAJID A. AHMED**

[e] sajcookie@gmail.com [c] +1.415.377.9514 [a] 1300 Prospect Drive, Redlands, CA

### **EXECUTIVE PROFILE**

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

### **AREAS OF EXPERTISE**

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

### **EXECUTIVE SUMMARY**

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

### **SELECTED KEY ACCOMPLISHMENTS**

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a \$5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed \$150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the \$38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)



Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed \$15M.
- Successfully awarded (now) over \$18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract (\$128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

### **SELECTED BOARDS & COMMITTEES**

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use \$38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;



- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over \$120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

## **SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)**

### **How Artificial Intelligence Will Revolutionize Healthcare**

<https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896>.

HIMSS March 15th, 2018

### **Keynote: Innovation through Disruption – How AI will transform Healthcare**

ITC Summit, Chennai, India, March 27<sup>th</sup>, 2017

### **Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;**

HIMSS17 Summit, Feb 21, 2017

### **Keynote: The Future of the CIO**

Health Information Technology Summit- January 2017

### **Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital**

Latin American Hospital Expansion Summit – October 15, 2016

### **Keynote: HIE is DEAD! Long live HIE!**

**Idea Exchange in Digital Healthcare Summit, University of California Irvine,**  
Wednesday, July 10, 2013

### **L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA**

Health Collaborative Meeting October 27, 2011

### **eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;**

2012 Annual Health Care Symposium

### **Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011**

eHealth Policy Presentation

**"eHealth Today – Community Impact & Reality"** A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

*(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)*

**PROFESSIONAL EXPERIENCE**

**Inland Empire Health Plan (IEHP)**, Rancho Cucamonga, CA 6/2017-Present  
Executive Lead, Virtual Care Programs  
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a \$9 Million budget.

**WISE Healthcare Corporation**, Redlands, CA **8/2017-Present**  
Chief Executive Officer  
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

**MLK Jr. Los Angeles Healthcare Corp**, Los Angeles, CA **2/2013-7/2017**  
Chief Information & Innovations Officer  
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

**L.A. Care Health Plan, Los Angeles, CA** **9/2008 – 3/2013**  
**Executive Director, Health Information Technology & Innovation**  
**Executive Director, Safety Net eConsult Program (2010 – 2013)**

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a \$ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over \$40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over \$120 Million in projects statewide

**Spot Runner, Inc., Los Angeles, CA** **4/2008 – 8/2008**  
**Sr. Data Architect & Systems Consultant**

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

**Home Box Office (HBO) Inc.**, Santa Monica, CA  
**Consultant, Sr. Data Architect**

**3/2007- 4/2008**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. ( [www.thisjustin.com](http://www.thisjustin.com) )
- Lead efforts to training internal and partner end-user clients

**SelfMD**, Pasadena, CA  
**Chief Technology Officer**

**3/2005-3/2007**

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

**IGP Technologies, Inc.**, Pasadena, CA

**7/1999 –2/2007**

**Chief Information Officer, Healthcare Information Architecture**

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over \$32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

**SELECTED AWARDS AND HONORS**

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech 2002-Present  
 Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

## **EDUCATION**

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

## **BOARD EXPERIENCE**

**Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.**

### **Tagnos, Inc. 2017 - Present**

A member of the board of advisory, providing direction to growth and new global markets.

### **Electronic Health Networks, Inc.**

**2017 – Present**

A member of the board of directors, providing direction to growth and new global markets.

### **California Provider Directory Advisory Board**

**2016 – Present**

A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

### **Advisory Board Member of SNC. Inc.**

**2012 – Present**

Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

**Board Member of the East Valley Family YMCA****2011 – Present**

On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

**Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013**

Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over \$2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

**Chair, L.A. Care Technical Advisory Board****2008 – 2013**

A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

**Board Member of Health-e-LA****2008 - 2012**

A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

# PETER J. SCHEID, M.D.

## EXPERIENCE

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8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

*Addiction Medicine Physician*

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

*Per Diem Physician*

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

*Medical Director, Clinical Operations*

- Oversight of Utilization Management Medical Directors
- Utilization Management
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

*Medical Director, Utilization Management*

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

E-MAIL PSCHEID12@GMAIL.COM  
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673  
(714) 227-4123 CELL  
(949) 229-7684 FAX



3/07-1/08 Primary Provider Management Company San Diego, CA  
*Medical Director, Family Choice Medical Group, Vantage Medical Group-  
San Diego*

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA  
*Physician Consultant, Medical Services for Indigents Program*

- Utilization Management
- Program Development
- Formulary Development

10/02-7/07 Community Care Health Centers Huntington Beach, CA  
*Associate Medical Director*

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA  
*Clinical Instructor of Family Medicine, Department of Family and Preventive  
Medicine*

E-MAIL PSCHIED12@GMAIL.COM  
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673  
(714) 227-4123 CELL  
(949) 229-7684 FAX

## EDUCATION

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7/2013-6/2014 Addiction Medicine Fellowship Loma Linda, CA  
*Loma Linda University Medical Center*

12/2006-9/2008 Health Care Leadership Program San Francisco, CA  
*Fellow of Program Sponsored by California Health Care Foundation*

7/2000-6/2001 Chief Resident San Diego, CA  
*UCSD Department of Family & Preventive Medicine*

7/1998-6/2001 Family Medicine Residency San Diego, CA  
*UCSD Department of Family & Preventive Medicine*

7/1994-6/1998 Medical School Detroit, MI  
*Wayne State University School of Medicine*

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English East Lansing, MI  
*Michigan State University*

## LICENSURE & CERTIFICATION

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2001-Present California A070698

2001-Present Diplomate, American Board of Family Practice

2014-Present Diplomate, American Board of Addiction Medicine

2020-Present Diplomate, American Board of Preventive Medicine,  
Addiction Medicine

## PROFESSIONAL ASSOCIATIONS

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American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

## REFERENCES AVAILABLE ON REQUEST

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E-MAIL [PSCHEID12@GMAIL.COM](mailto:PSCHEID12@GMAIL.COM)  
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673  
(714) 227-4123 CELL  
(949) 229-7684 FAX

# TANYA DANSKY, MD

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## PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

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## SKILLS/EXPERTISE

Executive Leadership  
Medi-Cal and CA Commercial HMO  
Quality Improvement  
Utilization Management  
Strategic Business Operations

Value Based Contracting  
Washington State Medicaid  
Population Health  
Innovation  
Social Determinants of Health

## WORK HISTORY

**Independent Consulting**

**Feb. 2020 – Present**

**Clinical Advisor, Harbage Consulting**

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

**Blue Shield of California**

**April 2017 – Feb. 2020**

**VP & Chief Medical Officer, Promise Health Plan**

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA

November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA

May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team’s remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA

January 2006 – May 2014

Chief Executive Officer (10/11–5/14)

Medical Director (7/06–5/14)

Inpatient Medical Director (1/06–7/06)

- Responsible for year over year financial and performance success of \$50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

## EDUCATION

California Healthcare Foundation Leadership Program  
Fellow, 2010 - 2012

University of California, San Diego  
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles  
MD, 1995

University of California, Davis  
BS in Physiology, 1991

## CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

\*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken April 2, 2020**

**Regular Meeting of the CalOptima Board of Directors**

### **Report Item**

6. Consider Authorizing Amendment to the County of Orange Public Healthcare Services Contract, for the Provision of Targeted Engagement and Housing Supportive Services

### **Contact**

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

Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400

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

### **Recommended Actions**

1. Authorize CalOptima's Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's Public Healthcare Services Contract with the County of Orange to include reimbursement for:
  - a. Targeted engagement services for the Health Homes Program (HHP) which are not provided under or duplicative of the County's Whole Person Care (WPC) program for CalOptima Direct (COD) and CalOptima Community Network (CCN) Medi-Cal members eligible for the HHP enrolled with WPC and already receiving services from County's WPC program;
  - b. Continuation of payment for housing supportive services for those CalOptima Direct (COD) and CCN Medi-Cal members receiving housing supportive services through the WPC program at the time of enrollment into the HHP, subject to the requirement that the County cannot receive payment for such services from DHCS under the WPC program; and.
2. Authorize unbudgeted expenditures from existing reserves of up to \$56,000 to provide funding for targeted engagement services and housing supportive services through June 30, 2020.

### **Background**

#### *Whole Person Care (WPC) – County of Orange Program*

WPC is a County of Orange-operated pilot program, administered by the Orange County Health Care Agency (OCHCA), providing infrastructure and integrated systems of care to coordinate services for vulnerable Medi-Cal beneficiaries and others experiencing homelessness. The County's WPC Pilot application was approved by the Department of Health Care Services (DHCS) in October 2016, and coordinates physical, behavioral health, and social services in a person-centered approach. Services provided through the WPC are billed to and funded by DHCS. The WPC Pilot provides targeted engagement services, housing supportive services which includes housing navigation and tenancy sustaining services, as well as recuperative care. Additional funding was provided for the WPC Pilot in July 2019, to expand existing housing navigation and supportive services for persons with Serious Mental Illness (SMI), as well as implement these services for persons who do not have a connection to OCHCA Behavioral Health Services.

#### *Health Homes Program (HHP) – CalOptima Program*

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. The intent of HHP is to improve member outcomes and reduce health care costs. In California, Assembly Bill 361 (2013) authorizes implementation of the HHP. HHP, which

is an entitlement benefit, was implemented in selected California counties in a phased-in implementation approach, with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors (Board) authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of HHP. HHP was implemented in Orange County on January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and Substance Use Disorders (SUD), and is expected to be implemented no sooner than July 1, 2020, for CalOptima Medi-Cal members with eligible SMI.

HHP provides the following six core service categories for members:

- Comprehensive care management
- Care coordination (physical health, behavioral health, community-based long-term services and support)
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services, including housing

In order to participate, members must choose to enroll into HHP and not be required to change their primary care provider or health network. Based on DHCS eligibility criteria, CalOptima actively conducts progressive outreach to members potentially eligible for HHP. Through this process, members are engaged through written, telephonic, and face-to-face encounters in order to encourage participation in HHP. Eligible members currently enrolled in WPC may also elect to enroll in HHP and simultaneously participate in both programs, however, members may not receive duplicative care coordination services from both programs. In order to receive HHP core services, members must receive care coordination services through the HHP. It is the responsibility of the WPC to ensure that a member participating in both WPC and HHP does not receive duplicative services or claimed for reimbursement from DHCS.

## **Discussion**

Both the WPC and HHP programs contain similar, or crossover services. As such, DHCS requires the MCPs - including CalOptima - to ensure there is no duplication of services for Members enrolled in both programs. WPC has a targeted outreach program that can be leveraged to provide benefit and enrollment information regarding HHP to CalOptima members. Additionally, there is crossover between WPC and HHP in that both programs provide housing supportive services. In order to increase awareness of HHP, maintain relationships between members and housing supportive providers, minimize disruption in care, and avoid duplication of services, staff recommends amending CalOptima's Public Healthcare Services contract to reimburse the County for providing the following services:

1. Expand WPC targeted engagement services to provide benefit and enrollment information to CalOptima Direct (COD) and CCN Medi-Cal members enrolled in the WPC program and eligible for HHP. Targeted engagement specifically for the HHP is not a service currently provided under the WPC and is not a duplicative service; and
2. Continuation of payment for housing supportive services for CalOptima Direct (COD) and CCN Medi-Cal members receiving housing supportive services through the WPC program at the time



of enrollment into the HHP, if appropriate. Housing supportive services is a duplicative service. WPC cannot receive reimbursement from DHCS when housing supportive services are provided through HHP.

CalOptima staff continues to partner and collaborate with the health networks, community partners and OCHCA, to coordinate services. Staff will continue to collaborate with stakeholders in Orange County in anticipation of the transition of the services of both the HHP and the WPC through DHCS' California Advancing and Innovating Medi-Cal (CalAIM) proposal.

### **Fiscal Impact**

Staff estimates the total cost for the nine-month period of April through December 2020 to provide reimbursement for targeted engagement services is approximately \$7,500 and to continue payment for housing supportive services is approximately \$142,560.

The recommended action to fund targeted engagement services and housing and supportive services through June 30, 2020, is an unbudgeted item. An allocation of up to \$56,000 from existing reserves will fund this action. Management will include expenses related to this contract amendment for the period beginning July 1, 2020, and after in future operating budgets.

### **Rationale for Recommendation**

The recommended actions will allow CalOptima to adhere to DHCS guidance ensuring duplicative services are not provided to members enrolled in both WPC and HHP, as well as and minimize disruption in member care.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

1. Contracted Entities covered by this recommended Board action
2. Board Action Dated June 7, 2018; Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

*Attachment to April 2, 2020 Board of Directors Meeting - Agenda Item 6*

**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
County of Orange	405 W 5 <sup>th</sup> Street, suite 756	Santa Ana	CA	92701

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

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

**Consent Calendar**

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

**Contact**

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

**Recommended Action**

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

**Background**

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

**Discussion**

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS’ proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff’s understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS’ requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

<b>Requirement</b>	
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless.  Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services.  Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

<b>Requirement</b>	
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

**Fiscal Impact**

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS’ proposed rates, staff estimates that the total annual program costs for

HHP will be \$12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

**Rationale for Recommendation**

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader  
**Authorized Signature**

5/30/2018  
**Date**

## 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:

<b>Amendments to Primary Agreement</b>	<b>Board Approval</b>
<b>A-01</b> 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
<b>A-02</b> 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
<b>A-03</b> 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
<b>A-04</b> included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
<b>A-05</b> 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
<b>A-06</b> 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
<b>A-07</b> 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
<b>A-08</b> 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
<b>A-09</b> 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 <b>Medicare Improvements for Patients and Providers Act</b> (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

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

<b>Amendments to Secondary Agreement</b>	<b>Board Approval</b>
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

<b>A-06</b> 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
<b>A-07</b> 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:

<b>Amendments to Agreement 16-93274</b>	<b>Board Approval</b>
<b>A-01</b> 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:

<b>Amendments to Agreement 17-94488</b>	<b>Board Approval</b>
<b>A-01</b> 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 April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

#### **Contact**

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

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

#### **Recommended Actions**

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.
2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.
3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

#### **Background/Discussion**

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

### **Fiscal Impact**

The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

### **Rationale for Recommendation**

The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachment**

1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

Policy: FF.2011  
Title: Directed Payments  
Department: Claims Administration  
Section: Not Applicable

*CEO Approval:*

Effective Date: 04/02/2020  
Revised Date: Not applicable

Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect
- PACE
- Administrative - Internal
- Administrative – External

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## I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

## II. POLICY

- A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.
- B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:
  - 1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;
  - 2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);
  - 3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;
  - 4. The Designated Provider was eligible to receive the Directed Payment;
  - 5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;
  - 6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.
- C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:
1. An Add-On Payment for Physician Services and Developmental Screening Services.
  2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.
- D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.
- E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:
1. A description of the minimum requirements for a Qualifying Service;
  2. How Directed Payments will be processed;
  3. How to file a grievance with the Health Network and second level appeal with CalOptima; and
  4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)
- F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.
- G. Directed Payment Reimbursement
1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.
    - a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.
  2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.
    - a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.
    - b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any



administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:
  - a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.
  - b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.
- H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.
- I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.
- J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

### III. PROCEDURE

#### A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.
  - a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.
2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.
  - a. The following Developmental Screening Services are eligible for an Add-On Payment:
    - i. A routine screening when provided:
      - 1) On or before the first birthday;
      - 2) After the first birthday and before or on the second birthday; or

- 3) After the second birthday and on or before the third birthday.
- ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.
  - b. Development Screening Services are not subject to any prior authorization requirements.
  - c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.
  - d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:
    - i. The tool that was used to perform the Developmental Screening Service;
    - ii. That the completed screen was reviewed;
    - iii. The interpretation of results;
    - iv. Discussion with the Eligible Member and/or the Eligible Member's family; and
    - v. Any appropriate actions taken.
  - e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.
  - f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.
3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.
- a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:
    - i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;
    - ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and
    - iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.
  - b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

- i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.
      - ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.
    - c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.
    - d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:
      - i. The tool that was used to perform the ACEs Screening Service;
      - ii. That the completed screen was reviewed;
      - iii. The interpretation of results;
      - iv. Discussion with the Eligible Member and/or the Eligible Member's family; and
      - v. Any appropriate actions taken.
    - e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.
  - 4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.
    - a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.
  - 5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.
    - a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.
    - b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

#### B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

- a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.
  - b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.
2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:
- a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.
  - b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.
3. Notice by CalOptima
- a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.
  - b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.
  - c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program (“Pending SPA”) and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

- a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.
- b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

- a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:
  - i. The Member has other sources of health coverage;
  - ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;
  - iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or
  - iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.
  - a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.
2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.
  - a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.
  - b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

- c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network.

#### D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.
2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.
3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.
4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

#### E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10<sup>th</sup> of the implementing month and as follows:
  - a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or
  - b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.
2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20<sup>th</sup> of the month for services paid in that month.
3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.



4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.
- F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.
- G. Reporting
1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.
    - a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.
    - b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.
  2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

#### **IV. ATTACHMENT(S)**

- A. Directed Payments Rates and Codes

#### **V. REFERENCE(S)**

- A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
- B. CalOptima Policy FF.1001: Capitation Payments
- C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
- D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
- E. CalOptima Policy GG.1619: Delegation Oversight
- F. CalOptima Policy HH.1101: CalOptima Provider Complaint
- G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
- H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
- I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
- J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
- K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
- L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

- M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
- N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

**VI. REGULATORY AGENCY APPROVAL(S)**

Date	Regulatory Agency

**VII. BOARD ACTION(S)**

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

**VIII. REVISION HISTORY**

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

For 20200402 BOD Review Only



**IX. GLOSSARY**

<b>Term</b>	<b>Definition</b>
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
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.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: <ol style="list-style-type: none"> <li>1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional;</li> <li>2. Establish Reliability: Reliability scores of approximately 0.70 or above;</li> <li>3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and</li> <li>4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.</li> </ol>

<b>Term</b>	<b>Definition</b>
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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal 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), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: <ol style="list-style-type: none"> <li>1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services;</li> <li>2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services;</li> <li>3. Non-contracted GEMT Providers for GEMT Services; and</li> <li>4. Non-contracted Providers for Abortion Services.</li> </ol>
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

<b>Term</b>	<b>Definition</b>
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, 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 Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

<b>Term</b>	<b>Definition</b>
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

For 20200402 BOD Review ONLY

## Attachment A: Directed Payments Rates and Codes

### Proposition 56: Physician Services

- 1) **Program:** Proposition 56 Physician Services
- 2) **Source:** DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
- 3) **Dates of Service (DOS):** July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	\$10.00	\$18.00	\$18.00
99202	Office/Outpatient Visit New	\$15.00	\$35.00	\$35.00
99203	Office/Outpatient Visit New	\$25.00	\$43.00	\$43.00
99204	Office/Outpatient Visit New	\$25.00	\$83.00	\$83.00
99205	Office/Outpatient Visit New	\$50.00	\$107.00	\$107.00
99211	Office/Outpatient Visit Est	\$10.00	\$10.00	\$10.00
99212	Office/Outpatient Visit Est	\$15.00	\$23.00	\$23.00
99213	Office/Outpatient Visit Est	\$15.00	\$44.00	\$44.00
99214	Office/Outpatient Visit Est	\$25.00	\$62.00	\$62.00
99215	Office/Outpatient Visit Est	\$25.00	\$76.00	\$76.00
90791	Psychiatric Diagnostic Eval	\$35.00	\$35.00	\$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00	\$35.00	\$35.00
90863	Pharmacologic Management	\$5.00	\$5.00	\$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	\$77.00	\$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	\$80.00	\$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	\$77.00	\$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	\$83.00	\$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	\$30.00	\$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	\$75.00	\$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	\$79.00	\$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	\$72.00	\$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	\$72.00	\$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	\$27.00	\$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

## Proposition 56: Developmental Screening Services

- 1) **Program:** Proposition 56 Developmental Screening Services
- 2) **Source:** DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
- 3) **Dates of Service (DOS):** On or after January 1, 2020

CPT Code	Description	Add-On Payment <sup>1</sup>
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument <sup>2</sup>	\$59.90

<sup>1</sup>KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

## Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

- 1) **Program:** Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
- 2) **Source:** DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
- 3) **Dates of Service (DOS):** On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment <sup>2</sup>	Notes
G9919	Screening performed – results positive and provision of recommendations provided	\$29.00	Providers must bill this HCPCS code when the patient’s ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	\$29.00	Providers must bill this HCPCS code when the patient’s ACE score is between 0 – 3 (lower risk).

<sup>2</sup>Payment obligations for rates of at least \$29 for eligible service codes

For 20200402 BOD Review

*Note: This communication is for reference only and is subject to future changes as directed by DHCS.*

## Proposition 56: Abortion Services (Hyde)

- 1) **Program:** Proposition 56 Abortion Services (Hyde)
- 2) **Source:** DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
- 3) **Dates of Service (DOS):** On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment <sup>3</sup>
59840	K	Induced abortion, by dilation and curettage	\$400.00
59840	O	Induced abortion, by dilation and curettage	\$400.00
59841	K	Induced abortion, by dilation and evacuation	\$700.00
59841	O	Induced abortion, by dilation and evacuation	\$700.00

<sup>3</sup>Payment obligations for rates of at least \$400 and \$700 for eligible service codes

For 20200402 BOD Review

Note: This communication is for reference only and is subject to future changes as directed by DHCS.



## Ground Emergency Medical Transport (GEMT) Services

- 1) **Program:** Ground Emergency Medical Transportation (GEMT) Services
- 2) **Source:** State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
- 3) **Dates of Service (DOS):** On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment <sup>4</sup>	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	\$339.00	\$339.00
A0427	Advanced Life Support, Level 1, Emergency	\$339.00	\$339.00
A0433	Advanced Life Support, Level 2	\$339.00	\$339.00
A0434	Specialty Care Transport	N/A	\$339.00
A0225	Neonatal Emergency Transport	N/A	\$400.72

<sup>4</sup>Payment obligations for rates of at least \$339.00 and \$400.72 for eligible service codes

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

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

**Report Item**

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

**Contact**

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

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

**Recommended Action**

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

**Background**

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

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

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

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

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

**Discussion**

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

**Initial Payments**

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

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

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

### Ongoing Processing

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

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

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

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

### **Fiscal Impact**

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

**Rationale for Recommendation**

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

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/30/2018  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken June 6, 2019** **Regular Meeting of the CalOptima Board of Directors**

#### **Consent Calendar**

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

#### **Contact**

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

#### **Recommended Actions**

Ratify standardized annual Proposition 56 provider payment process.

#### **Background**

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

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

#### **Discussion**

In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

### Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medical covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.
- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

### Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medical covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.
- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

### **Fiscal Impact**

The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

### **Rationale for Recommendation**

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

### **Concurrence**

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

### **Attachment**

June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader  
Authorized Signature

5/29/2019  
Date



## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken June 7, 2018**

### **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

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

#### **Contact**

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

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

#### **Recommended Action**

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

#### **Background**

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

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

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

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

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

**Discussion**

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

**Initial Payments**

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

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

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

### Ongoing Processing

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

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

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

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

### **Fiscal Impact**

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

**Rationale for Recommendation**

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

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/30/2018  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken September 5, 2019** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

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

#### **Contact**

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400  
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

#### **Recommended Actions**

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

#### **Background/Discussion**

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of \$339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of \$339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required \$339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

### **Fiscal Impact**

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

### **Rationale for Recommendation**

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader  
**Authorized Signature**

8/28/19  
**Date**

*Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9*

**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Legal Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
San Francisco Regional Office  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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February 7, 2019

Mari Cantwell  
Chief Deputy Director, Health Care Programs  
California Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

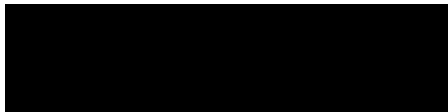
Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at [Cheryl.Young@cms.hhs.gov](mailto:Cheryl.Young@cms.hhs.gov).

Sincerely,



Richard Allen  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)  
Connie Florez, DHCS  
Angel Rodriguez, DHCS  
Angeli Lee, DHCS  
Amanda Font, DHCS

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

1 8 — 0 0 4

2. STATE  
California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)  
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
July 1, 2018

5. TYPE OF PLAN MATERIAL (*Check One*)

- NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION

Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT

a. FFY <sup>2018</sup> \$4,461,892  
b. FFY <sup>2019</sup> \$13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

~~Supplement 28, page 1, Attachment 4.19-B~~  
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)

None

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW (*Check One*)

- GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      The Governor's Office does not wish to  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL

[Redacted Signature]

16. RETURN TO

Department of Health Care Services  
Attn: Director's Office  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

13. TYPED NAME

Mari Cantwell

14. TITLE

State Medicaid Director

15. DATE SUBMITTED

July 11, 2018

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

July 11, 2018

18. DATE APPROVED

February 7, 2017

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL

/ s /

21. TYPED NAME

Richard Allen

22. TITLE Acting Associate Regional Administrator,  
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

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**ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY  
MEDICAL TRANSPORT SERVICES**

**Introduction**

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

“Emergency medical transport” means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

**Methodology**

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be \$339.00. The add-on is paid on a per-claim basis.

<b>Service Code</b>	<b>Description</b>	<b>Current Payment</b>	<b>Add On Amount</b>	<b>Resulting Total Payment</b>
A0429	Basic Life Support	\$118.20	\$220.80	\$339.00
A0427	Advanced Life Support, Level 1	\$118.20	\$220.80	\$339.00
A0433	Advanced Life Support, Level 2	\$118.20	\$220.80	\$339.00

TN 18-004  
Supersedes  
TN: None

Approval Date: February 7, 2019

Effective Date: July 1, 2018

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

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The resulting total payment amount of \$339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

TN 18-004  
Supersedes  
TN: None

Approval Date: February 7, 2019

Effective Date: July 1, 2018



JENNIFER KENT  
DIRECTOR

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



GAVIN NEWSOM  
GOVERNOR

**DATE:** June 14, 2019

ALL PLAN LETTER 19-007

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS<sup>1</sup>

**SUBJECT:** NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT  
PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as “Rogers Rates.”

**BACKGROUND:**

Pursuant to the Legislature’s addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

**POLICY:**

In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

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<sup>1</sup> This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be \$339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a “Rogers Rate” for a total reimbursement rate of \$339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of \$339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

#### **Timing of Payment and Claim Submission**

The projected value of this payment obligation will be accounted for in the MCPs’ actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

### **Impacts Related to Medicare**

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

### **Other Obligations**

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

ALL PLAN LETTER 19-007  
Page 4

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director  
Health Care Delivery Systems





[Home](#) → [Newsroom Archives](#)

## Ground Emergency Medical Transport Quality Assurance Fee

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**June 28, 2018**

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

**Add-on Amount:** \$220.80

**QAF Rate:** \$24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be \$339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the [Ground Emergency Medical Transport Quality Assurance Fee](#) website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: [GEMTQAF@dhcs.ca.gov](mailto:GEMTQAF@dhcs.ca.gov).

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## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

8. Consider Authorizing a Contract with an Additional Community-Based Adult Service (CBAS) Provider to Serve as an Alternative Care Setting (ACS) for CalOptima Program of All-Inclusive Care for the Elderly (PACE) Members and Establish Rates for ACS Contracts

#### **Contact**

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

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

#### **Recommended Actions**

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to, effective May 1, 2020:
  - a. Contract with CBAS Provider Alzheimer's Family Center as an Alternative Care Setting (ACS) for CalOptima PACE members; and
  - b. Establish PACE ACS rates 5% higher than the CalOptima Community-Based Adult Services rate for PACE.
2. Authorize unbudgeted expenditures from existing reserves of up to \$9,500 to provide funding for the ACS rate increase from May 1, 2020 through June 30, 2020.

#### **Background**

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima PACE currently serves approximately 400 members via the CalOptima PACE center and four operating alternative care settings.

At its February 1, 2018 meeting, the Board authorized contracts with five CBAS facilities that were selected through a Request for Proposal (RFP) process in December 2017. The CBAS facilities selected were:

- Acacia Adult Day Services
- SeniorServ – Anaheim Adult Day Health Care Center
- SeniorServ – Santa Ana Adult Day Health Care Center
- South County Adult Day Services
- Sultan Adult Day Health Care

In accordance with section 460.98 of Title 42 of the Code of Federal Regulations, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by CalOptima PACE. ACS sites provide the following six services:

CalOptima Board Action Agenda Referral  
Consider Authorizing a Contract with an Additional  
Community-Based Adult Service (CBAS) Provider to Serve as an  
Alternative Care Setting (ACS) for CalOptima Program of All-Inclusive Care for the Elderly  
(PACE) Members and Establish Rates for ACS Contracts  
Page 2

- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

In January 2020, Sultan Adult Day Health Care suddenly closed operations on short notice. While the Board authorized an RFP for expansion of ACS sites at the March 2019 regular meeting of the CalOptima Board of Directors, the RFP process is now being used to replace the closed Sultan ACS.

A map of the CalOptima PACE delivery system is included as Attachment 1. The graphic illustrates member density and location of the PACE center, ACS sites and Community-Based Physician office.

### **Discussion**

As of February 2020, approximately 15% of PACE members have chosen to receive PACE services via an ACS site. Using alternative care settings for CalOptima PACE members has increased access to culturally and linguistically competent, specialized services in close geographical proximity to members' residences. A one-year evaluation revealed promising and consistent quality metrics across the PACE program with implementation of the ACS strategy. In year two of ACS operations, CalOptima PACE had the highest overall participant satisfaction score amongst all 11 PACE organizations in California, strong financial performance and a census growing at a faster rate than before the ACS strategy was implemented.

Alzheimer's Family Center is a dementia-specific facility located in the coastal region of Orange County. An RFP evaluation committee reviewed the written proposal, completed a site visit and interviewed key personnel. Based on the specialized services and geographical location, the committee selected this bidder to meet the scope of services.

The RFPs (2017 and 2019) for the ACS scope of work included bundled per diem rates for day center services. The original rate was based on CalOptima PACE experience and projected unit cost of like services. After a June 2019 rate increase for CBAS, PACE ACS per diem rates are lower than CBAS rates, while requiring a higher level of service. In an August 2019 letter, the five contracted ACS sites proposed a rate increase of 20%. Staff recommend establishing a standard rate of 5% above the CBAS rate. To secure services where access may be limited, staff recommend a solution that promotes CBAS centers prioritizing PACE authorizations.

### **Fiscal Impact**

The recommended action to contract with CBAS Provider Alzheimer's Family Center as an ACS has no additional fiscal impact beyond what has been incorporated in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget.

The recommended action to establish ACS rates 5% higher than the CalOptima Medi-Cal CBAS rate for all PACE ACS provider contracts has an estimated annual impact of \$61,000 and 7.8%. The impact to the CalOptima PACE FY 2019-20 Operating Budget is an unbudgeted item. An allocation of up to \$9,500 from existing reserves will fund this action.

Management will include expenses related to the CBAS provider contract and increased ACS rate for the period beginning July 1, 2020, and after in future operating budgets.

### **Rationale for Recommendation**

While ACS sites throughout Orange County have increased access to eligible CalOptima members, access is needed in the most northern, southern and coastal areas of Orange County. Adding this additional site and establishing standard rates for all ACS providers increases access to the PACE comprehensive and integrated model of care.

### **Concurrence**

Gary Crockett, Chief Counsel

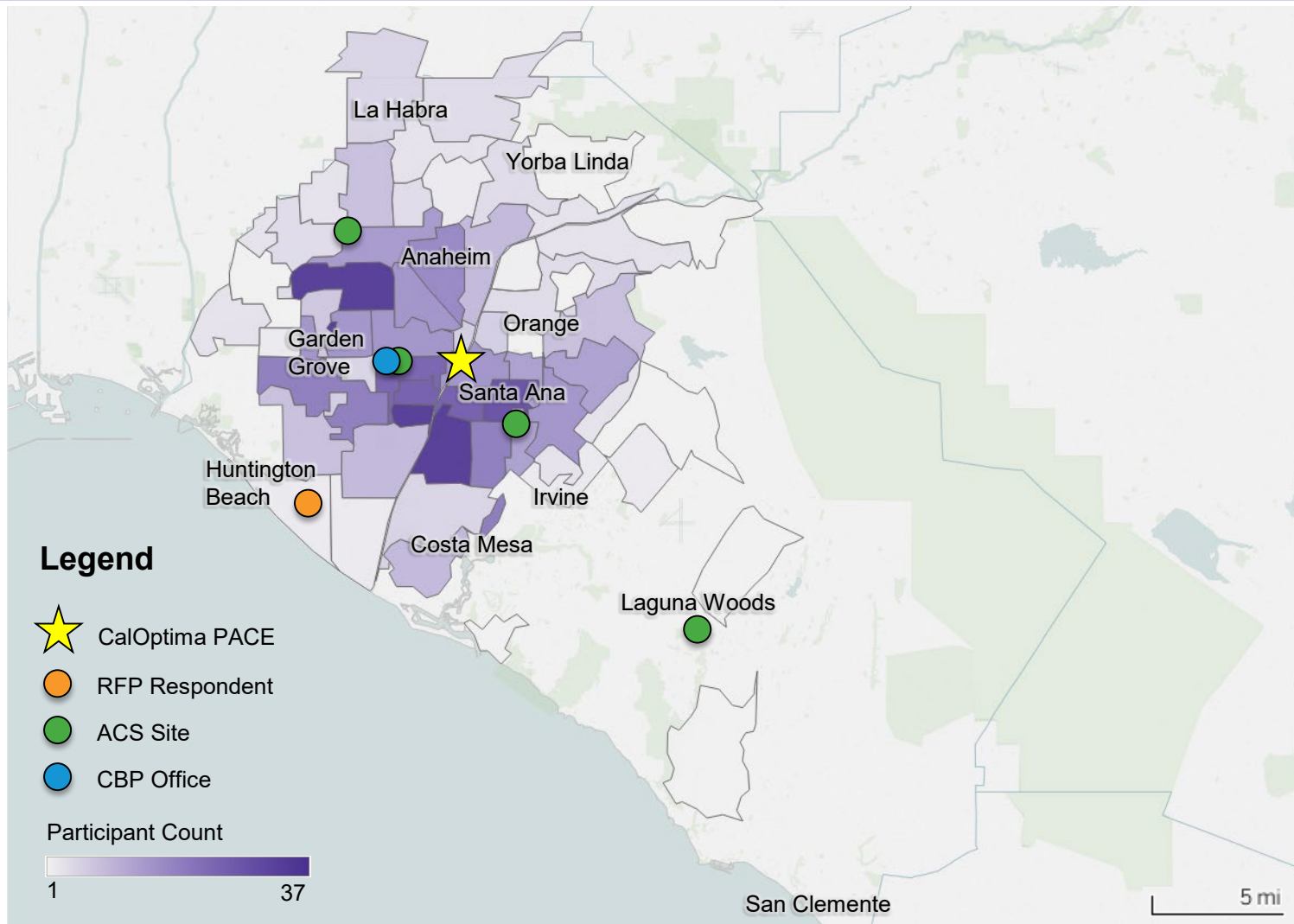
### **Attachment**

1. Service area map with CalOptima PACE Delivery System (February 2020)
2. Board Action dated March 7, 2019, Authorize Contracts with Additional Community-Based Adult Services Centers to Serve as Alternative Care Setting Sites for CalOptima Program of All-Inclusive Care for the Elderly (PACE) Members

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

# CalOptima PACE Delivery System



**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken March 7, 2019**  
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

12. Consider Authorizing Contracts with Additional Community-Based Adult Services Centers to Serve as Alternative Care Setting Sites for CalOptima Program of All-Inclusive Care for the Elderly (PACE) Members

**Contact**

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

**Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, and subject to Board approval, to add contracts with any willing and qualified Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members based on established operational and quality standards and potential PACE participant need.

Rev.  
3/7/2019

**Background**

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE program provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support coordinated from a central location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 308 members.

PACE programs are required to provide seven core services:

- Primary care
- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

The Centers for Medicare & Medicaid Services (CMS) defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of Title 42 of the Code of Federal Regulations. In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site center or by a community-based physician, on an individualized basis.

Interdisciplinary Team assessment and care planning remain components provided directly by the PACE center. Primary care may be provided at the CalOptima PACE site or by a community-based

physician, on an individualized basis. Necessary transportation services are provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards.

At its February 1, 2018 meeting, the Board authorized contracts with five CBAS facilities with the goal of increasing access to PACE in Orange County. The CBAS facilities were selected through a Request for Proposal (RFP) process in December 2017. The CBAS facilities were selected based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational capacity to provide services to a minimum of 15 CalOptima PACE members
- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process with their implementation date are listed in Attachment 1. A map of the CalOptima PACE delivery system is included as Attachment 2. The graphic illustrates member density and location of the PACE center and ACS sites.

### **Discussion**

Staff successfully developed a program design for CalOptima PACE members to utilize ACS sites, including operational and quality standards required to be designated as an ACS. The addition of ACS sites has increased access to CalOptima PACE's culturally and linguistically competent, specialized services while allowing members to remain in close geographical proximity to their residences. CalOptima PACE membership has increased from approximately 250 to more than 300 and there are currently 18 PACE members using the ACS sites, and over time, as referral patterns mature, larger numbers are anticipated. Financial, quality, and member experience performance metrics have been maintained at high levels with the additional ACS sites.

The northern, southern and coastal areas of Orange County continue to require increased access to PACE that can be addressed through the addition of local ACS sites in these areas. Multiple CBAS centers that were not included in the RFP selection have expressed interest in becoming ACS partners with CalOptima PACE. Additional ACS sites would allow CalOptima PACE to increase membership and better meet the needs of eligible residents of Orange County. CBAS centers interested in this opportunity would be required to submit a Letter of Interest to initiate the review process according to the criteria used in the RFP including geographical location.



### **Fiscal Impact**

The recommended action to add contracts with CBAS centers to serve as ACS sites for CalOptima PACE members is expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two to three members per month attributable to the addition of ACS sites. Increasing access to PACE services through the ACS strategy is expected to enable more eligible county residents to participate in the CalOptima PACE program and may improve operational efficiencies and increase economies of scale.

CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. For the given anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin for the PACE program will remain consistent with current levels through the current and next fiscal years.

### **Rationale for Recommendation**

Alternative care settings have increased access to care for current PACE members. Specifically, these services are culturally competent and specialized, and in more convenient geographical locations to PACE members' residences. As of February 2019, approximately 6% of CalOptima PACE participants receive services at an ACS, with the goal of 20% by the end of FY 2020. While ACS 'satellite' sites throughout Orange County have increased access to eligible CalOptima members, access is needed in the most northern, southern and coastal areas of Orange County. The implementation of the initial ACS sites is evidence of a viable model to meet the needs of Orange County seniors. Additional ACS contracts in the northern, southern and coastal areas will allow CalOptima PACE to scale operations to meet the needs of these frail seniors.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachments**

1. RFP-Qualified CBAS Providers
2. Service area map with CalOptima PACE Delivery System (February 2019)
3. Board Action dated February 1, 2018, Authorize PACE Alternative Care Setting Sites
4. PowerPoint Presentation: PACE Alternative Care Settings
5. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader  
**Authorized Signature**

2/27/2019  
**Date**





## RFP-Qualified CBAS Providers

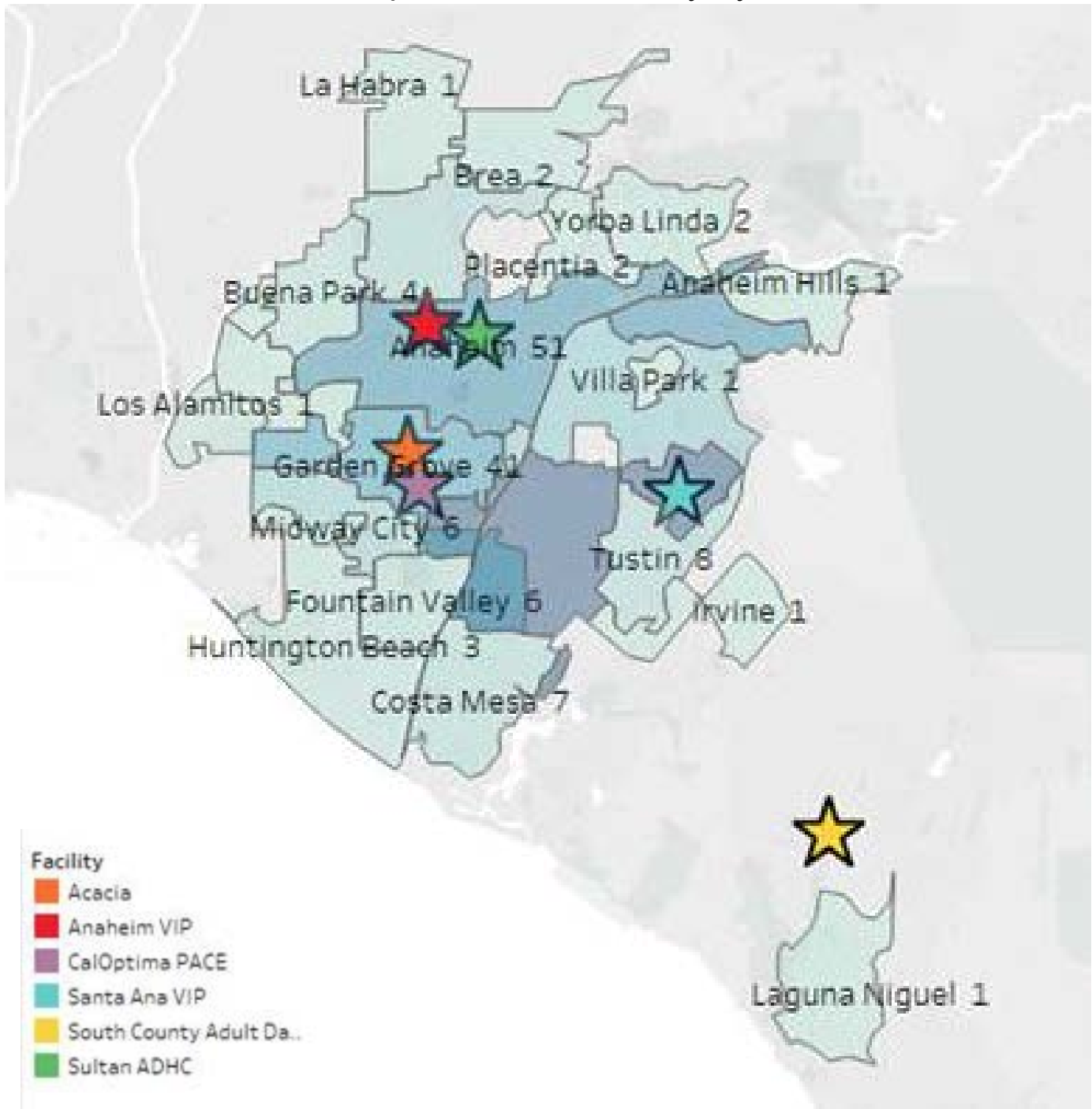
The following Community Based Adult Services (CBAS) Centers were qualified by the December 2017 Request for Proposals (RFP) for PACE Alternative Care Settings (ACS). All of the following centers are now operating as ACS sites.

The listing, with addresses, shows the location of existing PACE ACS sites operating within Orange County.

1. Acacia Adult Day Services  
11391 Acacia Parkway, Garden Grove, CA 92840
2. SeniorServ – Anaheim Adult Day Health Care Center  
1158 N. Knollwood Circle, Anaheim, CA 92801
3. SeniorServ – Santa Ana Adult Day Health Care Center  
1101 S. Grand Avenue, Suite K-M, Santa Ana, CA 92705
4. South County Adult Day Services  
24260 El Toro Road, Laguna Woods, CA 92637
5. Sultan Adult Day Health Care  
125 W. Cerritos Avenue, Anaheim, CA 92805



## Service Area Map with CalOptima PACE Delivery System



## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

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

#### **Report Item**

8. Consider Authorizing Contracts with Alternative Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)

#### **Contact**

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Enter into contracts with Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members; ~~and~~
2. Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs, subject to Board approval; and
3. Staff to report performance metrics back to the Board.

Rev.  
2/1/2018

#### **Background**

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 238 members at the single location.

At its February 4, 2016 meeting, the Board authorized submission of a service area expansion to the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), authorized a Request for Proposal (RFP) process for the ACS model for PACE expansion satellite locations to include CBAS centers, and directed staff to perform additional analysis. Subsequently, at its May 4, 2017 meeting, the Board requested that staff first issue a Request for Information (RFI) on alternative care settings. The RFI was released on May 26, 2017. Findings from the RFI, including a market analysis, locations and capabilities of potential ACS sites, were used to develop a RFP, which was released on November 3, 2017. Staff has completed scoring of the proposals and qualified five CBAS centers based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational for a minimum of one year
- Capacity to provide services to a minimum of 15 CalOptima PACE members

- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process are listed in Attachment 1.

While CalOptima's current service area is limited to north Orange County, the ACS model is expected to be an important step toward increasing access to PACE services throughout Orange County. CalOptima's request for expansion of the service area to include all Orange County Zip Codes is currently under review by CMS, with approval anticipated as soon as July 1, 2018. Four of the five CBAS centers qualified through the RFP are in the current service area, with one in the proposed expanded service area.

### **Discussion**

Using alternative care settings for CalOptima PACE members is expected to increase access to culturally and linguistically competent, specialized services in close geographical proximity to participants' residences. CMS defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of U.S. Code: Title 42 (Public Health and Welfare).

In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site. ACS sites will provide the following six services:

- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

Interdisciplinary Team assessment and care planning will remain components provided directly by the PACE center. Primary care may be provided by CalOptima PACE or a community-based physician, on an individualized basis. Transportation services will be provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards. The proposed contracts include rates and terms for ACS sites deemed capable of providing transportation services.

Through the RFP process, staff have developed a program design for CalOptima PACE to utilize ACS, including operational and quality standards required to be designated as an ACS. In the future, ACS sites may potentially be added based on a tool that determines operational and quality standards required to operate as an ACS, allowing CalOptima PACE to respond to access needs in specific areas of the county.

### **Fiscal Impact**

The recommended actions to authorize contracts with CBAS centers to serve as PACE ACS sites are expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two members per month related to the addition of the ACS sites. Increasing access to PACE services through the ACS strategy is expected to allow more eligible county residents to participate in the CalOptima PACE program, and may improve operational efficiencies and increase economies of scale. CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. Given the modest anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin will remain consistent with current levels through the fiscal year.

### **Rationale for Recommendation**

Alternative care settings will increase access to care for current PACE members. Specifically, these services are culturally competent and specialized, possibly in more convenient geographical locations to PACE members' residences. In addition, the alternative care setting strategy has been identified as a vehicle for expanding the PACE model of care to all Zip Codes of Orange County. Currently, service area is limited to 60-minute one-way ride radius from the PACE center in Garden Grove. With ACS 'satellite' sites throughout Orange County, eligible CalOptima members will have access to the coordinated quality care provided by CalOptima PACE.

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachment**

1. RFP-Qualified CBAS Providers
2. PowerPoint Presentation: PACE Alternative Care Setting (ACS) RFP Results

/s/ Michael Schrader  
**Authorized Signature**

1/25/2018  
**Date**

RFP-Qualified CBAS Providers

Center Name	Contract Name	Contract Effective Date	Center Address
Acacia Adult Day Services	Acacia Adult Day Services	7/1/12	11391 Acacia Parkway Garden Grove, CA 92840
Anaheim VIP Adult Day Health Care	Community Seniorserv, Inc., dba Anaheim VIP Adult Day Health Care	7/1/12	1158 North Knollwood Circle Anaheim, CA 92801
Santa Ana/Tustin VIP Adult Day Health Care	Community Seniorserv, Inc., dba Santa Ana/Tustin VIP Adult Day Health Care	7/1/12	1101 South Grand Avenue, Suite L Santa Ana, CA 92705
South County Adult Day Services	Alzheimer's Orange County	7/1/12	24260 El Toro Road Laguna Woods, CA 92637
Sultan Adult Day Health Care Center	Pacific GIS, Inc., dba Sultan Adult Day Health Care Center	7/1/12	125 W. Cerritos Avenue Anaheim, CA 92805



**PACE**  
**CalOptima**  
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# **PACE Alternative Care Setting (ACS) RFP Results**

**Board of Directors Meeting  
February 1, 2018**

**Richard Helmer, M.D., Chief Medical Officer  
Elizabeth Lee, Director, PACE**

# Goal of Implementing ACS

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- To expand access to PACE to all eligible Orange County seniors
  - Geographic coverage in current North County service area and future South County service area, anticipated in July 2018
- To ensure PACE supports participants' unique needs
  - Culture competence
  - Language access
  - Health conditions



# ACS Background

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- Staff progress on Board-approved ACS directives
  - September 2016: Presented financial information to Finance and Audit Committee (FAC)
  - February 2017: Updated FAC with additional financial performance metrics
  - May 2017: Conducted a three-hour PACE Study Session for the full Board, with a presentation by the state regulator and analysis of ACS by National PACE Association
  - May 2017: Issued a Request for Information (RFI) from potential ACS partners
  - August 2017: Distributed a 300-page PACE informational binder to the Board
  - November 2017: Released a Request for Proposal (RFP) for ACS partners

# PACE and CBAS Alignment

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- PACE and Community-Based Adult Services (CBAS) centers serve similar populations
  - Are nursing home-eligible
  - Have multiple chronic conditions
  - Need help with activities of daily living
- PACE and CBAS centers have an opportunity to better meet participants' preferences and needs
  - Increased convenience and appropriateness for participants
    - Conditions, language and ethnicity, and residence
- PACE and CBAS centers seeking new avenues for growth
  - CBAS centers are a referral source to PACE
  - Partnership provides CBAS centers with stable revenue

# CBAS as an ACS

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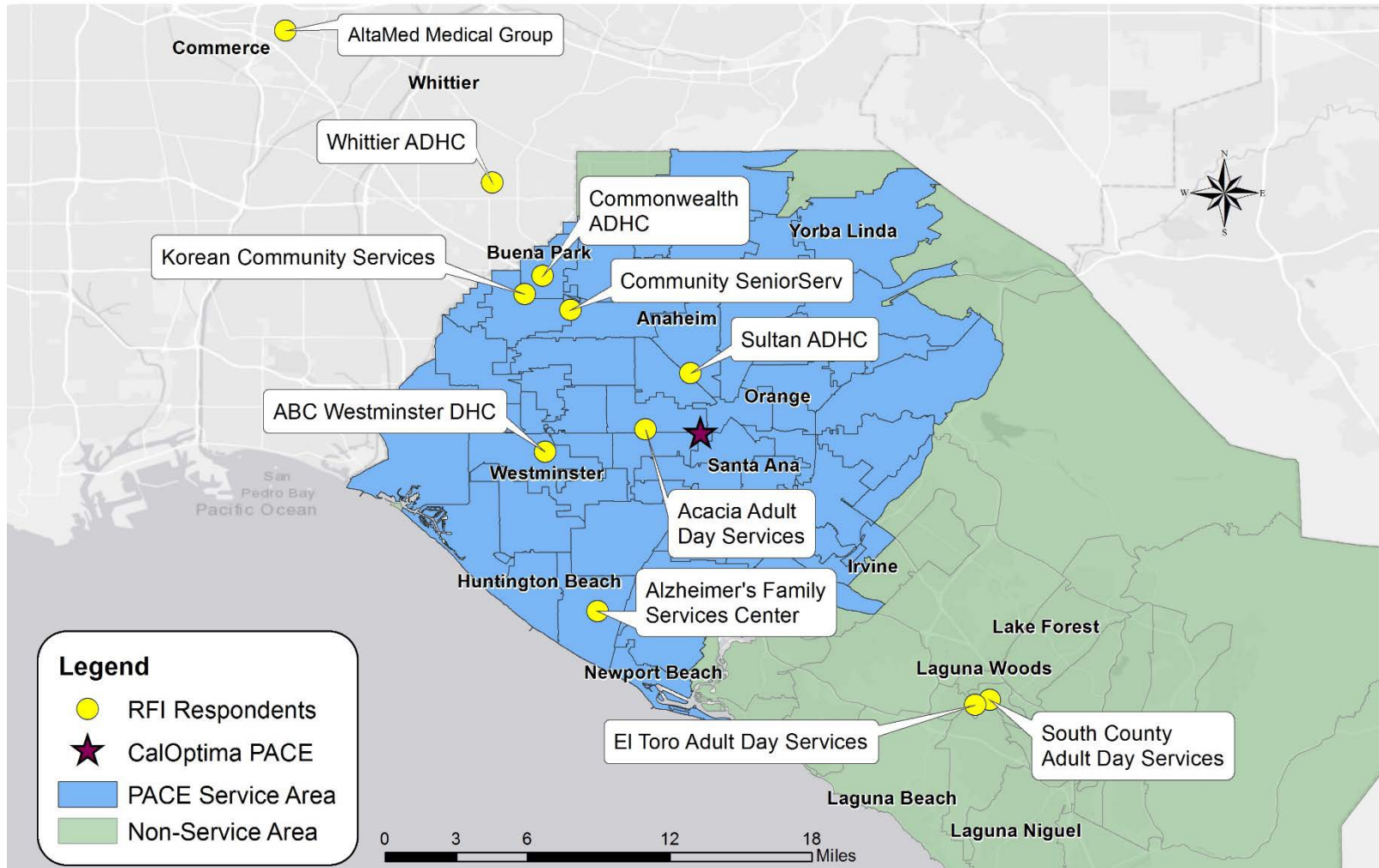
- CBAS centers deliver six of seven core PACE services
  - Social services
  - Restorative therapies
  - Personal care and supportive services
  - Nutritional counseling
  - Recreational therapy
  - Meals
- CalOptima PACE retains responsibility for the seventh core service
  - Primary care

# RFI Background

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- CalOptima issued an RFI for ACS sites in May 2017
- Responses were collected, with all Orange County respondents interviewed as of August 2017
- There were a total of 11 respondents, nine located in Orange County
  - Of those nine, eight were licensed CBAS centers

# RFI Respondents/PACE Service Area



# RFI Findings

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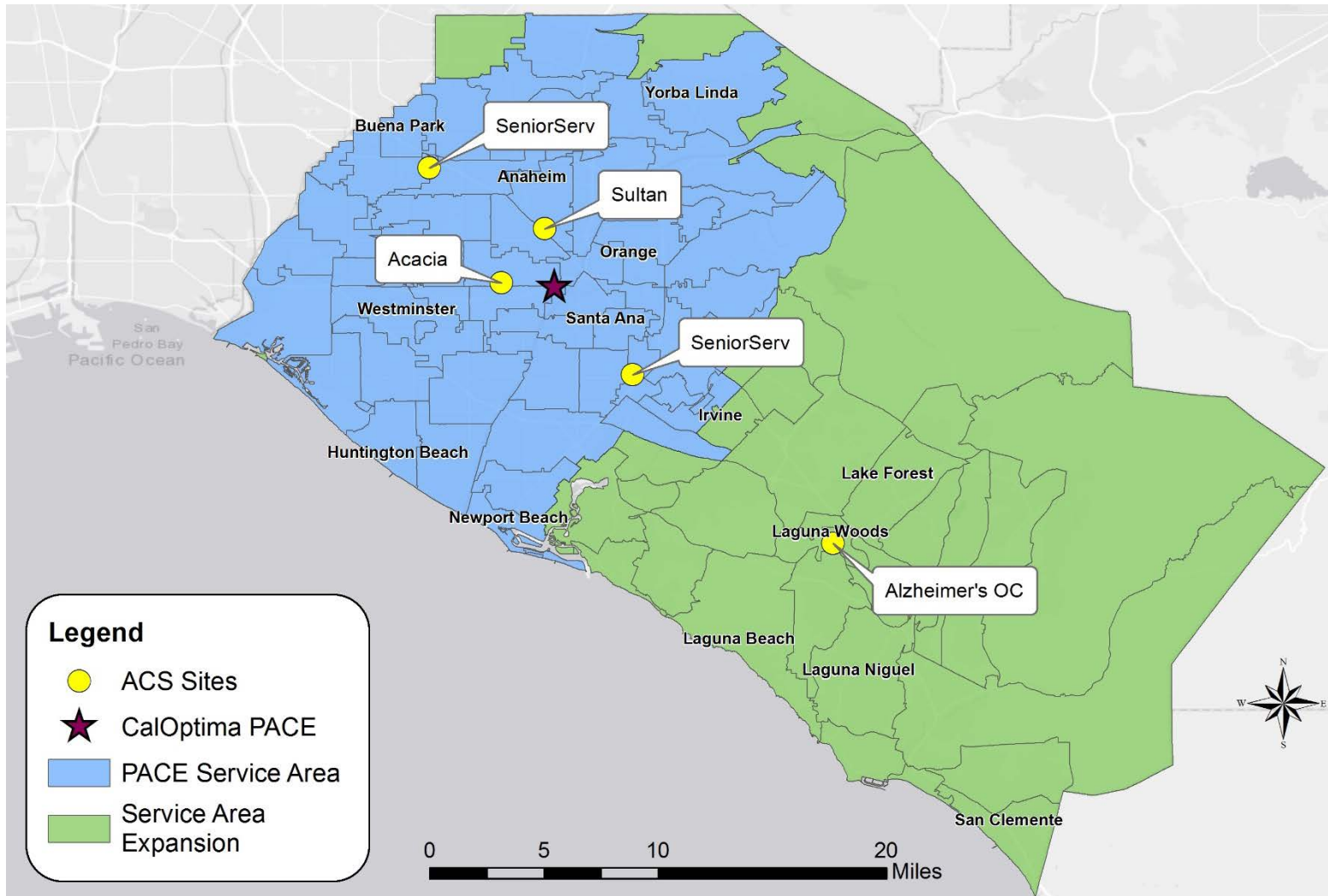
- Interest level provided a solid basis from which to move forward on a countywide RFP
- Respondents seemed to understand the ACS concept and have elements in place to participate
- Information from respondents helped the development of a program design, including operational, quality and capacity standards, for the RFP

# RFP Background

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- CalOptima issued an RFP for ACS sites in November 2017
  - RFP included detailed criteria
    - Operational
    - Security
    - Financial
    - Compliance
    - Analytics
  - RFP included a proposed contract amendment, which defined rates and requirements
- There were eight respondents
- Site visits were conducted with respondents meeting the initial criteria
- Five respondents were deemed qualified

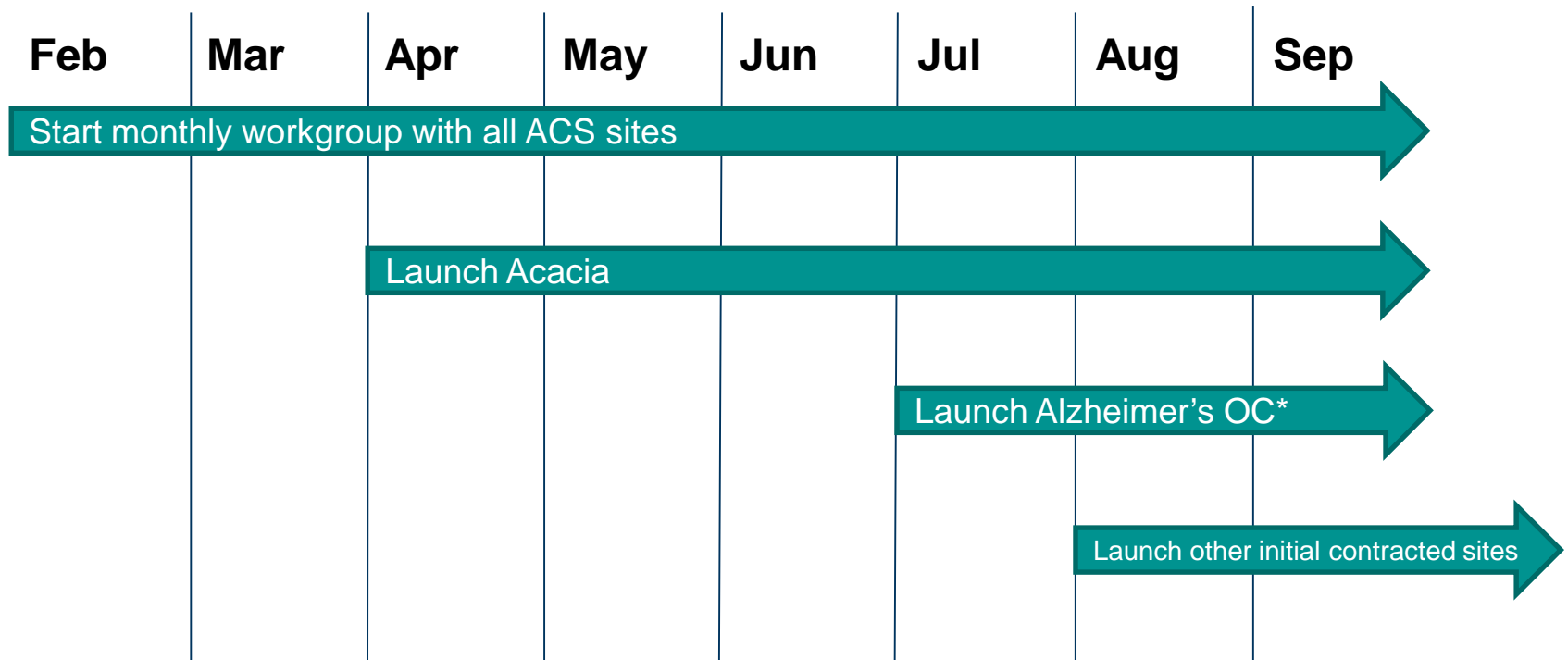
# Proposed ACS Sites





# Phased Implementation

- Phased implementation supports use of best practices
- Monthly workgroup fosters collaboration from the start



\* Pending CMS approval of service area expansion

# Additional ACS Sites

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- Program design allows for additional ACS sites to be added based on an application process that:
  - Assesses operational and quality standards
  - Considers potential PACE participant needs
  - Supports efficient use of time and resources
  - Accommodates future growth

# Staff Recommendation

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- Authorize the Chief Executive Officer, with the assistance of legal counsel, to:
  - Enter into contracts with CBAS centers to serve as ACS sites for CalOptima PACE members, and;
  - Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs.



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# **PACE Alternative Care Settings**

**Board of Directors Meeting**  
**March 7, 2019**

**Elizabeth Lee, MPA**  
**Director, PACE Program**

# Discussion Topics

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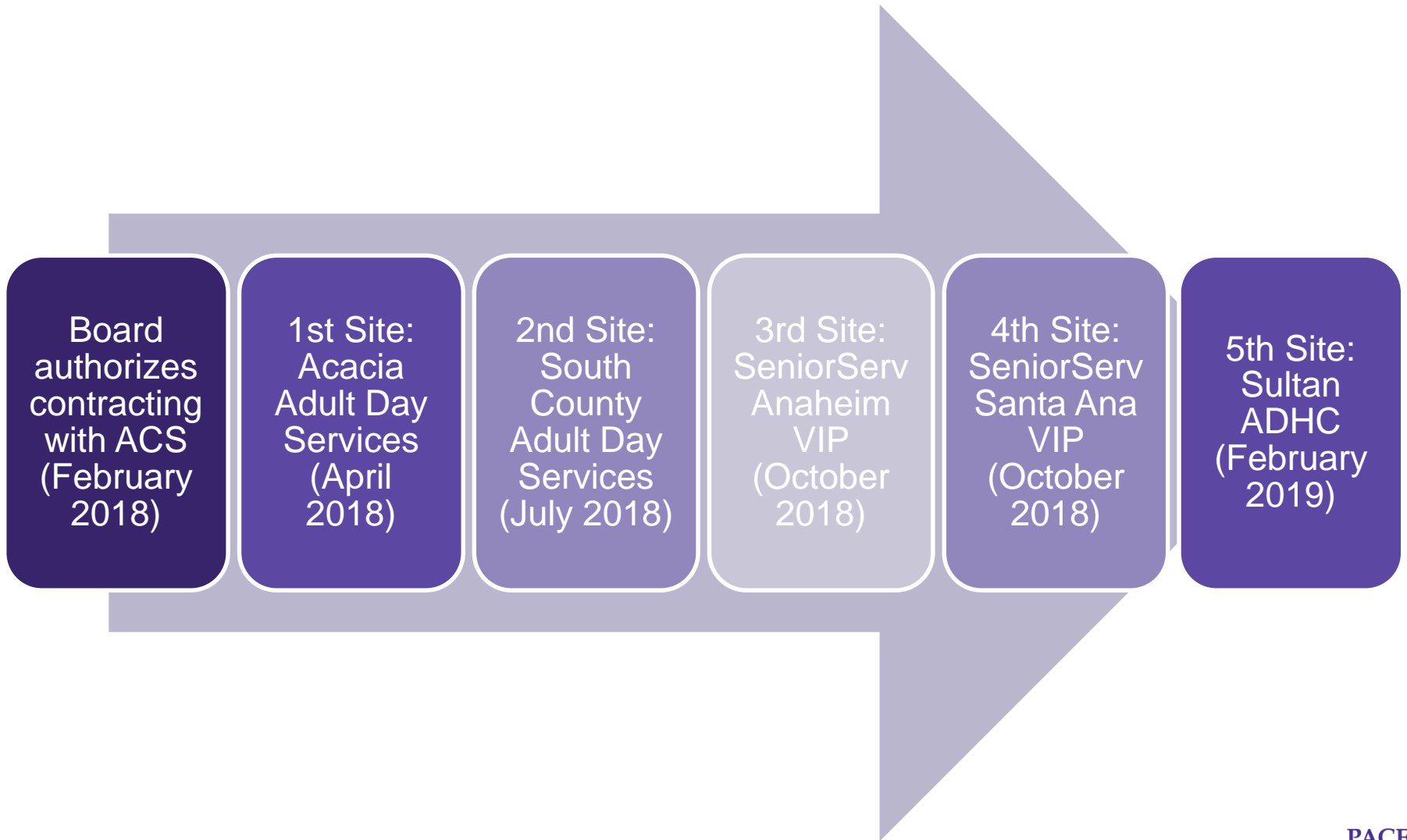
- CalOptima PACE's role in the community
- Access to PACE
- Board-requested performance metrics on Alternative Care Setting (ACS) implementation
- Proposed next steps

# PACE's Role in the Community

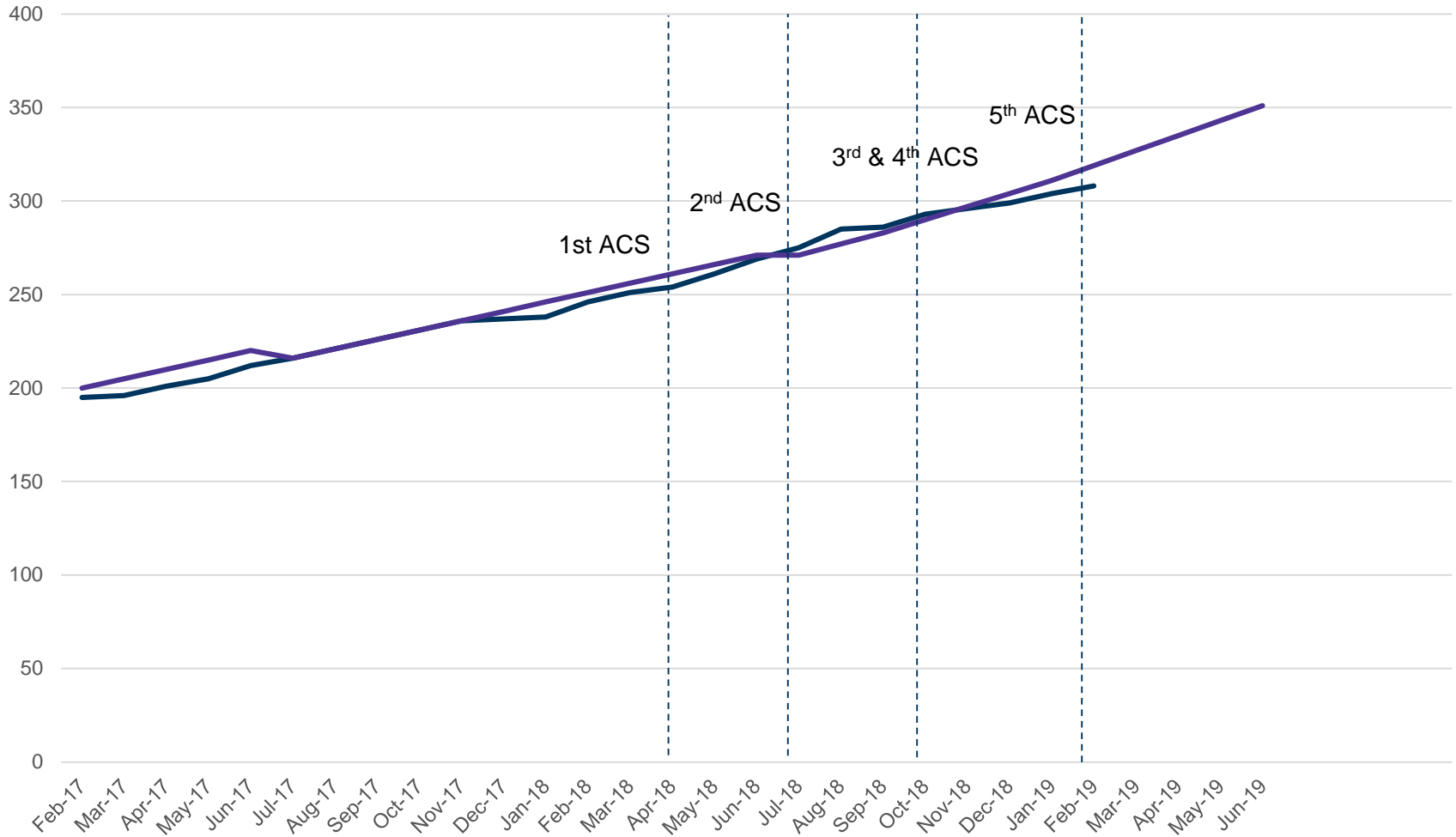
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- After five years, CalOptima PACE still holds steady to its original goal for seniors
  - Team-based services and support, with dignity and respect, that improve health and quality of life
  - Comprehensive health care services that promote independence
- PACE reflects the way health care should be delivered
  - Medical necessity: With creativity for improved health outcomes
  - Choices: A modern PACE center with options for care at home or in community centers that reflect cultural and geographic preferences
  - People: Compassionate, qualified and competent staff who to provide care for elderly with complex conditions

# PACE ACS Timeline



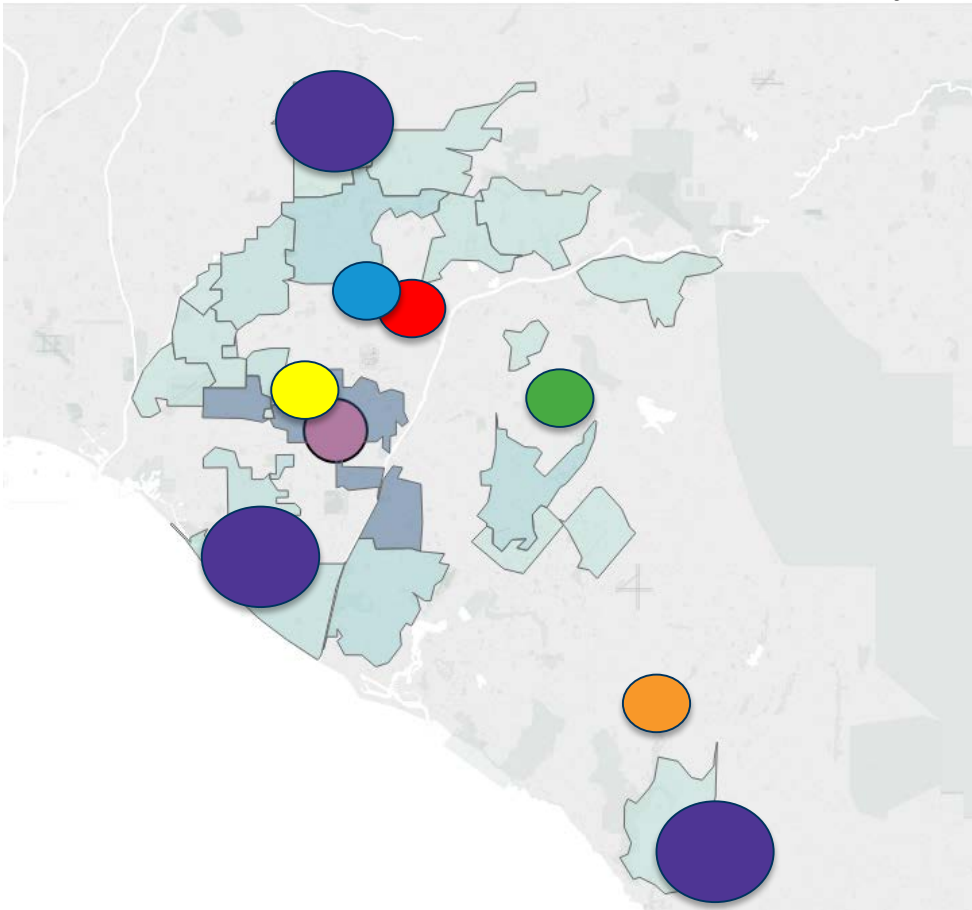
# Enrollment Trends With ACS





# PACE Delivery System

1 PACE Center + 5 Alternative Care Settings + Medical Services at the PACE Center, in the community and visits to members' homes



Need exists for increased access to specific areas of Orange County:

- North – Fullerton / La Habra area
- Coastal – Huntington Beach/Westminster
- South – San Clemente

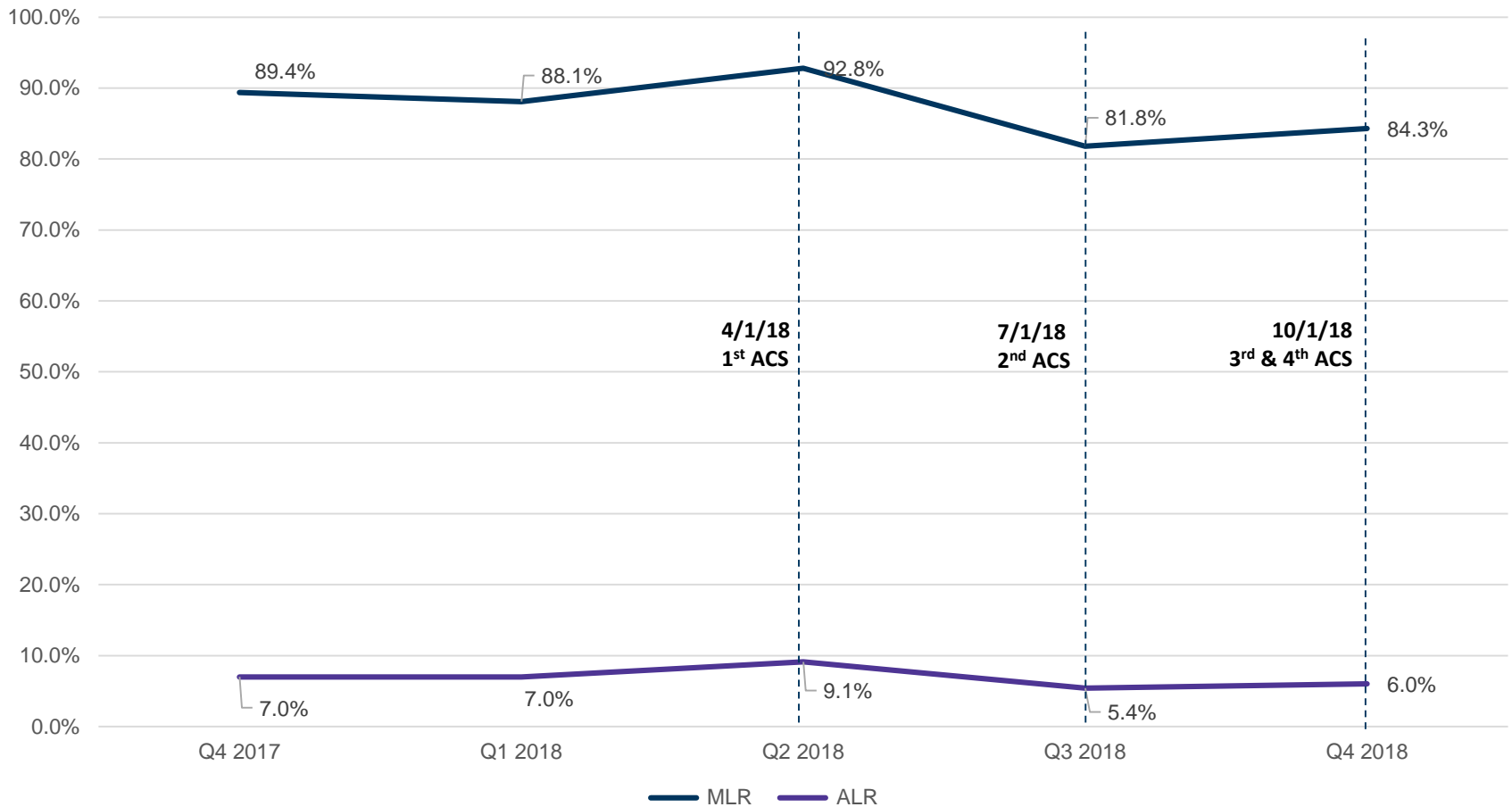
# Performance Metrics

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- Maintaining CY 2018 Quality Indicators while implementing Alternative Care Settings:
  - Only two participants were in LTC in 2018
  - Completed a successful DHCS/CMS Audit and two successful DHCS Level of Care Audits
  - 98% Influenza immunization rate
  - Infection Rates lower than national benchmarks
  - 95% medication reconciliation rate following a hospital discharge
  - 100% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
  - One ride over 60 minutes in duration out of 45,000+ trips
  - >92% transportation on-time performance

# Performance Metrics

Financial Performance: MLR / ALR



# Proposed Next Steps

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- Request authorization to add contracts with CBAS centers located in northern, southern and coastal areas of Orange County to serve as ACS sites for CalOptima PACE members based on established operational and quality standards and potential PACE participant needs.

**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
Anaheim VIP Adult Day Health Center	1158 N Knollwood Circle	Anaheim	CA	92801
New Life Adult Day Health Care Center	716 S Beach Blvd	Anaheim	CA	92804
Sultan Adult Day Health Care Center	125 W Cerritos Ave	Anaheim	CA	92805
Commonwealth Adult Day Health Care Center	7811 Commonwealth Ave.	Buena Park	CA	90621
St. Christopher Adult Day Health Care Center	4180 Green River Rd	Corona	CA	92880
Meridian Health Care Corp	4470 Lincoln Ave., Suite 1,2,3	Cypress	CA	90630
Sarang Adult Day Health Care Center	5171 Lincoln Ave	Cypress	CA	90630
Home Avenue Adult Day Health Care	8114 Telegraph Rd	Downey	CA	90240
Rehabilitation Institute of So Calif Fullerton	130 Laguna Rd	Fullerton	CA	92835
Acacia Adult Day Services	11391 Acacia Pkwy	Garden Grove	CA	92840
Evergreen World	9856 Westminster Ave	Garden Grove	CA	92844
Helping Hands for Better Living	10281 Chapman Ave	Garden Grove	CA	92840
Regent West Adult Day Health Care Center	8341 Garden Grove Blvd	Garden Grove	CA	92844
Alzheimer’s Family Services Center	9451 Indianapolis Ave	Huntington Beach	CA	92646
Irvine Adult Day Health Service Center	20 Lake Rd	Irvine	CA	92604
Happy (Brea) Adult Day Health Care	401 W Whittier Blvd., Suite 201	La Habra	CA	90631
La Puente Adult Day Health Care Center	17331 E Valley Blvd	La Puente	CA	91744
El Toro Adult Day Services	24300 El Toro Rd., Bldg A	Laguna Woods	CA	92637
SoCal Senior Services LLC	24260 El Toro Rd	Laguna Woods	CA	92637
Joy Adult Day Health Care	12110 Firestone Blvd	Norwalk	CA	90650
Life Sharing Health Care	13000 San Antonio Dr	Norwalk	CA	90650
Rehabilitation Institute of Southern California	1800 E La Veta Ave	Orange	CA	92866
Hzor Medical Services ADHCC	740 E Washington Blvd	Pasadena	CA	91104

*Attachment to March 7, 2019 Board of Directors Meeting – Agenda Item 12*

Well and Fit Adult Day Health Care	105 Mercury Cir	Pomona	CA	91768
Emerald Health Services Inc	17520 Castleton St., Suite 103	Rowland Heights	CA	91748
Joyful Adult Day Health Care Center	18951 Colima Rd	Rowland Heights	CA	91748
Rehabilitation Institute of So CA Rio San Clemente	2021 Calle Frontera	San Clemente	CA	92673
ABC Santa Ana Day Health Center	206 W 15 <sup>th</sup> Street	Santa Ana	CA	92701
Santa Ana/Tustin VIP Adult Day Health Care	1101 S Grand Ave., Suite K	Santa Ana	CA	92705
Get Together Adult Day Health Care	16636 S Crenshaw Blvd	Torrance	CA	90504
Spring Adult Day Health Care Center	19648 Camino De Rosa	Walnut	CA	91789
ABC Westminster Day Health Center	202 Hospital Circle	Westminster	CA	92683
Whittier Adult Day Health Care Center	14268 Telegraph Rd	Whittier	CA	90604

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

9. Consider Authorizing an Amendment to the Contract with Program of All-Inclusive Care for the Elderly (PACE) Transportation Provider Secure Transportation to Extend the Contract.

#### **Contact**

David Ramirez, M.D., Chief Medical Officer (714) 246-8400

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

#### **Recommended Action(s)**

Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current agreement for PACE transportation services with Secure Transportation for two years, effective June 1, 2020 through May 31, 2022.

#### **Background**

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima currently serves approximately 400 members via the CalOptima PACE center and four operating alternative care settings.

Transportation to and from the PACE center, alternative care settings, and medically necessary appointments in the community is an integral benefit of the PACE program. In 2019, more than 60,000 one-way trips were completed by Secure Transportation for CalOptima PACE participants.

Secure Transportation was selected as the initial PACE transportation vendor for CalOptima PACE in a 2012 RFP process, and renewed for two 1-year contract extensions. In 2017, a new RFP was released, with Secure Transportation being selected as the primary vendor for PACE transportation services. Secure Transportation has a 40-year history serving frail and elderly with non-emergency medical transportation. To serve the participants of CalOptima PACE, Secure Transportation operates a fleet of 17 Ford Transit Extended Vans, supplemented by subcontracted wheelchair-lift vans and sedans.

#### **Discussion**

A full replacement of PACE transportation services would take over a year to complete, including a Request for Proposals (RFP) process. It would require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

Secure Transportation currently serves nine PACE programs nationwide. Few competitors with the specialized services and experience exist in contracted solutions for PACE transportation services. In 2019, Secure Transportation had an average on-time performance record of 94% and 100% of trips were under the 60-minute threshold. Notably, transportation had a 96% participant satisfaction rating in 2019.

CalOptima’s Audit & Oversight (A&O) Department conducts an annual audit on Secure Transportation. The purpose of the annual audit is to monitor and assure that the scope of work is being performed satisfactorily. Secure Transportation is evaluated based upon applicable laws, regulations, contract terms, and CalOptima policies. The audit is comprised of two components, offsite and desk review. From the 2019 annual audit, Secure Transportation performed satisfactorily and received an overall compliance score of 100%.

Staff have been satisfied with Secure Transportation’s performance to date, and audit results are favorable. Based on these factors, staff recommend that the Board authorize an extension of the current contract with Secure Transportation for two years, through May 31, 2022.

Staff recommends revising elements of the scope of work for clarity purposes, to support census growth and increased availability of transportation vehicles. It is unlikely that a different vendor would be able to compete, or be selected, for the work of this contract given these intended revisions.

Proposed Revised Language to Secure Transportation Ancillary Contract dated June 1, 2017:

<b>Contract Revision</b>	<b>Business Justification</b>
Attachment A, Article 2, pg. 28 Ability to provide transportation services between the hours of 7:00 AM and 7:00 PM every weekday, and, have personnel and vehicles available for <b>weekend and after-hours service</b> for participants (i.e., late hospital discharges, <b>dialysis, PACE center weekend operating hours</b> ).	The PACE program requires the flexibility to provide services to PACE participants seven days per week to optimize care outcomes.
Attachment C, Section III, pg. 34: Subcontractor Fees – <b>No more than 30% of payments made to Secure Transportation may be for subcontracted partner services</b>	Utilizing a percentage allows contractor to scale services to census growth. Secure Transportation remains primary transportation provider, with subcontracted partners available for outpatient specialty, same-day and long-range trips.

**Fiscal Impact**

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, included forecasted PACE transportation service expenses that were consistent with current rates and utilization levels. The recommended action to extend the current agreement with Secure Transportation from June 1, 2020, through May 31, 2022, under the same terms and conditions, other than the recommended revisions above, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima FY 2020-21 or future operating budgets or through separate Board actions to amend the contract.



**Rationale for Recommendation**

The proposed approach allows CalOptima to continue the current PACE transportation services for two additional years while revising contract language to include clarifying statements to support census growth and increased availability of transportation vehicles.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated September 3, 2015; Authorize Amendments of Existing Meals and Transportation Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE) to Add Extension Options
3. Board Action dated October 6, 2016; Consider Authorizing Extension of Existing Transportation Contract for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

**ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
Secure Transportation Company Inc.	3780 Kilroy Airport Way	Long Beach	CA	90806

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

#### Consent Calendar

VII. B. Authorize Amendments of Existing Meals and Transportation Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE) to Add Extension Options

#### Contact

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

#### Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to ~~amend~~ extend existing meals and transportation contracts with vendors ~~to include and exercise three~~ for one (1) year, extension options each exercisable at CalOptima's sole discretion and during this one year period, staff to complete a Request for Proposal (RFP) process in accordance with CalOptima's Board-approved Purchasing Policy.

Rev.  
9/3/15

#### Background/Discussion

PACE is a managed care service delivery model for the frail elderly and integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants.

The PACE center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide necessary services to ensure the proper continuum of care. Vendors providing meals and transportation services are:

- Secure Transportation – Transportation to and from the PACE center and to medical appointments
- Community SeniorServ – Meals at the PACE center
- LifeSpring Nutrition – Home-delivered meals

On November 3, 2011, the Board of Directors authorized the CEO to enter into new vendor contracts for the PACE center. The new transportation and meals contracted vendors were selected through RFP processes. The transportation and meals contracts were executed in November 2012 for a 3-year term and expire in November 2015. Management is satisfied with the performance of these three vendors as they continue to provide services to the PACE center.

#### Fiscal Impact

Based on forecasted PACE enrollment, the fiscal impact for FY 2015-16 to extend the existing meals and transportation contracts is approximately \$1.2 million or \$795 per member per month. The recommended actions are budgeted items under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

**Rationale for Recommendation**

CalOptima staff recommends that the Board authorize three-year extensions through November 2018, to existing contracts with meals and transportation vendors to ensure that PACE members continue to have access to these covered services.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

8/28/2015  
**Date**

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken October 6, 2016**  
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

14. Consider Authorizing Extension of Existing Transportation Contract for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

**Contact**

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400

**Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the existing CalOptima Program of All-Inclusive Care for the Elderly (PACE) transportation contract with vendor Secure Transportation for six months, with an option for the CEO to extend the contract for an additional six months.

**Background/Discussion**

PACE is a managed care service delivery model for the frail elderly and integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants.

The CalOptima PACE center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide necessary services to ensure the proper continuum of care. The current vendor Secure Transportation, provides transportation for program participants from their homes to and from the PACE center and to medical appointments.

On November 3, 2011, the Board of Directors authorized the CEO to enter into vendor contracts for the PACE center. The current transportation contracted vendor was selected through a Request for Proposal (RFP) process. The transportation contract was executed in November 2012 for a 3-year term and expired in November 2015. Management was satisfied with this vendor's performance at that time, and based on the Board's authorization of a one year extension at its September 3, 2015 meeting, the contract was extended through November 2016. At its September 3, 2015 meeting, the Board also directed staff to complete a RFP process in accordance with CalOptima's Board-approved Purchasing Policy.

Since this time, issues with Secure Transportation's performance have surfaced despite PACE Management's efforts to improve the quality of the transportation services the vendor is providing. Per the Board's direction, a RFP was issued; however, the only bidder was Secure Transportation.

Based on this limited response, staff would like to withdraw the current RFP for PACE transportation without awarding the contract, and issue a Request for Information (RFI) to assist management in identifying other potential transportation vendors and options for meeting the transportation needs of PACE participants. As this process continues, management proposes to continue to contract with Secure Transportation to provide this service. Following the RFI, another RFP will be issued to select

vendor(s) for transportation services at PACE, and staff will return to the Board with further recommendations.

**Fiscal Impact**

The CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016, included forecasted PACE transportation service expenses that were consistent with current rates and utilization levels. Staff included approximately \$1 million annually or \$435.29 per member per month in the budget for PACE transportation services.

Assuming continuance of the terms of the current contract and no overlap between the current and future vendor, the recommended action to execute a contract amendment to extend the terms of the contract for PACE transportation services from November 2016 through May 2017 is a budgeted item with no additional anticipated fiscal impact.

**Rationale for Recommendation**

CalOptima staff recommends that the Board authorize a six month extension through May 2017, with an option to extend for an additional six months if no other vendors have been identified, to existing contract with Secure Transportation to ensure that PACE members continue to have access to these covered services.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

Board Action dated September 3, 2015, Authorize Amendments of Existing Meals and Transportation Contracts for CalOptima Program of All Inclusive Care for the Elderly (PACE) to Add Extension Options

/s/ Michael Schrader  
**Authorized Signature**

09/29/2016  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

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

#### **Consent Calendar**

VII. B. Authorize the Extension of Existing Meals and Transportation Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

#### **Contact**

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

#### **Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend existing meals and transportation contracts with vendors for additional three (3)-year terms, through November 30, 2018.

#### **Background/Discussion**

PACE is a managed care service delivery model for the frail elderly and integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants.

The PACE center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide necessary services to ensure the proper continuum of care. Vendors providing meals and transportation services are:

- Secure Transportation – Transportation to and from the PACE center and to medical appointments
- Community SeniorServ – Meals at the PACE center
- LifeSpring Nutrition – Home-delivered meals

On November 3, 2011, the Board of Directors authorized the CEO to enter into new vendor contracts for the PACE center. The new transportation and meals contracted vendors were selected through RFP processes. The transportation and meals contracts were executed in November 2012 for a 3-year term and expire in November 2015. Management is satisfied with the performance of these three vendors as they continue to provide services to the PACE center.

#### **Fiscal Impact**

Based on forecasted PACE enrollment, the fiscal impact for FY 2015-16 to extend the existing meals and transportation contracts is approximately \$1.2 million or \$795 per member per month. The recommended actions are budgeted items under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

#### **Rationale for Recommendation**

CalOptima staff recommends that the Board authorize three-year extensions through November 2018, to existing contracts with meals and transportation vendors to ensure that PACE members continue to have access to these covered services.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader

**Authorized Signature**

8/28/2015

**Date**



## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

10. Consider Actions Related to the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospital Contracts

#### **Contact**

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

Nancy Huang, Chief Financial Officer (714) 246 8400

#### **Recommended Action(s)**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Hospital Contracts through June 30, 2021, under the same terms and conditions.

#### **Background/Discussion**

CalOptima currently contracts with several hospitals to provide services to Medi-Cal, OneCare, OneCare Connect and PACE members. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS Hospital contracts, through June 30, 2021.

The renewal of these contracts with existing hospitals will support the stability of CalOptima's contracted FFS hospital network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS hospital contracts through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

#### **Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the hospital network and to fulfill regulatory requirements.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the Medi-Cal,  
OneCare, OneCare Connect and PACE  
Fee-For Service Hospital Contracts  
Page 2

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

## Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

### Report Item

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

### Contact

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

### Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts under the same terms and conditions through June 30, 2021 except those associated with Children's Hospital of Orange County, the University of California, Irvine or St. Joseph Health and its Affiliates

### Background/Discussion

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on an FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts, except those associated with Children's Hospital of Orange County, the University of California, Irvine, and St. Joseph Health and its Affiliates, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

### Fiscal Impact

The recommended action to extend CalOptima FFS specialist physician contracts, except those associated with Children's Hospital of Orange County, the University of California, Irvine or St. Joseph Healthcare and its affiliates, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Community  
Network, Medi-Cal, OneCare, OneCare Connect, and  
PACE Fee-For-Service Specialist Physician Contracts  
Except Those Associated with Children’s Hospital of  
Orange County, the University of California, Irvine and  
St. Joseph Health and its Affiliates  
Page 2

will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

12. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with the University of California, Irvine

#### **Contact**

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

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

#### **Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with the University of California, Irvine, under the same terms and conditions through June 30, 2021.

#### **Background/Discussion**

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on an FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with the University of California, Irvine, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS specialist physician contracts associated with the University of California, Irvine through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima  
Community Network, Medi-Cal, OneCare,  
OneCare Connect, and PACE Fee-For-Service  
Specialist Physician Contracts associated with  
the University of California, Irvine  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

3/26/2020  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

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

#### **Contact**

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

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

#### **Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with St. Joseph Health and its Affiliates, under the same terms and conditions through June 30, 2021.

#### **Background/Discussion**

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on an FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with St. Joseph Health and its Affiliates, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS specialist physician contracts associated with St. Joseph Healthcare and its affiliates, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Community  
Network, Medi-Cal, OneCare, OneCare Connect, and  
PACE Fee-For-Service Specialist Physician Contracts  
Associated with St. Joseph Health and its Affiliates  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**



## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020**

### **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

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

#### **Contact**

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

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

#### **Recommended Action**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with Children's Hospital of Orange County (CHOC) under the same terms and conditions through June 30, 2021

#### **Background/Discussion**

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS specialist physician contracts associated with Children's Hospital of Orange County through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Community  
Network, Medi-Cal, OneCare, OneCare Connect, and  
PACE Fee-For-Service Specialist Physician Contracts  
Associated with Children’s Hospital of Orange County  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
CHOC Children’s Specialist-CS Allergy	1201 W. La Veta Ave..	Orange	CA	92868
CHOC Children’s Specialist-CS Cardiology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Critical Care	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Develop-Behavioral	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Endocrinology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Hematology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Hospitalists	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Infectious Diseases	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Nephrology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Neurology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Oncology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Otolaryngology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Rheumatology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-CS Surgery	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialist-Psychology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialists-CS Gastroenterology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialists-CS Metabolic Disorders	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialists-CS Neonatology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialists-CS Ophthalmology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC Children’s Specialists-CS Pulmonology	1201 W. La Veta Ave.	Orange	CA	92868
CHOC CS Genetics	1201 W. La Veta Ave.	Orange	CA	92868

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

15. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated with the University of California, Irvine, or St. Joseph Healthcare and its Affiliates

#### **Contact**

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts under the same terms and conditions through June 30, 2021, except those associated with the University of California, Irvine, or St. Joseph Healthcare and its affiliates

#### **Background/Discussion**

CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS clinic contracts, except those associated with the University of California, Irvine, or St. Joseph Healthcare and its affiliates, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima clinic contracts, except those associated with the University of California, Irvine or St. Joseph Healthcare and its affiliates, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Authorizing Extensions and Amendments  
of the CalOptima Medi-Cal, OneCare, OneCare  
Connect and PACE Clinic Contracts, Except Those  
Associated with the University of California, Irvine,  
or St. Joseph Healthcare and its Affiliates  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

16. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with the University of California, Irvine

#### **Contact**

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts associated with the University of California, Irvine, under the same terms and conditions through June 30, 2021.

#### **Background/Discussion**

CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS clinic contracts associated with the University of California, Irvine, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima clinic contracts associated with the University of California, Irvine, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Medi-Cal, OneCare,  
OneCare Connect and PACE Clinic Contracts Associated with the  
University of California, Irvine  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Entities Covered by this Recommended Board Action

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
UCI Family Health Center - Anaheim	300 W. Carl Karcher Way	Anaheim	CA	92801
UCI Family Health Center - Santa Ana	800 N. Main St.	Santa Ana	CA	92701



## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

17. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with St. Joseph Healthcare and its Affiliates

#### **Contact**

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

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts associated with St. Joseph Healthcare and its Affiliates, under the same terms and conditions through June 30, 2021.

#### **Background/Discussion**

CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS clinic contracts associated with St. Joseph Healthcare and its affiliates, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima clinic contracts associated with St. Joseph Healthcare and its affiliates, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

#### **Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Medi-Cal,  
OneCare, OneCare Connect and PACE Clinic Contracts  
Associated with St. Joseph Healthcare and its Affiliates  
Page 2

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
La Amistad De Jose Family Health Center	725 W. La Veta Ave. Ste. 260	Orange	CA	92868
St Jude Neighborhood Health Centers	731 S. Highland Ave.	Fullerton	CA	92832

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

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

#### **Contact**

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

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts under the same terms and conditions through June 30, 2021, except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates.

#### **Background/Discussion**

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS Primary Care physician contracts, except those associated with the University of California, Irvine, and St. Joseph Health and its Affiliates, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS PCP contracts, except those associated with the University of California, Irvine or St. Joseph Healthcare and its affiliates, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Authorizing Extensions and Amendments of the CalOptima  
Community Network, Medi-Cal, OneCare, OneCare Connect and PACE  
Fee-for-Service Primary Care Physician Contracts, Except Those  
Associated with the University of California, Irvine or St. Joseph  
Healthcare and its Affiliates  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

19. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with St. Joseph Healthcare and its Affiliates

#### **Contact**

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts associated with St. Joseph Healthcare and its Affiliates under the same terms and conditions through June 30, 2021.

#### **Background/Discussion**

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS Primary Care physician contracts associated with St. Joseph Health and its Affiliates, through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS PCP contracts associated with St. Joseph Healthcare and its affiliates, through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Community  
Network, Medi-Cal, OneCare, OneCare Connect and  
PACE Fee-for-Service Primary Care Physician Contracts  
Associated with St. Joseph Healthcare and its Affiliates  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

20. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with the University of California, Irvine

#### **Contact**

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

#### **Recommended Actions**

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts associated with the University of California, Irvine, under the same terms and conditions through June 30, 2021

#### **Background/Discussion**

CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS Primary Care physician contracts, associated with the University of California, Irvine through June 30, 2021.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

#### **Fiscal Impact**

The recommended action to extend CalOptima FFS PCP contracts associated with the University of California, Irvine through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.



CalOptima Board Action Agenda Referral  
Consider Actions Related to the CalOptima Community  
Network, Medi-Cal, OneCare, OneCare Connect and PACE  
Fee-for-Service Primary Care Physician Contracts Associated  
with the University of California, Irvine  
Page 2

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

## Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

### Report Item

21. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts and Contracts with MedImpact Healthcare Systems, Inc. and Vision Service Plan

### Contact

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

### Recommended Action(s)

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services contracts and contracts with ~~MedImpact Healthcare Systems, Inc. (MedImpact)~~ and Vision Service Plan (VSP), through June 30, 2021 under the same terms and conditions

Amended  
4/2/2020

### Background/Discussion

CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service (FFS) basis to CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval. CalOptima also contracts on a capitated administrative fee basis (with the administrator passing the medical costs through to CalOptima on a FFS basis) with MedImpact for Pharmacy Benefit Management (PBM) services, and with VSP for vision-related services.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE Ancillary contracts, and contracts with MedImpact and VSP, through June 30, 2021.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted ancillary provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

### Fiscal Impact

The recommended action to extend CalOptima ancillary contracts through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

**Rationale for Recommendation**

CalOptima staff recommends this action to maintain and continue the contractual relationship with the ancillary provider network and to fulfill regulatory requirements.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Board Action Dated February 6, 2020; Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services
2. 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  
**Authorized Signature**

03/26/2020  
**Date**

**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,

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  
**Authorized Signature**

7/24/19  
**Date**

CalOptima Board Action Agenda Referral  
Consider Authorizing an Amendment to the Contract with  
Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc.  
to Extend the Contract  
Page 3

**CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

## 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:

<b>Criteria</b>	<b>Possible Score</b>
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.

### **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:

<b>Vendor</b>	<b>Score</b>
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension



options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

**Fiscal Impact**

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

**Rationale for Recommendation**

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/1/2015  
**Date**

## **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.

**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**

**CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

**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:

<b>Criteria</b>	<b>Possible Score</b>
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.

### **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:

<b>Vendor</b>	<b>Score</b>
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

**Fiscal Impact**

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

**Rationale for Recommendation**

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/1/2015  
**Date**

## **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



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.

**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  
**Authorized Signature**

01/28/2020  
**Date**

*Attachment to February 6, 2020 Board of Directors Meeting – Agenda Item 10*

**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131

## 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:

<b>Criteria</b>	<b>Possible Score</b>
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.

### **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:

<b>Vendor</b>	<b>Score</b>
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

**Fiscal Impact**

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

**Rationale for Recommendation**

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/1/2015  
**Date**

## **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.

**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**



**CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

**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:

<b>Criteria</b>	<b>Possible Score</b>
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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.

### **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:

<b>Vendor</b>	<b>Score</b>
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Catamaran	1,069
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Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

**Fiscal Impact**

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

**Rationale for Recommendation**

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/1/2015  
**Date**

## **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

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  
**Authorized Signature**

1/30/2019  
**Date**

**CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems, Inc.	10181 Scripts Gateway Court	San Diego	CA	92131



## **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,

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  
**Authorized Signature**

7/24/19  
**Date**

CalOptima Board Action Agenda Referral  
Consider Authorizing an Amendment to the Contract with  
Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc.  
to Extend the Contract  
Page 3

**CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

## 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:

<b>Criteria</b>	<b>Possible Score</b>
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.

### **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:

<b>Vendor</b>	<b>Score</b>
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

**Fiscal Impact**

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

**Rationale for Recommendation**

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/1/2015  
**Date**

## **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.

**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**



**CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION**

<b>Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

**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:

<b>Criteria</b>	<b>Possible Score</b>
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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.

### **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:

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Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

**Fiscal Impact**

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

**Rationale for Recommendation**

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

5/1/2015  
**Date**

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

#### Report Item

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

#### Contact

Brigette Gibb, Executive Director, Human Resources, (714) 246-8400

#### Recommended Action

Adopt Resolution approving updates to CalOptima Human Resources Policy GA.8042: Supplemental Compensation.

#### Background/Discussion

On November 1, 1994, the Board of Directors delegated authority to the 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 of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

At the Special Board of Directors Meeting on March 12, 2020, the Board requested that suggested changes to the Supplemental Compensation Policy be presented to the Board of Directors for consideration. The following table lists the existing Human Resources policy that has been updated and is being presented for review and approval.

	<b>Policy No./Name</b>	<b>Summary of Changes</b>	<b>Reason for Change</b>
1.	GA.8042 Supplemental Compensation (Page 7, Section III.I)	<ul style="list-style-type: none"><li>Increasing the number of retention bonuses from twelve (12) to twenty-five (25) and the maximum amount for which the CEO is authorized to offer from ten percent (10%) to twenty percent (20%).</li><li>Changing the applicable period from calendar year to fiscal year</li></ul>	<ul style="list-style-type: none"><li>Over the years, the number of CalOptima employees has more than doubled since 2014, but the number of retention bonuses has remained the same. Increasing the number and amount of retention incentives allows CalOptima to more effectively prevent or delay critical employee departures that may adversely impact business operations</li></ul>

**Fiscal Impact**

The recommended action to update Human Resources Policy GA.8042: Supplemental Compensation to increase the number and amount of retention incentives is budget neutral. The estimated total annual increase could be as much as approximately \$554,000. Management anticipates that unspent budgeted funds for salaries and benefits in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget will be sufficient to fund the additional retention incentives offered before 07/01/2020. Management will include updated administrative expenses in the CalOptima’s future Operating Budget.

**Rationale for Recommendation**

Approval is recommended to the updated Human Resources Policy to allow Human Resources to meet its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations. This policy serves as a framework for CalOptima’s operations.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Resolution No. 20-0402-01 Approve Updated CalOptima Human Resources Policy
2. Revised CalOptima Policy:
  - a. GA.8042 Supplemental Compensation with Attachments (redlined and clean copies)  
– with attachments

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

**RESOLUTION NO. 20-0402-01**

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

**APPROVE UPDATED HUMAN RESOURCES POLICY**

**WHEREAS**, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

**WHEREAS**, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

**WHEREAS**, California Code of Regulations, Title 2, Section 571, requires that all items of special compensation be contained in a written labor policy and duly approved and adopted by the governing body in accordance with requirements of applicable public meeting laws.

**NOW, THEREFORE, BE IT RESOLVED:**

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy GA.8042: Supplemental Compensation.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2<sup>nd</sup> day of April 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 Dwiars, Clerk of the Board

Policy #: GA.8042  
 Title: **Supplemental Compensation**  
 Department: Human Resources  
 Section: Not Applicable

CEO Approval: **Michael Schrader**

Effective Date: 01/01/2011  
 Revised Date: ~~02/07/2019~~04/  
02/2020

*Board Approved Policy*

---

1 **I. PURPOSE**

2  
 3 This policy establishes general guidelines concerning the use of supplemental compensation above  
 4 regular base pay to compensate for business needs and to identify items to be reported to CalPERS as  
 5 “Special Compensation.”  
 6

7 **II. POLICY**

8  
 9 A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the  
 10 California Code of Regulations (CCR):

- 11 1. Bilingual Pay/Bilingual Premium;
- 12 2. Night Shift Premium/Shift Differential;
- 13 3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
- 14 4. Executive Incentive Program/Bonus Pay.

15  
 16 B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay  
 17 for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one  
 18 (1) workweek at the rate of 1.5 times the employee's regular rate of pay. Employees should obtain  
 19 prior authorization from their supervisors or managers prior to working overtime or incurring  
 20 overtime pay. Exempt employees are not covered by the overtime provisions and do not receive  
 21 overtime pay.  
 22

23 C. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-  
 24 exempt employees who are fluent in at least one (1) of CalOptima’s threshold languages. This is  
 25 considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to  
 26 CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:  
 27

Proficiency	Rate Per Pay Period
Bilingual language usage with members is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee’s job duties.	\$60.00
Bilingual language usage with members is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee’s job duties.	\$40.00



1 D. Translation Pay: In certain circumstances when, for business reasons and for the benefit of  
 2 CalOptima members, there is a need to translate documents and other written material into  
 3 languages other than English, the Exempt Employee providing such service will be paid  
 4 supplemental pay. Non-exempt employees are not eligible for translation pay.  
 5

- 6 1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services  
 7 Department (C&L) and who is not required as part of his or her regular job responsibilities to  
 8 translate but is qualified to translate based on successfully passing the CalOptima Bilingual  
 9 Screening Process, may be eligible for translation pay for performing translation work. Eligible  
 10 employees, who are interested in performing translation work during non-work hours, may elect  
 11 to provide translation services during his or her own personal time based on the rates indicated  
 12 below. The C&L Department shall assign the work to qualified Exempt Employees on an  
 13 occasional, as-needed basis.
- 14 2. There are two (2) key activities in providing translation services:
  - 15 a. Translation of materials from English into the desired language, or from another language  
 16 into English; and
  - 17 b. Review and revision of the translation to ensure quality and consistency in usage of terms.
- 18 3. Translating is more difficult and time-consuming than reviewing and editing of the already  
 19 translated materials, and as a result, translation of materials will be reimbursed at a higher rate.  
 20 CalOptima will reimburse for services at the following rates:
  - 21 a. Translation – Thirty-five dollars (\$35.00) per page; and
  - 22 b. Review and revision of translated materials – Twenty-five dollars (\$25.00) per page.
- 23 4. The use of this supplemental pay is limited to situations where the use of professional  
 24 translation services is either not available or unfeasible due to business constraints.  
 25

26 E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift.  
 27 Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima  
 28 management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is  
 29 to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the  
 30 following schedule:  
 31

32 <b>Definition</b>	33 <b>Eligibility</b>	34 <b>Rates (per hour)</b>
35 Night Shift – Seven (7) consecutive hours or 36 more of work between 3 p.m. and 8 a.m.	37 Non-exempt employees	38 \$2.00 per hour.

39 F. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call  
 40 Back and On Call requirement. Assignments for Call Back and On Call are subject to business  
 41 needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay  
 42 are based on the following schedule:  
 43  
 44

Definition	Eligibility	Rates (per hour)
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees	\$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by Employee’s supervisor. In no event shall Employee’s supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt Employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

- G. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars (\$100) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee’s job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.
- H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize executive staff, including interim appointments, using incentive compensation as described in this Policy. For executive staff who achieve superior performance, the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.
- I. Sales Incentive Program: The OneCare/OneCare Connect Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.
  - 1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars (\$165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per

enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty five dollars (\$165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five (\$175), which equals an incentive of three thousand eight hundred twenty five dollars (\$3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

Tier Min	Tier Max	Payout for Enrollment within Each Tier
1	30	\$0.00
31	50	\$165.00
51	65	\$175.00
66+		\$200.00

- 3 The sales incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the Member Outreach & Education Department. The Manager, Member Outreach & Education will receive ten dollars (\$10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the sales incentive for that Community Partner or Sr. Community Partner.

- J. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima’s business needs and mission, vision, and values.
- K. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.
- L. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.
- M. Incentive programs may be modified or withdrawn, at any time. Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between executive staff or employees and CalOptima.
- N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:
  - 1. Hired, promoted, or transferred into a management staff position, including interim appointments; and
  - 2. Included in one (1) of the following categories:

- a. A CalPERS Classic Member; or
- b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

- O. Annual Performance Lump Sum Bonus: Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this Policy, provided that their performance meets the goals and objectives set forth by their managers.
- P. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in executive staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars (\$500) for the use of their personal vehicle for CalOptima business.
- Q. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in executive staff positions, the contribution rate shall be uniform for all employees. Executive staff positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in executive staff positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. The executive staff member must still be employed by CalOptima at the time the additional supplemental contributions to PARS is distributed in order to be eligible to receive the additional supplemental contributions. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

### III. PROCEDURE

- A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.
- B. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.
- C. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.
- D. Night Shift:
  - 1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.

- 1 2. Employees who, at their own request and for their own convenience, adjust their work schedule,  
2 such as requesting make up time or alternative hours, and as a result, would be eligible for night  
3 shift pay, shall be deemed as having waived their right to same. When appropriate, a new  
4 Action Form should be submitted, removing the employee from the night shift.  
5

6 E. Call Back and On Call Pay:

- 7  
8 1. If an employee is on call or gets called back to work, the employee is responsible for adding this  
9 time to their schedule through CalOptima's time keeping system, which is then approved by  
10 their supervisor.  
11

12 F. Active Certified Case Manager (CCM) Pay:

- 13  
14 1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the  
15 employee's case management certification issued by the Case Management Society of America  
16 to the Human Resources Department.  
17

18 G. Incentive Compensation

- 19  
20 1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is  
21 expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the  
22 executive staff.  
23  
24 2. The CEO may establish an incentive compensation program for executive staff based on the  
25 Executive Incentive Program attached within budgeted parameters in accomplishing specific  
26 results according to the department and individual goals set forth by the CEO and the level of  
27 achievement. Executive staff will receive a performance evaluation based on the Performance  
28 Review of Executives Template attached, which measures their performance against the  
29 established goals. Based on the level of performance, the executive staff member may be  
30 eligible for a lump sum bonus payment. The executive staff member must still be employed by  
31 CalOptima and in good standing at the time the bonus is distributed in order to be eligible to  
32 receive the bonus payment. For eligible executive staff members who achieve superior  
33 performance, CalOptima will report the bonus payment to CalPERS as Special Compensation.  
34 The CEO is authorized to make minor revisions to the Executive Incentive Program and  
35 Performance Review of Executives Template from time to time, as appropriate.  
36  
37 3. As circumstances warrant and at the discretion of the CEO, employees not at the executive staff  
38 level, whose accomplishments have provided extraordinary results, may be considered for  
39 incentive compensation.  
40

41 H. Sales Incentive Program

- 42  
43 1. The OneCare/OneCare Connect Community Partner and Sr. Community Partner staff, in the  
44 Member Outreach & Education Department, shall have an active Resident Insurance Producer  
45 license to enroll eligible members into the OneCare and OneCare Connect Programs.  
46  
47 2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales  
48 incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new  
49 members into the OneCare and OneCare Connect Programs. Sales incentive pay for the  
50 Manager, Member Outreach & Education, shall be based on the number of members enrolled  
51 into the OneCare and OneCare Connect Programs by the Community Partner and Sr.  
52 Community Partner as described in Section II.I.2 of this Policy.  
53



- 1 a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back  
2 guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive  
3 with the exceptions as specified under the guidelines and applicable CalOptima policies.  
4
- 5 3. CalOptima shall pay the sales incentive to the eligible employee on a monthly basis  
6 approximately one and a half (1 ½) months after the month in which the eligible employee  
7 earned the sales incentive.  
8
- 9 a. In the event a OneCare or OneCare Connect member disenrolls from their respective  
10 program within ninety (90) calendar days for reasons other than the exceptions specified  
11 under the guidelines and applicable CalOptima policies, the sales incentive previously  
12 earned will be deducted from a future sales incentive.  
13
- 14 4. The Chief Operating Officer, Executive Director of Network Operations, and Director Network  
15 Management who oversee the Member Outreach & Education Department shall approve the  
16 sales incentive payout.  
17
- 18 5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated  
19 for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or  
20 a leave of absence.  
21
- 22 6. The Director, Network Management, Executive Director of Network Operations, and the Chief  
23 Operations Officer will review the sales incentive structure on an annual basis.  
24
- 25 I. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention  
26 incentive to prevent or delay departures that may adversely impact business operations. The  
27 employee offered a retention incentive must be in good standing and accept and sign a retention  
28 agreement which contains the condition(s) to be met in order to receive payment. Payment of the  
29 incentive will be made when the terms of the agreement have been fully met and at the conclusion  
30 of the retention period. The CEO has the authority to offer retention incentives for up to ~~twelve (12)~~  
31 twenty-five (25) employees per ~~calendar~~ fiscal year in an amount not to exceed ~~twenty ten~~  
32 (240%) of the employee's current base annual salary. Retention incentives that exceed ~~twenty ten~~  
33 (240%) of the employee's current base annual salary require Board of Directors approval.  
34
- 35 J. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based  
36 on the Compensation Administration Guidelines managed by the Human Resources Department to  
37 entice an individual to join CalOptima. Board of Directors approval is required for recruitment  
38 incentives offered for Executive Director and Chief positions. In order to receive the recruitment  
39 incentive, the individual offered the incentive is required to accept and sign an offer letter which  
40 contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full  
41 amount of the recruitment incentive if the recipient voluntarily terminates employment with  
42 CalOptima within twenty-four (24) months of the date of hire.  
43
- 44 K. Annual Performance Lump Sum Bonus: Once an employee has reached the pay range maximum,  
45 the employee may be eligible for merit bonus pay delivered as a lump sum bonus, provided that his  
46 or her annual performance evaluation meets the established goals and objectives set forth by their  
47 managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix  
48 and reflects the employee's superior performance measured against established objectives. Annual  
49 performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when  
50 merit salary increases are normally distributed and the second half six (6) months later. The  
51 employee must still be employed by CalOptima in order to be eligible to receive the lump sum  
52 bonus payments.  
53

1 L. Automobile Allowance: As circumstances warrant, the CEO may offer to employees in executive  
 2 staff positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that  
 3 would otherwise apply in the use of their personal vehicle in the performance of their duties. Such  
 4 automobile allowance will be identified on the executive staff's W-2 forms as taxable income. In  
 5 addition, as a condition of receiving such allowance, the executive staff member must comply with  
 6 the following requirements:

- 7 1. He or she must maintain adequate levels of personal vehicle insurance coverage;
- 8 2. He or she shall purchase his or her own fuel for the vehicle; and
- 9 3. He or she shall ensure that the vehicle is properly maintained.

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12  
13  
14 **IV. ATTACHMENT(S)**

- 15 A. Executive Incentive Program
- 16 B. Performance Review of Executives Template

17  
18  
19 **V. REFERENCE(S)**

- 20 A. CalOptima Employee Handbook
- 21 B. Compensation Administration Guidelines
- 22 C. Government Code, §20636 and 20636.1
- 23 D. Title 2, California Code of Regulations (CCR), §571

24  
25  
26 **VI. REGULATORY AGENCY APPROVAL(S)**

27 None to Date

28  
29  
30 **VII. BOARD ACTION(S)**

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

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32  
33 **VIII. REVISION HISTORY**

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative

For 20200402 BOD Review Only



1 IX. GLOSSARY  
2

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima’s Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima’s bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as “annual performance bonus” and “merit pay.” If provided only during a member's final compensation period, it shall be excluded from final compensation as “final settlement” pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee’s base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

3

Policy #: GA.8042  
 Title: **Supplemental Compensation**  
 Department: Human Resources  
 Section: Not Applicable

*CEO Approval:*

Effective Date: 01/01/2011  
 Revised Date: 04/02/2020

**I. PURPOSE**

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as “Special Compensation.”

**II. POLICY**

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual Pay/Bilingual Premium;
2. Night Shift Premium/Shift Differential;
3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
4. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of 1.5 times the employee's regular rate of pay. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima’s threshold languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

<b>Proficiency</b>	<b>Rate Per Pay Period</b>
Bilingual language usage with members is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee’s job duties.	\$60.00
Bilingual language usage with members is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee’s job duties.	\$40.00

- D. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.
1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services Department (C&L) and who is not required as part of his or her regular job responsibilities to translate but is qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during his or her own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.
  2. There are two (2) key activities in providing translation services:
    - a. Translation of materials from English into the desired language, or from another language into English; and
    - b. Review and revision of the translation to ensure quality and consistency in usage of terms.
  3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:
    - a. Translation – Thirty-five dollars (\$35.00) per page; and
    - b. Review and revision of translated materials – Twenty-five dollars (\$25.00) per page.
  4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.
- E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	\$2.00 per hour.

- F. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

<b>Definition</b>	<b>Eligibility</b>	<b>Rates (per hour)</b>
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees	\$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by Employee's supervisor. In no event shall Employee's supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt Employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

- G. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars (\$100) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.
- H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize executive staff, including interim appointments, using incentive compensation as described in this Policy. For executive staff who achieve superior performance, the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.
- I. Sales Incentive Program: The OneCare/OneCare Connect Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.
1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars (\$165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per

enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty five dollars (\$165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five (\$175), which equals an incentive of three thousand eight hundred twenty five dollars (\$3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

<b>Tier Min</b>	<b>Tier Max</b>	<b>Payout for Enrollment within Each Tier</b>
1	30	<b>\$0.00</b>
31	50	<b>\$165.00</b>
51	65	<b>\$175.00</b>
66+		<b>\$200.00</b>

- 3 The sales incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the Member Outreach & Education Department. The Manager, Member Outreach & Education will receive ten dollars (\$10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the sales incentive for that Community Partner or Sr. Community Partner.

J. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima’s business needs and mission, vision, and values.

K. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

L. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.

M. Incentive programs may be modified or withdrawn, at any time. Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between executive staff or employees and CalOptima.

N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a management staff position, including interim appointments; and
2. Included in one (1) of the following categories:

- a. A CalPERS Classic Member; or
  - b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
- O. Annual Performance Lump Sum Bonus: Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this Policy, provided that their performance meets the goals and objectives set forth by their managers.
- P. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in executive staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars (\$500) for the use of their personal vehicle for CalOptima business.
- Q. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in executive staff positions, the contribution rate shall be uniform for all employees. Executive staff positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in executive staff positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. The executive staff member must still be employed by CalOptima at the time the additional supplemental contributions to PARS is distributed in order to be eligible to receive the additional supplemental contributions. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

### III. PROCEDURE

- A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.
- B. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.
- C. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.
- D. Night Shift:
- 1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.



2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

E. Call Back and On Call Pay:

1. If an employee is on call or gets called back to work, the employee is responsible for adding this time to their schedule through CalOptima's time keeping system, which is then approved by their supervisor.

F. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

G. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the executive staff.
2. The CEO may establish an incentive compensation program for executive staff based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive staff will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the executive staff member may be eligible for a lump sum bonus payment. The executive staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible executive staff members who achieve superior performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.
3. As circumstances warrant and at the discretion of the CEO, employees not at the executive staff level, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

H. Sales Incentive Program

1. The OneCare/OneCare Connect Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.
2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.

- a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.
3. CalOptima shall pay the sales incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee earned the sales incentive.
  - a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the sales incentive previously earned will be deducted from a future sales incentive.
4. The Chief Operating Officer, Executive Director of Network Operations, and Director Network Management who oversee the Member Outreach & Education Department shall approve the sales incentive payout.
5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a leave of absence.
6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.
- I. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors approval.
- J. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Directors approval is required for recruitment incentives offered for Executive Director and Chief positions. In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.
- K. Annual Performance Lump Sum Bonus: Once an employee has reached the pay range maximum, the employee may be eligible for merit bonus pay delivered as a lump sum bonus, provided that his or her annual performance evaluation meets the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects the employee's superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima in order to be eligible to receive the lump sum bonus payments.



L. Automobile Allowance: As circumstances warrant, the CEO may offer to employees in executive staff positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply in the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the executive staff's W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the executive staff member must comply with the following requirements:

1. He or she must maintain adequate levels of personal vehicle insurance coverage;
2. He or she shall purchase his or her own fuel for the vehicle; and
3. He or she shall ensure that the vehicle is properly maintained.

**IV. ATTACHMENT(S)**

- A. Executive Incentive Program
- B. Performance Review of Executives Template

**V. REFERENCE(S)**

- A. CalOptima Employee Handbook
- B. Compensation Administration Guidelines
- C. Government Code, §20636 and 20636.1
- D. Title 2, California Code of Regulations (CCR), §571

**VI. REGULATORY AGENCY APPROVAL(S)**

None to Date

**VII. BOARD ACTION(S)**

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

**VIII. REVISION HISTORY**

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative

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**IX. GLOSSARY**

<b>Term</b>	<b>Definition</b>
Bilingual Certified Employee	An employee who has passed CalOptima’s Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima’s bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as “annual performance bonus” and “merit pay.” If provided only during a member's final compensation period, it shall be excluded from final compensation as “final settlement” pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee’s base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

## CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

The Leadership Incentive Plan is an annual plan for the members of CalOptima’s executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

**A. Purpose:** To align the performance of CalOptima’s executive staff towards the accomplishment of the agency’s long-term strategic plan and to reward superior accomplishment of annual key business strategies and initiatives.

**B. Eligibility:** To be eligible to participate in the Leadership Incentive Plan, an employee must be in an executive level position with job titles containing the designation of “Chief” or “Executive”.

**C. Goals and Objectives:** Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across the department
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

**D. Performance Period:** Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

**E. Incentive Opportunity:** Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is 10% of the participant’s annual base compensation. The amount can be prorated based on the number of months participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

**F. Modification of Plan:** The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

**Sample Form**  
**Executive Incentive Goals for FY \_\_\_\_\_ - \_\_\_\_\_**

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	Goal XYZ	10	Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.	15	Chief Operating Officer	Partial completion.
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
<b>Total Score</b>						

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# Performance Review – Executive (Directors and Above)

## EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT
SUPERVISOR/EVALUATOR	REVIEW PERIOD to	

**SELF REVIEW:** In the following section, provide your responses to the following questions for the review period April 1, 2016 through March 31, 2017.

- 1) What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, customer service)
- 2) What are you continuing to work on that you set as goal(s) from last year?
- 3) What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?

1)

2)

3)

**Manager Review:** Below are the Core Competencies to be completed by your manager

### CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

### Competency Rating Scale Definitions:

- Outstanding** – Performance regularly exceeds job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.
- Exceeds Expectations** - Often demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.
- Fully Meets Expectations** - Demonstrates effective and desired behaviors that **consistently meet expected** performance standards.
- Needs Development** - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.
- Unacceptable** - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant and immediate** improvement

<p><b>COMMUNICATION:</b></p> <ul style="list-style-type: none"> <li>Communicates well with others in both verbal and written form by adapting his/her tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully.</li> <li>Listens attentively to ideas of others; cooperates and builds good working relationships with others.</li> <li>Provides colleagues with regular and reliable information, including updates on his/her own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.</li> </ul>	<input type="checkbox"/> Outstanding <input type="checkbox"/> Exceeds Expectations <input type="checkbox"/> Fully Meets Expectations <input type="checkbox"/> Needs Development <input type="checkbox"/> Unacceptable
<p>Describe specific examples or details of past performance and self development during this review cycle that support the rating:</p>	
<p><b>CUSTOMER FOCUS (internal and/or external)</b></p> <ul style="list-style-type: none"> <li>Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems.</li> <li>Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond his/her ability.</li> <li>Viewed as a team player.</li> </ul>	<input type="checkbox"/> Outstanding <input type="checkbox"/> Exceeds Expectations <input type="checkbox"/> Fully Meets Expectations <input type="checkbox"/> Needs Development <input type="checkbox"/> Unacceptable
<p>Describe specific examples or details of past performance and self development during this review cycle that support the rating:</p>	
<p><b>LEADERSHIP:</b></p> <ul style="list-style-type: none"> <li>Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year.</li> <li>Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.</li> </ul>	<input type="checkbox"/> Outstanding <input type="checkbox"/> Exceeds Expectations <input type="checkbox"/> Fully Meets Expectations <input type="checkbox"/> Needs Development <input type="checkbox"/> Unacceptable
<p>Describe specific examples or details of past performance and self development during this review cycle that support the rating:</p>	
<p><b>STRATEGIC THINKING:</b></p> <ul style="list-style-type: none"> <li>Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes.</li> <li>Includes key stakeholders in strategic planning.</li> <li>Is an innovative strategic partner.</li> </ul>	<input type="checkbox"/> Outstanding <input type="checkbox"/> Exceeds Expectations <input type="checkbox"/> Fully Meets Expectations <input type="checkbox"/> Needs Development <input type="checkbox"/> Unacceptable
<p>Describe specific examples or details of past performance and self development during this review cycle that support the rating:</p>	
<p><b>DECISION MAKING/PROBLEM SOLVING:</b></p> <ul style="list-style-type: none"> <li>Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources.</li> <li>Able to make decisions even when conditions are uncertain or information is not available by</li> </ul>	<input type="checkbox"/> Outstanding <input type="checkbox"/> Exceeds Expectations <input type="checkbox"/> Fully Meets Expectations <input type="checkbox"/> Needs Development <input type="checkbox"/> Unacceptable



<p>using the correct balance of logic and intuition; discusses his/her decision and its impact with those who will be affected; the group benefits from his/her input in problem solving and brainstorming sessions.</p> <ul style="list-style-type: none"> <li>Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.</li> </ul>	
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Describe specific examples or details of past performance and self development during this review cycle that support the rating:

**PREVIOUS MANAGER’S COMMENTS (if applicable):**

**List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:**

<b>FINAL OVERALL RATING</b>	<input type="checkbox"/> Outstanding <input type="checkbox"/> Exceeds Expectations <input type="checkbox"/> Fully Meets Expectations <input type="checkbox"/> Needs Development <input type="checkbox"/> Unacceptable

**Manager’s/Evaluator’s Comments**

Manager’s/Evaluator’s Signature:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Second Level Manager’s Comments and Signature:

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Signature

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Date

Employee's Acknowledgement and Comments:

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Signature

---

Date

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## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action To Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Report Item**

23. Consider Approval of an Executive Employment Agreement for a Temporary (Interim) Chief Executive Officer.

#### **Contact**

Brigette Gibb, Executive Director, Human Resources (714) 246-8400

#### **Recommended Action(s)**

Approve Executive Employment Agreement for a Temporary (Interim) Chief Executive Officer.

#### **Background**

On March 4, 2020, CalOptima's Chief Executive Officer (CEO), Michael Schrader provided his notice of resignation and informed the Board of Directors that his last day of service with CalOptima will be May 3, 2020.

#### **Discussion**

Mr. Schrader's departure will leave a vacancy in CalOptima's highest executive leadership position. To provide day-to-day leadership during the national search for CalOptima's next CEO, it is recommended that an Interim CEO be appointment by the Board to carry out the day-to-day administrative functions and to meet all regulatory requirements that an individual be designated/identified to serve in the capacity of CEO.

At its March 23, 2020 special meeting, the Board of Directors directed staff to support Chair Yost and Vice Chair Khatibi to assist them with negotiating an executive employment agreement with Orange County Health Care Agency Director and CalOptima Board Member Richard Sanchez for the position of Temporary (Interim) CEO. The proposed Executive Employment Agreement is currently being drafted and will be forwarded to the Board for consideration at its April 2, 2020 Regular meeting.

#### **Fiscal Impact**

The recommended action to approve the Executive Employment Agreement for the Temporary (Interim) CEO is budget neutral. Staff anticipates funding included in the CalOptima Fiscal Year 2019-20 Operating Budget for salaries and benefits will be sufficient to cover expenses after May 3, 2020. The estimated total cost for the transition period prior to May 3, 2020 (i.e., the period of overlap that is intended to ensure a smooth transition), will not exceed \$51,000. Staff anticipates unspent budgeted funds for salaries and benefits in the CalOptima Fiscal Year 2019-20 Operating Budget will fund this action.

#### **Rationale for Recommendation**

Approval of the Interim CEO contract is recommended to ensure the continued smooth operations of CalOptima and coverage for CEO responsibilities on an interim basis until the Board of Directors appoints a permanent CEO.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Temporary (Interim) CEO Employment Agreement

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

## **EXECUTIVE EMPLOYMENT AGREEMENT**

THIS EXECUTIVE EMPLOYMENT AGREEMENT ("Agreement") is made and entered into effective April 6, 2020 ("Effective Date") by and between, the Orange County Health Authority, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("Employer" or "CalOptima") and Richard Sanchez ("Employee"). Employer and Employee are collectively referred to herein as the "Parties" or singularly as a "Party."

### **RECITALS**

WHEREAS, Employer is a Health Authority and local public agency responsible for administering a county operated health system for the provision of health care services to individuals qualifying for various government-funded health care programs; and

WHEREAS, Employee has executive health care and other relevant experience, and the Board of Directors ("Board") believes that it is in the best interest of CalOptima that Employee be named the Interim Chief Executive Officer; and

WHEREAS, Employee is willing to accept such employment on the terms and conditions set forth in this Agreement below.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained in this Agreement, it is hereby agreed as follows:

### **AGREEMENT**

1. Employment:
  - a. Subject to CalOptima's satisfactory completion of background and reference checks, Employee shall serve as the Interim Chief Executive Officer ("CEO") of CalOptima during the term of this Agreement. Employee will perform such duties as are customarily performed by CEOs of like organizations and as may be assigned from time to time by the Board. These duties shall include working closely with the Board to establish internal policies, structures and procedures and to promote cooperative relationships with local, state and federal officials and agencies in support of CalOptima programs. In performing his duties, Employee will abide by all applicable federal, state, and local laws as well as CalOptima's bylaws, rules, regulations and policies as may be amended from time to time.
  - b. Employee shall devote his entire productive time, ability and attention to Employer's business during the term of this Agreement and use his best efforts to promote CalOptima's interests. Employee's duties may involve expenditures of time in excess of the regularly established workday or in excess of a forty (40) hour work period and may include time outside normal office hours. Employee will generally be expected to keep office hours at CalOptima Monday through Friday during normal business hours. Employee shall not engage in any other

business duties or pursuits whatsoever, or directly or indirectly render any services of a business, commercial, or professional nature to any other person or organization, whether for compensation or otherwise. Employee shall not directly or indirectly acquire, hold, or retain any interest in any business competing with or similar in nature to the business of Employer or which in any other way creates a conflict of interest. During the term of this Agreement, Employee shall not in any way engage or participate in any business that is in competition with Employer.

- c. Employee acknowledges that in the course of his employment contemplated herein, Employee will be given or will have access to confidential and proprietary documents and information relating to CalOptima, its operations, employees, providers, and members. (“Confidential Information”) Employee acknowledges and agrees that the sale, unauthorized use or disclosure of any of Employer's Confidential Information or trade secrets constitutes unfair competition and a violation of applicable laws or CalOptima policies, and that Employee will not engage in any unauthorized disclosure of Confidential Information or unfair competition with Employer, either during the term of this Agreement or thereafter. Employee further acknowledges and agrees that for one year following separation from CalOptima, Employee will not actively recruit, solicit, or offer employment to any then current CalOptima employee on behalf of Employee, or any other employer, agency, or organization.
  - d. Employer may fix other terms and conditions of employment, as it may determine from time to time, relating to the performance of Employee, provided such terms and conditions are not inconsistent with or in conflict with the provisions of this Agreement or applicable law.
2. Term:
- a. CalOptima agrees to employ Employee and Employee accepts employment with CalOptima on an interim basis from the effective date of this Agreement through December 31, 2020, continuing thereafter on a month-to-month basis, subject to the termination provisions in accordance with this Agreement.
3. Salary and Benefits:
- a. **Salary:** Beginning on the effective date of this Agreement, Employee will receive a Base Annual Salary of four hundred and nine thousand two hundred forty-nine dollars (\$409,249) payable in equal installments according to the Employer's regular payroll schedule, less any applicable taxes and withholding. Employer shall also deduct sums Employee is obligated to pay because of participation in plans or programs described in Paragraph 3.c. of this Agreement. Base compensation is subject to annual review by the Board. Merit increases, if any, will be determined by the Board at a future date(s).
  - b. **Car Allowance:** Employer will provide Employee with \$550 per month to be used as an automobile allowance. Employee will be responsible for all operating

expenses of his automobile as well as for procuring and maintaining automobile liability insurance.

- c. Benefits: Employee is entitled to participate in all employee benefit programs and plans established by CalOptima from time to time for the benefit of its employees generally, and for which Employee is eligible. Employee shall also receive the following:
  - i. To the extent permitted under applicable law, (a) Employer will pay for Employee's portion of contributions to his CalPERS ("PERS") retirement plan under the applicable PERS formula and legal limitations, if applicable; and (b) Employer will make supplemental Public Agency Retirement System ("PARS") retirement contributions based on the same percentage applicable to all employees, subject to wage and other limits under applicable laws. .
  - ii. At Employee's option, Employer will (a) provide term life insurance in the amount of two (2) times Employee's annual salary, or (b) pay Employee an amount equal to the premium for such life insurance.
  - iii. Upon the Effective Date of this Agreement, Employer shall provide Employee with two (2) weeks of paid time off ("PTO"), equivalent to eighty (80) hours, in the Employee's PTO account.
  - iv. In addition to the PTO provided on the Effective Date of this Agreement, Employee shall accrue PTO at a rate of 33 days per year (prorated on a bi-weekly basis).
- d. Expenses:
  - i. Employee will be reimbursed for the cost of all reasonable expenses incurred by Employee for CalOptima business, so long as the expenses are incurred and submitted according to Employer's expense reimbursement policies and procedures and supported by documentation meeting the Employer's standard requirements.

#### 4. Termination of Employment:

- a. Employee is appointed by and serves at the pleasure of the Board of Directors. CalOptima, acting through the Board, may terminate this Agreement and Employee's employment at any time with or without Cause. Employee may terminate this Agreement and Employee's employment at any time upon sixty (60) days advance written notice. Such advance written notice may be waived by the Board and the termination by the Employee may be accepted immediately.
- b. In the event Employee is terminated for Cause, Employee shall not be entitled to any severance compensation or any other compensation from CalOptima except for such salary and benefits as Employee may have earned prior to Employee's termination. If terminated for Cause, said termination may, at CalOptima's sole and absolute discretion, take effect immediately. For purposes of this Agreement,

the Board may terminate this Agreement for "Cause" which includes but is not limited to the following reasons:

- i. Employee's continued failure to substantially perform his job duties and responsibilities (which shall include failure, caused by Death, Disability or other physical or mental incapacity), provided that written notice is provided by CalOptima and the performance problem is not satisfactorily cured.
    - ii. Employee's willful, reckless or negligent act or omission that is materially injurious to CalOptima.
    - iii. Employee's conviction of a felony or perpetration of common law fraud, misappropriation or embezzlement.
    - iv. Employee's suspension, debarment, or exclusion from participation in any federal or state contract or program.
    - v. Employee's engaging in actions involving moral turpitude which would bring discredit upon Employer or any affiliate entity.
  - c. In the event CalOptima appoints a permanent CEO to commence employment prior to December 31, 2020, Employee's employment will terminate on the date the permanent CEO commences employment, and Employee may receive severance pay in an amount equal to the lesser of the Employee's prorated Annual Base Salary for the remaining term through December 31, 2020, or three times the Employee's current Base Monthly Salary. Employee's right to any such severance is contingent upon his prior execution of Employer's standard Separation Agreement. Any severance provided must be reimbursed to Employer if Employee is convicted of a crime involving abuse of his position as defined by Government Code section 53243.4.
5. Indemnification. Consistent with the California Government Code, Employer shall defend and indemnify Employee, using legal counsel of Employer's choosing, against expense or legal liability for acts or omissions by Employee occurring within the course and scope of Employee's employment under this Agreement. In the event there is a conflict of interest between Employer and Employee in such a case so that independent counsel is required for Employee, Employer may select the independent counsel after having considered the input of Employee and shall pay the reasonable fees of such independent counsel. If Employee is convicted of a crime involving abuse of his position as defined in Government Code section 53243.4, Employee shall reimburse Employer for all legal defense fees and costs.
6. Withholding of Taxes: CalOptima will withhold from any monies payable pursuant to this Agreement all federal, state, city or other taxes as may be required by any law, governmental regulation or ruling.
7. Notices: Notices and all other communications under this Agreement shall be in writing and shall be deemed given when personally delivered or when mailed by U.S. registered or certified mail, return receipt requested, postage prepaid, addressed as follows



If to the Employer:  
CalOptima  
505 City Parkway West  
Orange, California 92868  
Attention: Chair, Board of Directors

If to the Employee:

Richard Sanchez

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Waiver of Breach: The waiver by either Party, or the failure of either Party to claim a breach of any provision of this Agreement, shall not operate or be construed as a waiver of any subsequent breach.
9. Assignment: The rights and obligations of the respective Parties hereto under this Agreement shall inure to the benefit of and shall be binding upon the heirs, legal representatives, successors and assigns of the Parties hereto; provided, however, that this Agreement shall not be assignable by either Party without prior written consent of the other Party.
10. Entire Agreement: This Agreement sets forth the final, complete and exclusive agreement between the Parties relating to the employment of Employee by Employer, and supersedes any and all other agreements, either oral or in writing, between the Parties hereto with respect to the subject matter hereof and contains all of the covenants and agreements between the Parties with respect to said subject matter in any manner whatsoever. Any modification of this Agreement will be effective only if it is in writing and signed by both Employee and the Board Chairman of the CalOptima. The foregoing notwithstanding, Employee acknowledges that, except as expressly provided in this Agreement, his employment is subject to the Employer's generally applicable rules and policies pertaining to employment matters, such as those addressing equal employment opportunity, harassment and violence in the workplace, as they currently or may in the future exist, and his employment is, and will continue to be, at the will of the Board.
11. No Liability of the County of Orange: As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties hereto acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability hereunder.

12. Governing Law: This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts, with venue in Orange County.
13. Partial Invalidity: If any provision of this Agreement is found to be invalid or unenforceable by any court, the remaining provisions hereof shall remain in effect unless such partial invalidity or unenforceability would defeat an essential business purpose of this Agreement.
14. Independent Review. Employee acknowledges that he has had the opportunity and has conducted an independent review of the financial and legal effects of this Agreement. Employee acknowledges that he has made an independent judgment upon the financial and legal effects of this Agreement and has not relied upon any representation of CalOptima, its officers, agents or employees other than those expressly set forth in this Agreement. Employee acknowledges that he has been advised to obtain, and has available himself of, legal advice with respect to the terms and provisions of this Agreement.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be duly executed and delivered on the 6<sup>th</sup> day of April 2020, at Orange County, California.

ORANGE COUNTY HEALTH AUTHORITY

Employer:

By: \_\_\_\_\_  
Paul Yost, Chairman

Employee:

By: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Richard Sanchez

# CALOPTIMA BOARD ACTION AGENDA REFERRAL

## Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

### Report Item

24. Consider Authorizing Contract with an Executive Search Firm for Chief Executive Officer Recruitment

### Contact

Brigette Gibb, Executive Director, Human Resources (714) 246-8400

### Recommended Actions

1. Authorize selection of an executive search firm for chief executive officer (CEO) recruitment ~~and authorize staff to enter into a contract with the selected firm~~ consistent with the Board-approved purchasing policy; and directed staff to return with recommendations, requesting that the selected firm not charge a recruitment fee in the event that an internal candidate is selected; and
2. Authorize unbudgeted expenditures from existing reserves for recruitment services and related expenditures in the amount not to exceed \$250,000 to fund the CEO recruitment contract.

Rev.  
04/02/2020

### Background

Michael Schrader has served as CalOptima's CEO for the past seven years and recently informed the Board of Directors that his last day of service with CalOptima will be May 3, 2020.

### Discussion

Mr. Schrader's departure will leave a vacancy in CalOptima's highest level staff position. CalOptima's CEO is appointed by and serves at the pleasure of the Board. The CEO provides organizational strategic direction, collaborates with the executive team and business unit leaders and is responsible for acting as the duly authorized representative of CalOptima in all matters in which the Board has not formally designated some other person to act.

In order to fill the CEO vacancy, it is essential to recruit properly qualified candidates in a highly competitive market. In order to conduct a nationwide executive search, staff recommends contracting with a qualified executive search firm. These firms possess the expertise to determine a pool of potential candidates, narrow the field to promising candidates, and then ensure that the Board interviews the most qualified candidates.

CalOptima has successfully utilized executive search firms in the past to locate other executive officers and estimates an executive search will take approximately three - six months to complete.

The executive search firms listed on the attachment charge fees in the range of 25% to 33.33% of the anticipated total cash compensation. Administrative costs of up to 12% plus travel-related reimbursement are additional. Based on the discussion at the Board's March 12, 2020 special meeting and the Board member inquiries and direction provided, staff has reached out to the leading executive recruiters to obtain the requested information. Responses to the questions raised by Board members at the March 12<sup>th</sup> meeting are summarized in the attached table. As proposed, and assuming the Board has no reservations regarding any of the listed firms or their ability to successfully complete the search, staff would contract with the vendor offering the most favorable terms.

**Fiscal Impact**

The recommended action to contract with an executive search vendor is an unbudgeted item. An allocation of up to \$250,000 from existing reserves will fund this action.

**Rationale for Recommendation**

Finding suitable and qualified candidates for CalOptima's CEO position in this very competitive market will entail a nationwide search. Using an executive search firm is the most efficient way to conduct such a search and promises to be the most successful manner in which to recruit and retain a new CEO given CalOptima's past experience in recruiting executive officers.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachments**

1. Executive Search Firms Vendor Comparisons

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

**Authorize Contract(s) with Vendor(s) for CEO Recruitment Services and Related Expenditures**

<b>Legal Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
Korn Ferry International	2600 Michelson Dr., Ste. 720	Irvine	CA	92614
Morgan Consulting Resources, Inc.	7923 Geary Blvd.	San Francisco	CA	94121
Spencer Stuart	2020 Main Street, Suite 350	Irvine	CA	92614
Witt Kieffer	2015 Spring Road, Suite 510	Oak Brook	IL	60523

## Executive Search Firms

	Korn Ferry	Morgan	Spencer Stuart	Witt Kieffer
	<b>General Background:</b>			
<b>Year Founded</b>	1969	1995	1956	1969
<b>Services Offered</b>	Talent Acquisition  Organization Strategy, Assessment & Succession, Leadership Development, and Rewards & Benefits	Healthcare Executive Recruiting	Executive Search and Recruitment Board Services, CEO Succession Planning, Executive Assessment Services, Leadership Advisory Services	Executive Search Senior and Mid-Level Executive Search Interim Leadership, Board Services
<b>Number of Offices and Location</b>	103 offices in 50 Countries Local offices in LA, San Francisco and Irvine	All staff work virtually out of 7 cities	60 offices in 31 countries Local offices in Orange County, LA, San Francisco	20+ offices in 3 Countries Local Offices Irvine, San Francisco
<b>Number of Employees</b>	8,500+	10	2,200+	250+
	<b>Past Experience:</b>			
<b>References</b>	Confidential	Community Health Center of Snohomish County (CEO) IEHP (CMO/CFO)	Confidential	IEHP Partnership Health Plan of CA
<b>Orange County Clients</b>	CHOC Hoag UCI	American Addiction Centers MemorialCare Health System	Confidential	CHOC Hoag Memorial Care Mission Hospital Providence Share Our Selves UCI
<b>Client(s) most similar to CalOptima</b>	Affinity HP AHIP AltaMed Health First Molina	Alameda Alliance for Health Community Health Group Gold Cost Health Plan of San Joaquin Health Plan of San Mateo IEHP LA Care	Confidential	AlohaCare CareOregon Community Healthplan of Washington Gold Coast Healthplan IEHP Partnership HP of CA Santa Clara Family Healthplan San Francisco Healthplan
<b>Direct CalOptima Experience</b>	None Provided	No Previous Experience	No Previous Experience	CalOptima COO, CIO, CFO, CEO

## Executive Search Firms

	Korn Ferry	Morgan	Spencer Stuart	Witt Kieffer
<b>Recruiter Resumes</b>	<p>Brian Joyce Principal for Health Insurance Practice. 21 years experience, 18 in HealthCare. Stamford CT.</p> <p>Jessica Johnson Principal for Healthcare Services, 13 years with Korn Ferry, with experience in Providers, Payors, and others, Irvine, CA</p>	<p>Paula Morgan 20+ years in Healthcare Recruiting</p> <p>Rosie Saenz 20+ years in health benefits, managed care and workers comp</p> <p>Lu Miller 20+ years in multiple Health insurance product</p> <p>Lisa Coyne 15+ years experience</p> <p>Donna Hulse, Alex Drury, Lynn Barboza and Kim Phillips round out the team with other experience in Recruitment, Healthcare and insurance. Lynn or Lisa will be assigned to CalOptima.</p>	<p>Dieter Freer 25+ years of experience in global healthcare and insurance practices. Experienced in Payor segment in both profit and non-profit. Past regional president of Cigna, and served at both BCBS of NJ and NY.</p> <p>Kristine Johnson Sr Leader in the firms nonprofit and Gov't Practice, experience in recruiting and CEP succession planning and Board transitions. Past, Director of executive recruitment for Disney.</p>	<p>Mark Andrew 20+ years experience at Witt Kieffer, experience with Providers, Payers, in Gov't and public health. Previously, Mark was founding partner and chief executive officer of a medical search in California, where he recruited execs and physicians in several medical disciplines.</p> <p>Christopher Neumann also has over 10+ years experience, with focus in hospitals, health systems and MCO's.</p>
<b>Prior/Recent Placements</b>	CEO - Affinity, AHIP, Beacon, BCBS of AZ, LA, MN and NC, Care First, Care Source, Emblem, Health First, Humana, Molina, MVP Health Care, and others	CEO - SeniorSelect Partners, Wyoming eHealth Partnership, Care Wisconsin, Cal eConnect, Hospitality Health, Health Share of Oregon, Alameda Alliance, Missouri HIO,. Many COO's, CFO's and CMOs for similar organizations.	Confidential	CEO - IEHP, Partnership HP of CA, Santa Clara Family HP, Gold Coast HP, San Francisco HP, CareOregon, AlohaCare, Community HP of Washington.
<b>Success Rates</b> <i>Note: retained firms are paid under a non-contingent format (paid regardless if they fill the position or not)</i>	Not Provided	100% for CEO Placements	Not Provided	Last 3 years, 97%.
<b>Recruitment Process:</b>				
<b>Timeline / Activities</b>	<p>Define Requirements with CalOptima</p> <p>Use Korn Ferry Four Dimensional Executive Assessment (KF4D)</p> <p>Build strong candidate pool</p> <p>Screen candidates</p> <p>Arrive at short list</p> <p>Assess finalists</p> <p>Hold behavioral interviews</p> <p>Receive executive feedback</p> <p>Approx 16 weeks</p>	<p>Intake and site visit</p> <p>Develop marketing material</p> <p>Finalizing the position description</p> <p>Marketing the position</p> <p>Initial slate of candidates</p> <p>Ongoing slate of candidates</p> <p>Interviews</p> <p>Offer</p> <p>Follow-up</p> <p>Average 16.2 weeks</p>	<p>Framing the need with CO leadership and stakeholders</p> <p>Preliminary Research</p> <p>Targeted outreach and development, thorough assessment of candidates, customized interview process, strong closing between offer and onboarding. Approx 20 weeks</p>	<p>Discovery Phase</p> <p>Development of Leadership Profile and Recruitment Strategy</p> <p>Recruitment and Candidate Evaluation, Candidate Review</p> <p>Semi-Finalists Interviews</p> <p>Finalist Interviews</p> <p>Selection and Negotiations</p> <p>Approx 19-20 weeks</p>
<b>Contracting:</b>				

## Executive Search Firms

	Korn Ferry	Morgan	Spencer Stuart	Witt Kieffer
<b>Contract Changes</b>	10-15 Changes (mostly minor)	5 Changes (minor)	25+ Changes (minor to moderate)	5-10 changes (minor)
<b>If Awarded, Can they start immediately</b>	YES	YES	YES	YES
<b>Current Disputes/Litigation</b>	None	None	We enter into routine litigation over receivables in the ordinary course of business which do not typically exceed \$500,000.	None
<b>Current Governmental Investigations</b>	None	None	None	None
<b>Inquiry Letters / Negative Audit Results</b>	None	None	None	None
<b>Use of any subcontractors</b>	None	None	None	None
	<b>Price:</b>			
<b>Other Candidate Sources</b>	As a retained search firm, Korn Ferry would equally process an internal candidate like any external candidate. They would take any referrals through our website/ positing/ or internal referrals and process them as we would any external candidate identified by Korn Ferry.	Candidates who surface from all sources including internal candidates will be referred to MCR for screening and will be considered MCR candidates.	N/A	Candidates who surface from all sources including internal candidates will be referred to Witt Kieffer for screening and will be considered Witt Kieffer candidates.
<b>Guarantee Language</b>	12 month guarantee from the selected candidate's start date; if the candidate resigns or is terminated Korn Ferry will conduct a new search at no additional fee, only billing direct expenses as incurred	MCR agrees to conduct a replacement search for no additional search fee if the candidate placed by MCR should leave or is terminated for cause within twelve months of employment.	12 month guarantee if discharged or resigns at no cost, other than direct costs as before.	12 month guarantee if discharged or resigns at no cost, other than direct costs as before.



## **CALOPTIMA BOARD ACTION AGENDA REFERRAL**

### **Action to Be Taken April 2, 2020** **Regular Meeting of the CalOptima Board of Directors**

#### **Consent Calendar**

25. Consider Recommended Appointment to the CalOptima Board of Directors' Member Advisory Committee

#### **Contact**

Belinda Abeyta, Executive Director, Operations (714) 246-8400  
Ladan Khamseh, Chief Operating Officer (714) 246-8400

#### **Recommended Action**

The CalOptima Member Advisory Committee (MAC) recommends the appointment of:

1. Appoint Hai Hoang to serve as the Persons with Disabilities Representative of the Member Advisory Committee for the remainder of the term ending June 30, 2021.

#### **Background**

The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, the CalOptima Board appoints each member of the MAC for a two-year term except for the two standing seats, the Orange County Social Services Agency representative and the Orange County Health Care Agency representative, which have an unlimited term. The CalOptima Board is responsible for the appointment of all MAC members. In September 2019, MAC incurred a vacancy for the Persons with Disabilities Representative due to the resignation of Suzanne Butler.

#### **Discussion**

CalOptima conducted special recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. Recruitment was undertaken by sending out community newsletters and announcing the open seat on the CalOptima website and at various CalOptima sponsored events, such as the Community Alliances Forum. CalOptima staff received applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on February 10, 2020, subcommittee members evaluated each of the applicants. Subcommittee Members Connie Gonzalez, Pamela Pimentel and Christine Tolbert met on met and made recommendations to the MAC for consideration.

At its February 25, 2020 meeting, MAC agreed to recommend the candidate the Nominations Ad Hoc recommended.

Two candidates applied for the open position:

#### **Person with Disabilities Representative**

Hail Hoang\*

\*Indicates MAC recommendation

Lucille Kowalski

**Hai Hoang** is currently the Chief Operating Officer at the Illumination Institute working directly with CalOptima's youth, disabled and adult/older adult populations. Presently the Illumination Institute continues a parent mentoring program for children with intellectual/developmental disabilities and their families that was established by Mr. Hoang when he was with Boat People SOS. The Illumination Institute also works with the Garden Grove and Santa Ana school districts assisting the medical and mental health support of children. Mr. Hoang has worked with the Vietnamese community since 2009 assisting children with intellectual/developmental disabilities and their families with health care navigation. Mr. Hoang has been a life-long advocate of the persons with disabilities population of Orange County for their medical and behavioral health needs.

**Lucille Kowalski** is a Benefits Specialist with the Regional Center of Orange County (RCOC). Ms. Kowalski assists RCOC staff, individuals with disabilities and their families navigate through Social Security, Medi-Cal and Medicare benefits and how to access the appropriate services and supports through those agencies. During the prior 18 years with the RCOC, she served as a service coordinator for children and adults with intellectual/developmental disabilities.

**Fiscal Impact**

There is no fiscal impact.

**Rationale for Recommendation**

As requested by the CalOptima Board of Directors, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc's recommendation and forwards the recommended candidate to the Board of Directors for consideration.

**Concurrence**

Member Advisory Committee Nominations Ad Hoc  
Member Advisory Committee  
Gary Crockett, Chief Counsel

**Attachments**

None

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

\*Indicates MAC recommendation

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken April 2, 2020

### Regular Meeting of the CalOptima Board of Directors

#### Report Item

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

#### Contact

David Ramirez, Chief Medical Officer (714) 246-8400

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

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

#### Recommended Actions

1. Approve the recommended allocation of IGT 9 funds in the amount of \$45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
  - a. Additional initiative(s) related to member access and engagement; and
  - b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

#### 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 2020-2011 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.

The IGT funds received under IGT 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. 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.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima’s estimated share is expected to be approximately \$45 million. Following consideration by the Quality Assurance Committee and Finance and Audit Committee at their respective February 2020 meetings and the committees’ recommendations for approval by the full Board, this item was presented for approval at the March CalOptima Board meeting. At that meeting, staff was directed to conduct further study and provide additional details related to the Whole Child Model pilot program (WCM) and the program’s financial performance. Details on the WCM program are provided in a separate WCM-specific Information Item.

**Discussion**

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima’s Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately \$45 million in IGT 9 funding. Staff has identified initiatives within four focus areas targeting \$40.5 million of the anticipated \$45 million. Staff proposes approval of the five initiatives and allocation of funds in the focus areas as noted below and as further described in the attached IGT Funding Proposals:

<b>Proposals</b>	<b>Focus Area</b>	<b>Term</b>	<b>Amount Requested</b>
1. Expanded Office Hours	Member access and engagement	Two–years	\$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	\$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	\$2.0 million

4. IGT Program Administration	Other priority areas	Five-years	\$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One-year	Up to \$31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	\$4.5 million

CalOptima staff will return to the Board with recommendations related the remaining estimated \$4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, if necessary.

**Fiscal Impact**

The recommended action has no net fiscal impact to CalOptima’s operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

**Rationale for Recommendation**

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

**Concurrence**

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

**Attachments**

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**



**CalOptima**  
Better. Together.

# Intergovernmental Transfer (IGT) 9 Update

**Board of Directors Meeting**

**April 2, 2020**

**David Ramirez, M.D., Chief Medical Officer**

**Nancy Huang, Chief Financial Officer**

**Candice Gomez, Executive Director, Program Implementation**

# IGT Background

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- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

# IGT Funding Process

## High-Level Overview

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 to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% 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% fee and where applicable, retained amount for MCO 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 (Spring 2020)
IGT 10*	TBD	TBD
<b>Total Received</b>	<b>\$121.31 million</b>	

\* Pending DHCS guidance

# IGT 9 Status

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- 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
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget
- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other priority areas

# Proposed Allocation and Initiatives

- Staff has identified initiatives targeted \$40.5 million of the anticipated \$45 million

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	\$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	\$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	\$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	\$2.0 million
5. Whole Child Model Program	Other priority areas	One–year	Up to \$31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	\$4.5 million

# 1. Member Access and Engagement: Expanded Office Hours

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- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of \$2.0 million (\$500,000 in FY 2019–20)

## 2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of \$3.4 million (\$1 million in FY 2019–20)

# 3. Data Exchange: Hospital Data Exchange Incentive

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- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of \$2.0 million (CY 2020)

# 4. Other Priorities: IGT Program Administration

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- Definition

- Administrative support for prior, current and future IGTs
  - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
  - Fund Grant Management System license, public activities and other administrative costs

- Guidelines

- Will be consistent with CalOptima policies and procedures
- Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs

- Key Components

- Five years of support
- Budget request of \$2.0 million

# 5. Other Priorities: Whole-Child Model (WCM) Program

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- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to \$31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to \$31.1 million to fund the deficit from WCM program in FY 2019–20



# Next Steps

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- Return to the Board as needed regarding
  - New or modified policy and procedures
  - Contracts
  - Additional initiatives

# CalOptima's Mission

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



# CalOptima

Better. Together.



Medi-Cal

# CalOptima

Better. Together.



OneCare (HMO SNP)

# CalOptima

Better. Together.



OneCare Connect

# CalOptima

Better. Together.



PACE

# CalOptima

Better. Together.

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

#### **Report Item**

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

#### **Contact**

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

#### **Recommended Actions**

Ratify and 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 Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
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 Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 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 seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for 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. 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 unmet needs.

#### **Discussion**

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), IGT funds must now be used in the current rate year for CalOptima covered

services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. 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 ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight 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 your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

### **Fiscal Impact**

The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

### **Rationale for Recommendation**

Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

### **Concurrence**

Gary Crockett, Chief Counsel

### **Attachment**

Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader  
**Authorized Signature**

8/29/2018  
**Date**



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

July 31, 2018

Greg Hamblin  
Chief Financial Officer  
CalOptima  
505 City Parkway West  
Orange, CA 92868

**SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal**

Dear Mr. Hamblin:

The 2018-19 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 period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 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.

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Capitated Rates Development Division  
1501 Capitol Avenue, P.O. Box 997413, MS 4413  
Sacramento, CA 95899-7413  
Phone (916) 345-8268  
[www.dhcs.ca.gov](http://www.dhcs.ca.gov)

[Back to Agenda](#)

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

### **PROCESS FOR SFY 2018-19:**

MCPs should refer to the estimated SFY 2018-19 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 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 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 2018-19 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.

#### 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 SFY 2018-19. 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 "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** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:
    1. The governmental funding entity's name and Federal Tax Identification Number,
    2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
    3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).
  - The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.
  - The proposals and letters of interest are due to DHCS **by 5pm on Friday, August 31, 2018**. Please send a PDF copy of the required documents by e-mail to [Sandra.Dixon@dhcs.ca.gov](mailto:Sandra.Dixon@dhcs.ca.gov). **Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 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



Greg Hamblin  
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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 2018-19 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](mailto:Sandra.Dixon@dhcs.ca.gov).

Sincerely,



Jennifer Lopez  
Division Chief  
Capitated Rates Development Division

#### Attachments

cc: Michael Schrader, Chief Executive Officer  
CalOptima  
505 City Parkway West  
Orange, CA 92868

Sandra Dixon  
Financial Management Section  
Capitated Rates Development Division  
Department of Health Care Services  
P.O. Box 997413, MS 4413  
Sacramento, CA 95899-7413

Greg Hamblin  
Page 5

## ATTACHMENT A – LETTER OF INTEREST TEMPLATE

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 period of July 1, 2018, to June 30, 2019. 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 up to \$                      for the SFY 2018-19 rating period 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

**Attachment B**  
**SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment**

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](mailto:sandra.dixon@dhcs.ca.gov)) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.

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, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (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, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)?   
 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. For any capitation payments to be funded by the IGT, please provide the following:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (state, county, city, other):

(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.)

(iv) Does the transferring entity have general taxing authority?

(v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction?

5. Comments / Notes

ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

Orange County Organized Health System dba Cal Optima - Orange (HCP 506)  
 IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	\$ 138,114,451	\$ 68,412,249	\$ 7,133,302	\$ 62,568,900
Federal Match	\$ 98,985,353	\$ 34,206,125	\$ 6,277,306	\$ 58,501,922
Governmental Funding Entity's Portion	\$ 39,129,098	\$ 34,206,124	\$ 855,996	\$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories <sup>1</sup>	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage <sup>2</sup>	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	\$ 84.85	\$ 89.93	\$ 5.08	-	\$ 5.08	\$ 12,571,887
Child - MCHIP	1,273,587	\$ 84.85	\$ 89.93	\$ 5.08	-	\$ 5.08	\$ 6,469,822
Adult - non MCHIP	1,082,406	\$ 299.18	\$ 316.64	\$ 17.46	-	\$ 17.46	\$ 18,898,809
Adult - MCHIP	38,000	\$ 299.18	\$ 316.64	\$ 17.46	-	\$ 17.46	\$ 663,480
SPD	466,754	\$ 755.18	\$ 798.48	\$ 43.30	-	\$ 43.30	\$ 20,210,448
SPD/Full-Dual	22,794	\$ 219.25	\$ 229.52	\$ 10.27	-	\$ 10.27	\$ 233,170
BCCTP	7,156	\$ 1,225.69	\$ 1,296.82	\$ 71.13	-	\$ 71.13	\$ 509,006
LTC	14,686	\$ 10,472.34	\$ 10,858.28	\$ 385.94	-	\$ 385.94	\$ 5,667,915
LTC/Full-Dual	0	\$ 6,036.73	\$ 6,235.58	\$ 198.85	-	\$ 198.85	\$ -
OBRA	0	\$ -	\$ -	\$ -	-	\$ -	\$ -
Whole Child Model	74,642	\$ 1,824.65	\$ 1,962.92	\$ 138.27	-	\$ 138.27	\$ 10,321,014
Optional Expansion	2,853,119	\$ 442.21	\$ 471.45	\$ 29.24	7.31	\$ 21.93	\$ 62,568,900
	8,307,835	\$ 309.49	\$ 328.62	\$ 19.14	2.51	\$ 16.62	\$ 138,114,451

<sup>1</sup>The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.

<sup>2</sup>Other Departmental Usages decreases available rate funding.

**CALOPTIMA BOARD ACTION AGENDA REFERRAL**

**Action To Be Taken June 6, 2019**  
**Regular Meeting of the CalOptima Board of Directors**

**Report Item**

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

**Contact**

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

**Recommended Actions**

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

**Background**

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "...decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "...the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

### **Discussion**

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

#### *Phase I*

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate



application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

### *Phase II*

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.



**Fiscal Impact**

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed \$2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

**Rationale for Recommendation**

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader  
**Authorized Signature**

5/29/2019  
**Date**



**CalOptima**  
Better. Together.

# **Post-Acute Infection Prevention Quality Initiative**

**Regular Meeting of the Board of Directors  
June 6, 2019**

**Dr. Emily Fonda, MD, MMM, CHCQM**

**Medical Director**

**Care Management, Long-Term Services and Supports and  
Senior Programs**

# Background

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- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 → overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

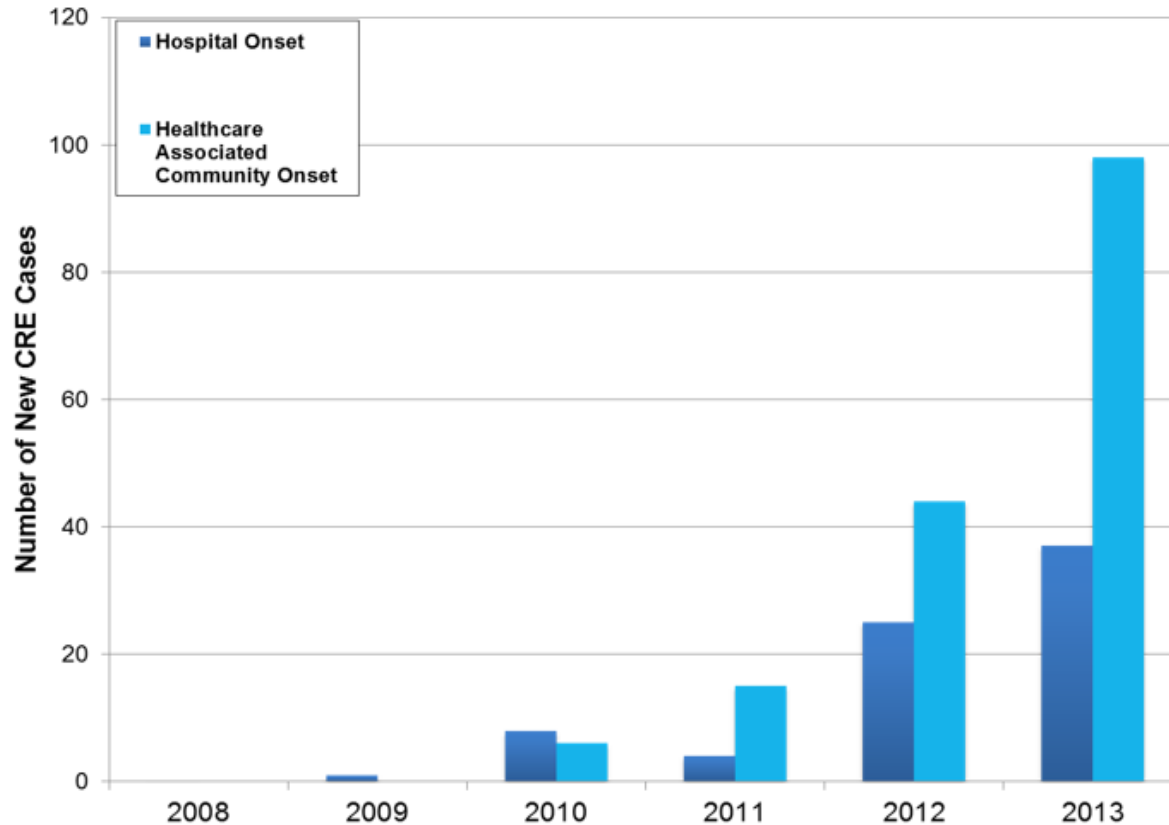
# Background

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- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15% of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

# CRE Trends in Orange County, CA

**Hospital and Healthcare-Associated Community  
Onset CRE Incidence**  
(N = 21 Hospitals)



Gohil S. AJIC 2017; 45:1177-82

# CDC Interest

Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency



Early Release / Vol. 64

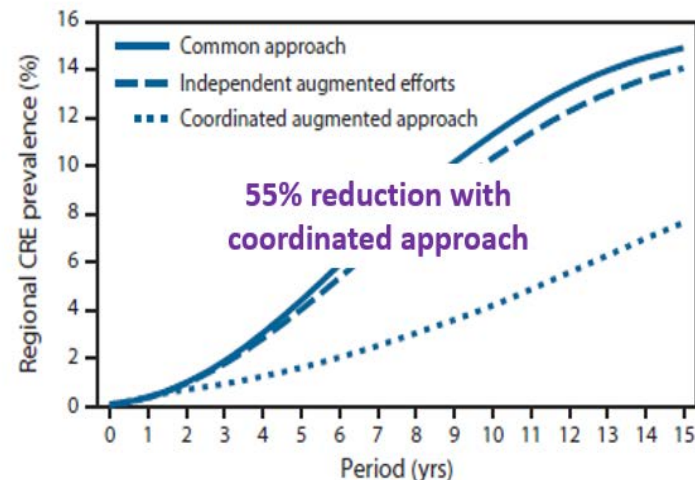
Morbidity and Mortality Weekly Report

August 4, 2015

## Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

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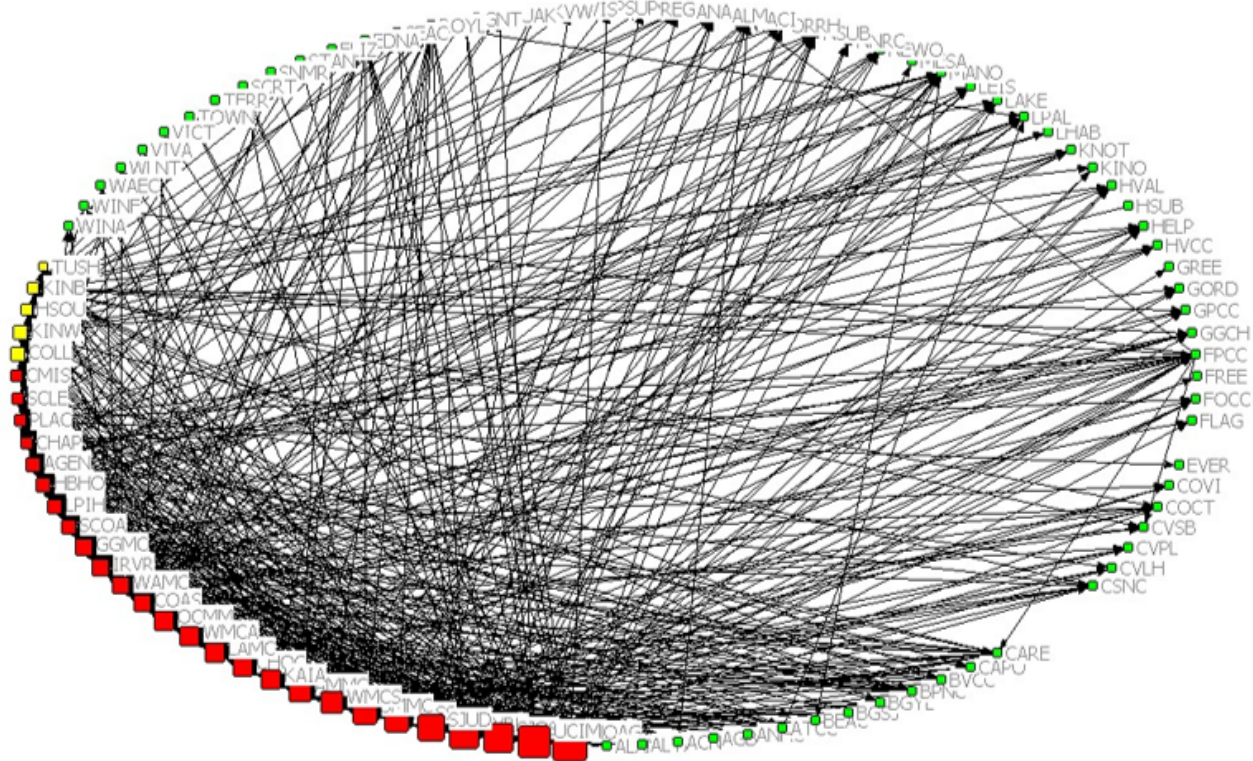
FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California\*



\* Additional information available at <http://www.cdc.gov/drugresistance/resources/publications.html>.

# Extent of the Problem

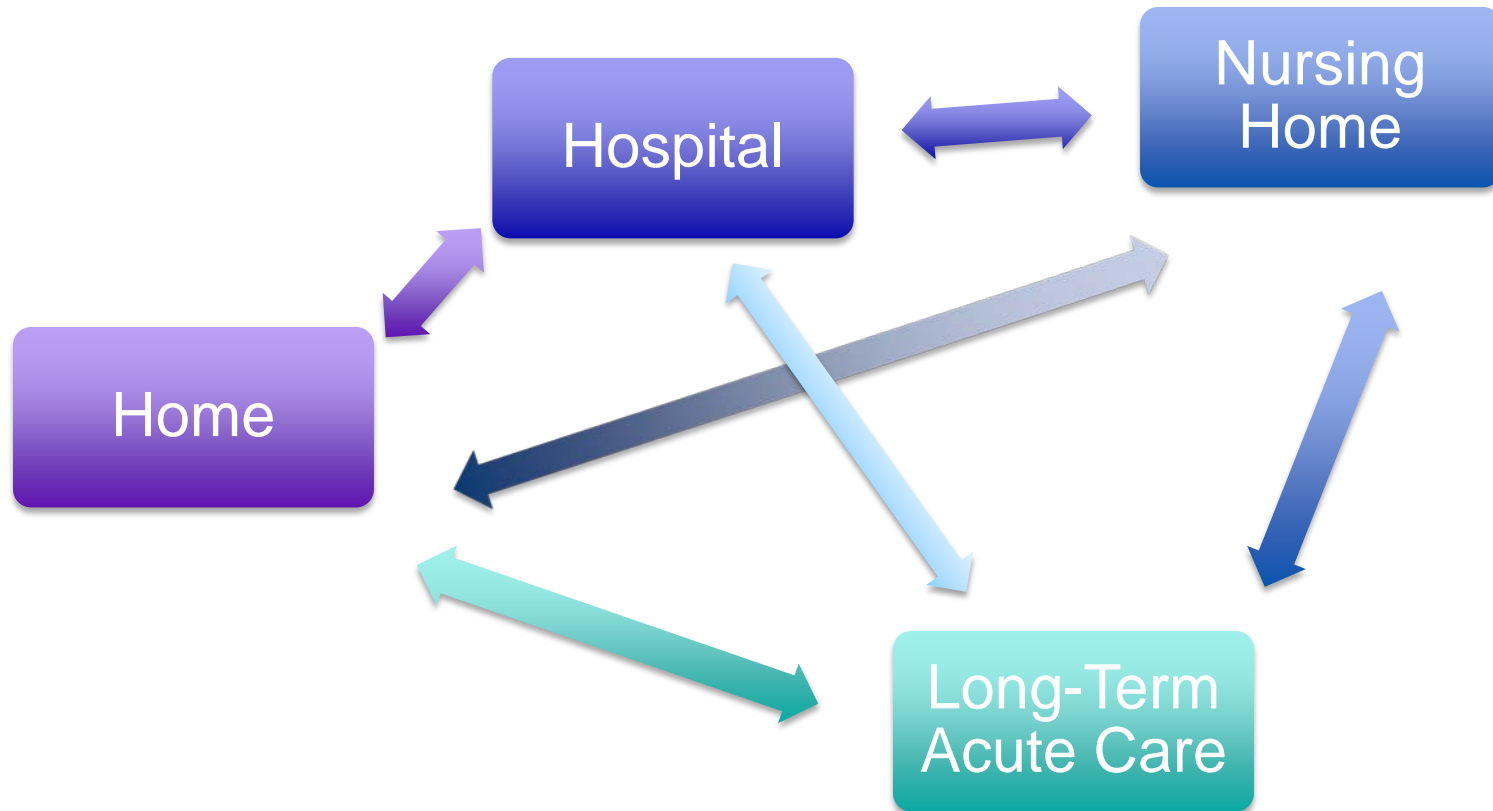
## OC Hospitals and Nursing Homes 10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342



# Extent of the Problem





# Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	900	<b>64%</b>	<b>42%</b>	<b>16%</b>	<b>34%</b>	<b>2%</b>

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored  $\geq 1$  MDRO unknown to facility

# Participating Health Care Facilities

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## 16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

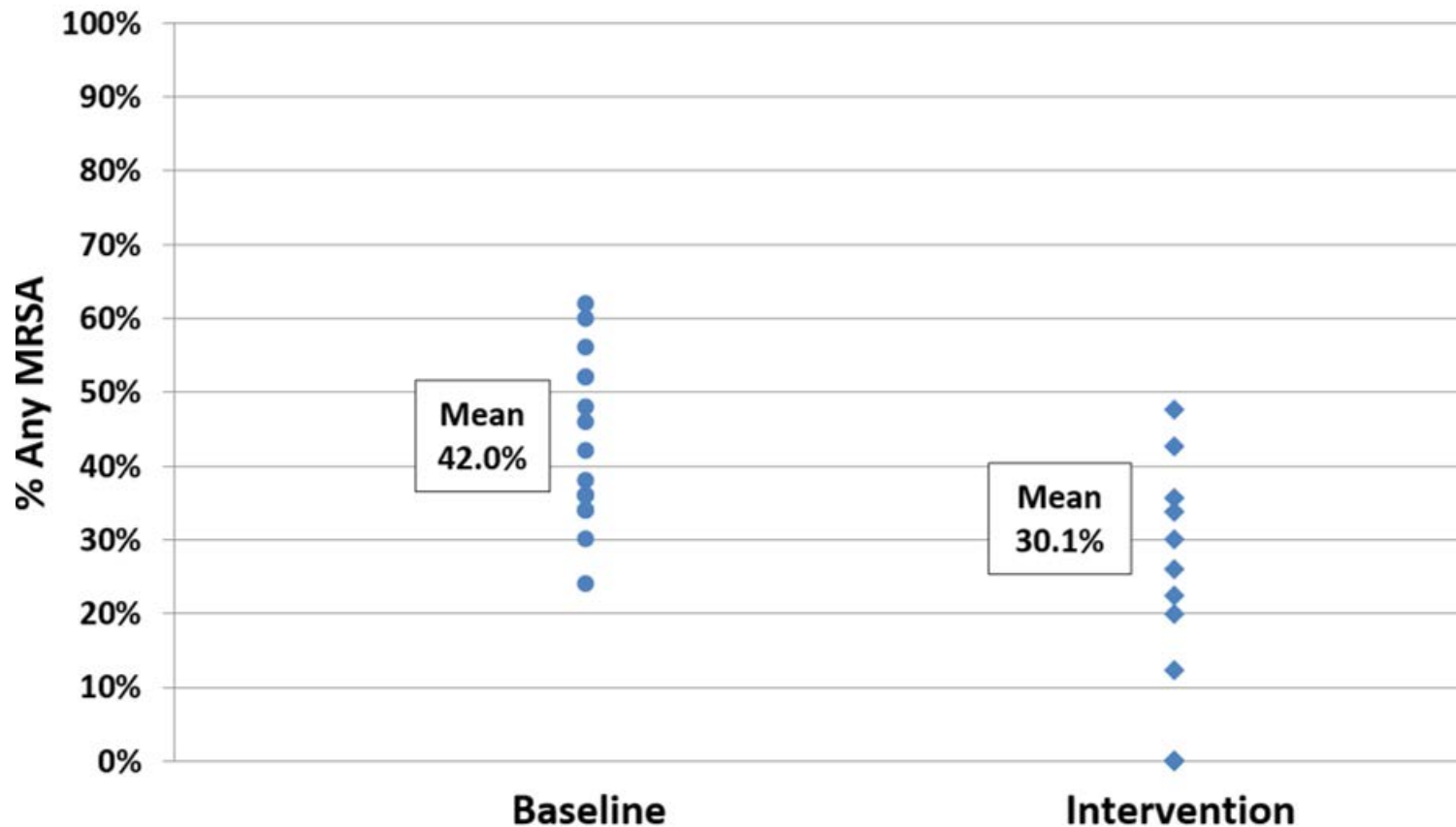
# SHIELD OC Decolonization Protocol

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- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - <https://www.cdc.gov/hai/research/cdc-mdro-project.html>
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

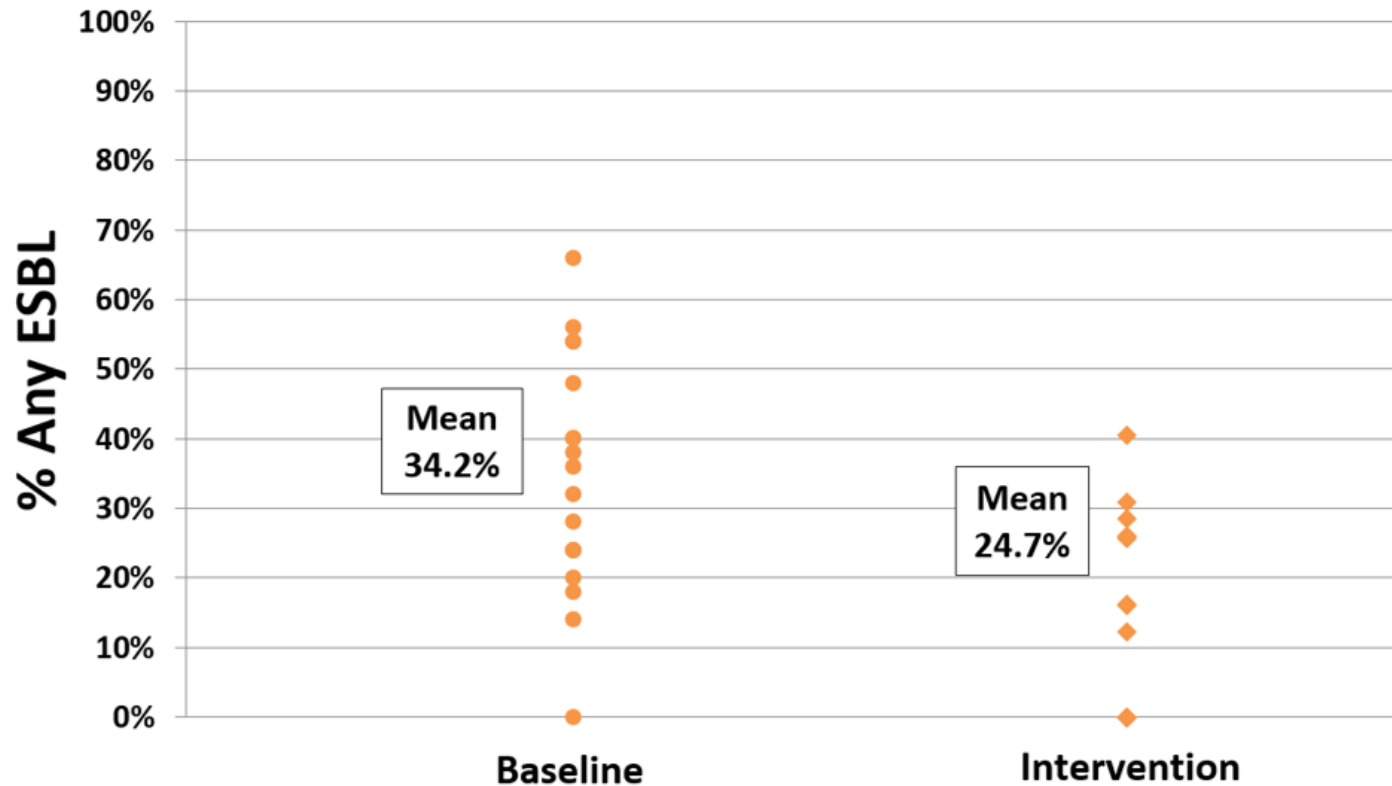
# SHIELD Outcomes

## SHIELD Impact: Nursing Homes 28% reduction in MRSA



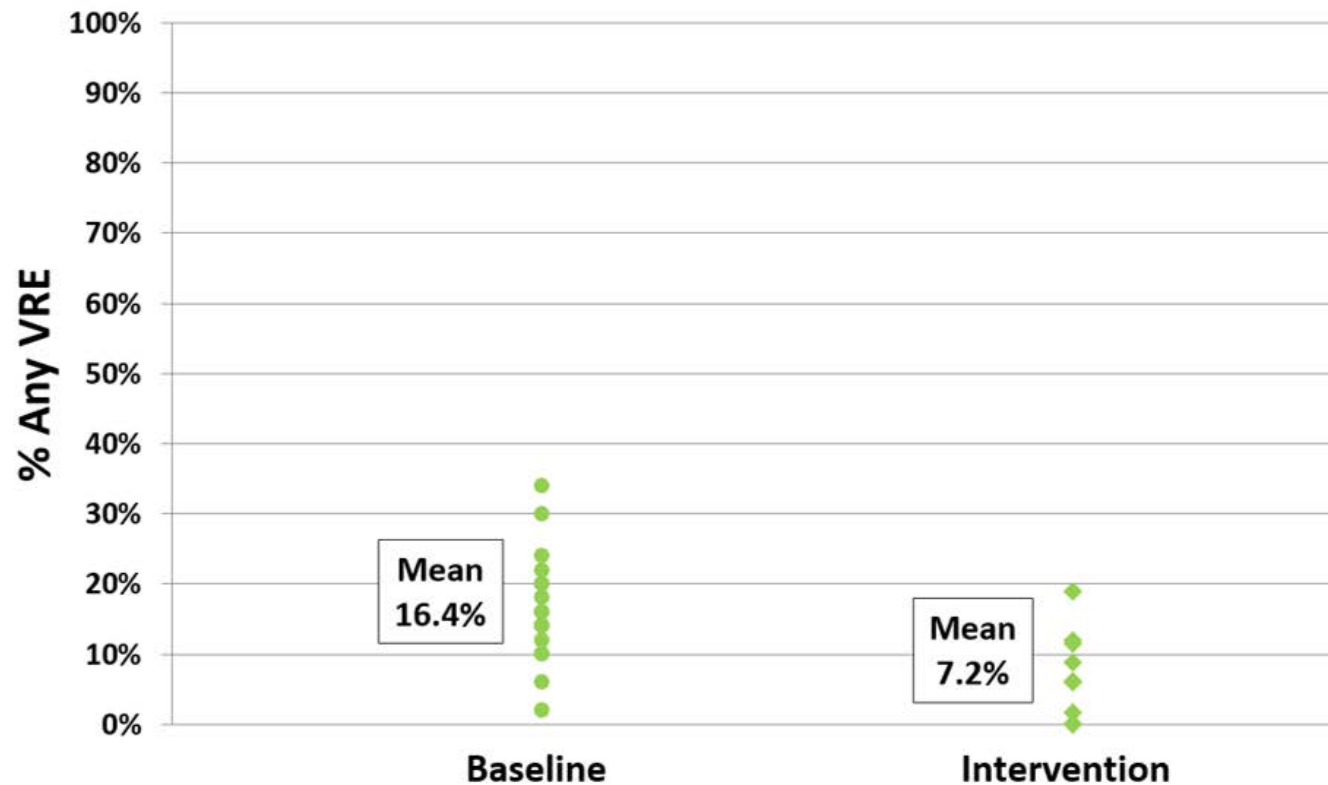
# SHIELD Outcomes (cont)

## SHIELD Impact: Nursing Homes 28% reduction in ESBLs



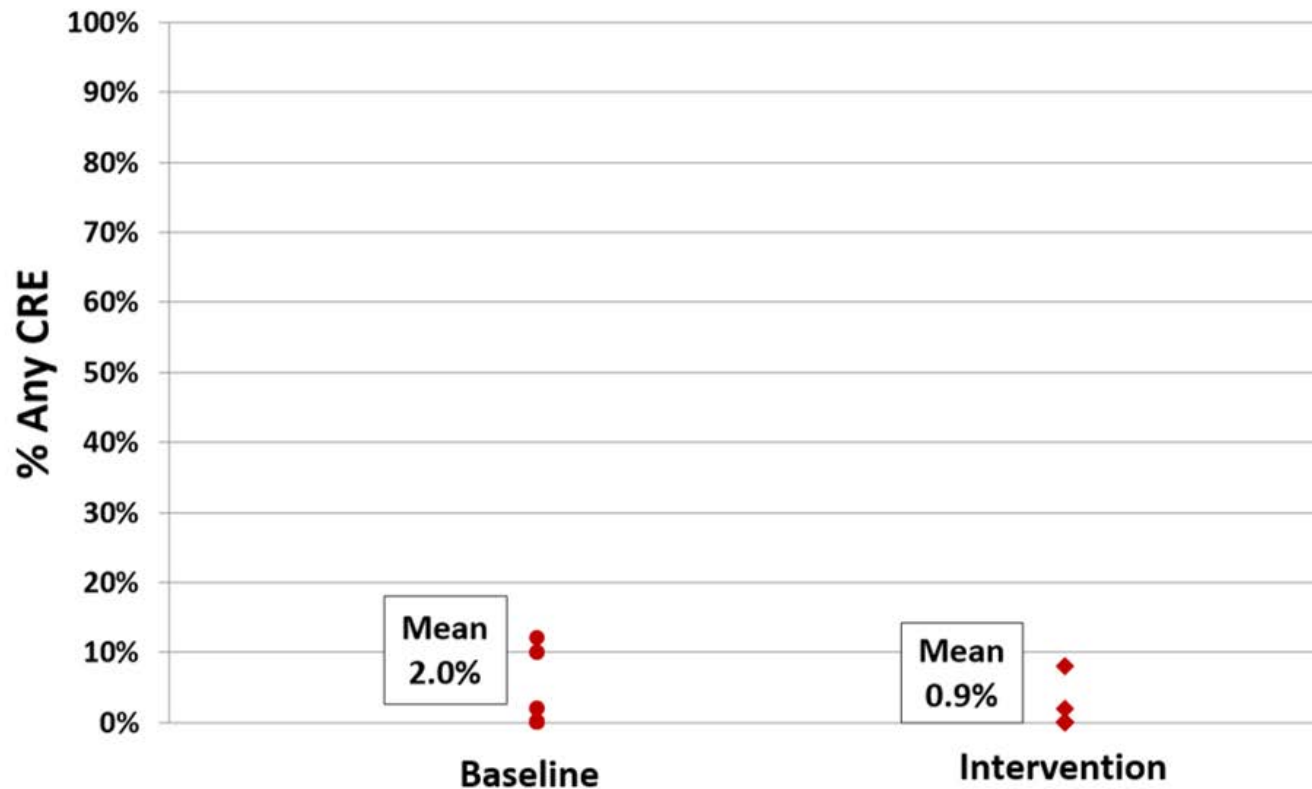
# SHIELD Outcomes (cont)

## SHIELD Impact: Nursing Homes 56% reduction in VRE



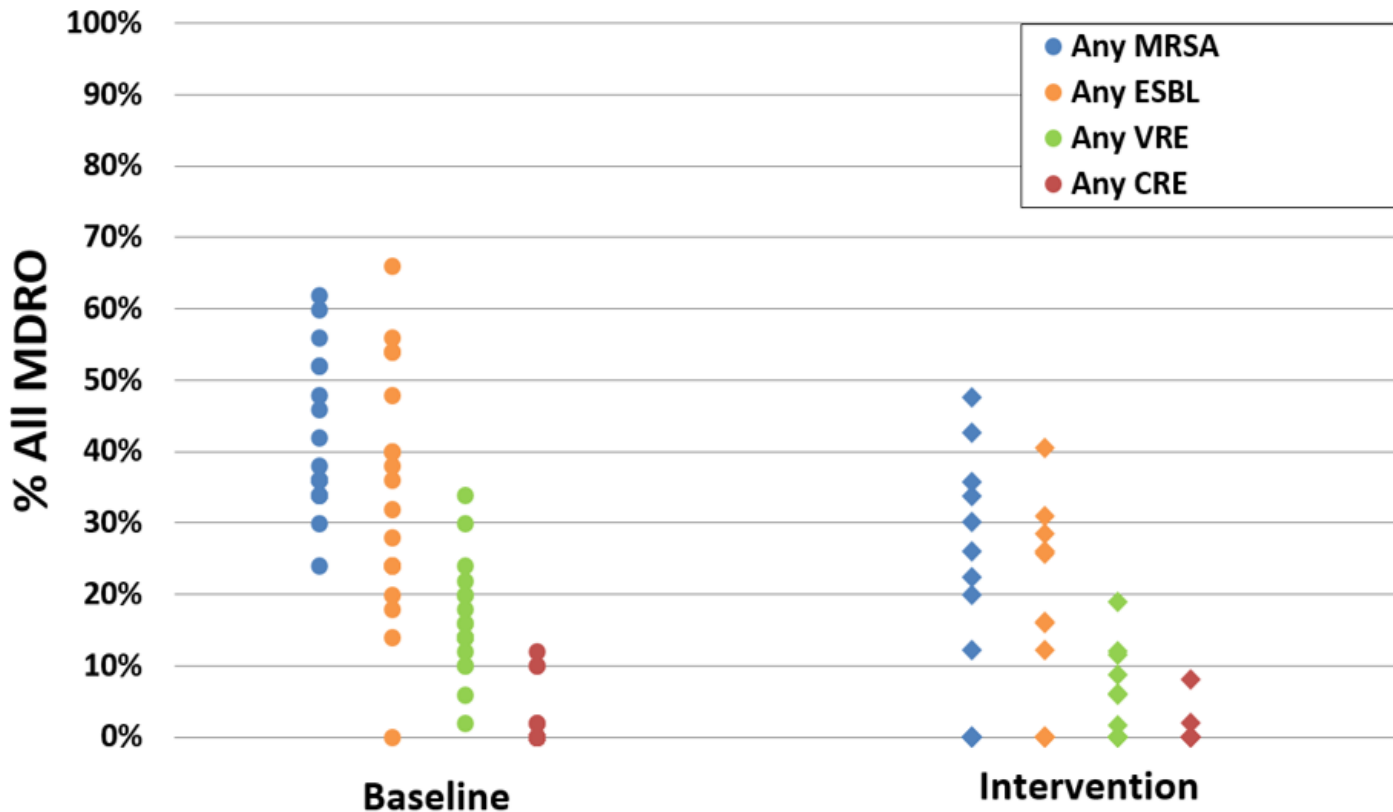
# SHIELD Outcomes (cont)

## SHIELD Impact: Nursing Homes 55% reduction in CRE



# SHIELD Outcomes (cont)

## SHIELD Impact: Nursing Homes 25% reduction in all MDROs





# Quarterly Inpatient Trends

## SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: **ORANGE**

From: **2015-10** To: **2018-12**

Category P - Primary Diagnosis

		Select Year-Month Begin 2015-10	Select Year-Month End 2018-12	Select Category P Diagnosis Level Category P - Primary Diagnosis	Select Risk Group * Multiple values	Select LTC Facility County ORANGE								
		<div style="display: flex; justify-content: space-around;"> <span>Before SHIELD OC</span> <span>During SHIELD OC</span> </div>												
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	\$682,769	\$854,676	\$1,159,922	\$920,317	\$1,691,337	\$1,231,903	\$997,810	\$1,236,197	\$634,628	\$979,762	\$1,113,238	\$1,176,910	\$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	\$133,362	\$311,661	\$124,676	\$189,669	\$227,224	\$209,419	\$175,738	\$164,181	\$40,354	\$84,565	\$127,609	\$41,123	\$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

\* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

# Quarterly Inpatient Trends

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- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = \$1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = \$468,009
    - \$728,002 lowered inpatient expenditure (61%) for infection in the participating facilities
- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters = \$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = \$3,761,009 if the CHG protocol had been expanded

# SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

# CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

# Recommended Actions

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- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to \$2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

# CalOptima's Mission

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



# CalOptima

Better. Together.





**Shared  
Healthcare  
Intervention to  
Eliminate  
Life-threatening  
Dissemination of MDROs in  
Orange County**

## **SHIELD Orange County – Together We Can Make a Difference!**

### **What is SHIELD Orange County?**

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

#### **SHIELD OC Goals:**

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

**Visit our CDC webpage here!**

<https://www.cdc.gov/hai/research/dc-mdro-project.html>

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

### **Who is participating?**

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

### **What is the decolonization intervention?**

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

**With questions, please contact the SHIELD OC Coordinating Team**

(949) 824-7806 or [SHIELDOrangeCounty@gmail.com](mailto:SHIELDOrangeCounty@gmail.com)





# CalOptima Checklist

Nursing Home Name: \_\_\_\_\_

Month Audited (Month/year): \_\_\_\_\_ / \_\_\_\_\_

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Completed by: \_\_\_\_\_

- Proof of product purchase
- Evidence the decolonization program handout is in admission packet
- Monitor and document compliance with bathing one day each week
- Monitor and document compliance with iodophor one day each week iodophor is used
- Conduct three peer-to-peer bathing skills assessments per month

## Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	<input type="checkbox"/>	_____ gallons	_____ gallons
10% Iodine Swabsticks	<input type="checkbox"/>	_____ boxes	_____ boxes

\_\_\_\_\_ swabs per box

### INTERNAL USE ONLY –APPROVAL:

Facility Name: \_\_\_\_\_ Unit: \_\_\_\_\_ Date: \_\_\_\_\_

## STAFF Skills Assessment: CHG Bed Bath Observation Checklist

### Individual Giving CHG Bath

Please indicate who performed the CHG bath.

Nursing Assistant (CNA)     Nurse     LVN     Other: \_\_\_\_\_

### Observed CHG Bathing Practices

Please check the appropriate response for each observation.

- Y     N    Resident received CHG bathing handout
- Y     N    Resident told that no rinse bath provides protection from germs
- Y     N    Provided rationale to the resident for not using soap at any time while in unit
- Y     N    Massaged skin *firmly* with CHG cloth to ensure adequate cleansing
- Y     N    Cleaned face and neck well
- Y     N    Cleaned between fingers and toes
- Y     N    Cleaned between all folds
- Y     N     N/A    Cleaned occlusive and semi-permeable dressings with CHG cloth
- Y     N     N/A    Cleaned 6 inches of all tubes, central lines, and drains closest to body
- Y     N     N/A    Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers
- Y     N     N/A    Used CHG on surgical wounds (unless primary dressing or packed)
- Y     N    Allowed CHG to air-dry / does not wipe off CHG
- Y     N    Disposed of used cloths in trash /does not flush

### Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

\_\_\_\_\_

2. If more than 6 cloths was used, provide reason.

\_\_\_\_\_

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

\_\_\_\_\_

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

\_\_\_\_\_

5. Do you ever wipe off the CHG after bathing?

\_\_\_\_\_

## ORIGINAL ARTICLE

# Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

## ABSTRACT

**BACKGROUND**

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

**METHODS**

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

**RESULTS**

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96;  $P=0.03$ ; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

**CONCLUSIONS**

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Huang at the University of California Irvine School of Medicine, Division of Infectious Diseases, 100 Theory, Suite 120, Irvine, CA 92617, or at sshuang@uci.edu.

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**M**ETHICILLIN-RESISTANT *STAPHYLOCOCCUS aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.<sup>1</sup> It is the most common cause of skin, soft-tissue, and procedure-related infections.<sup>2</sup> Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.<sup>1,3,4</sup>

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.<sup>5,6</sup> Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).<sup>7-10</sup> Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

## METHODS

### TRIAL DESIGN AND INTERVENTION

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge

(Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

### RECRUITMENT AND ELIGIBILITY CRITERIA

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

### FOLLOW-UP

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits (\$25, \$30, \$35, and \$50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

#### TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.<sup>11</sup> A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)<sup>12</sup> or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine ( $\geq 8 \mu\text{g}$  per milliliter) on microbroth dilution.<sup>13,14</sup> All outcomes were assessed on the basis of the first event per participant.

#### DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the par-

ticipant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and non-adherence (no doses used).

#### STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.<sup>15</sup> Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

## RESULTS

### PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ( $P=0.32$ ); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ( $P<0.001$ ); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ( $P=0.41$ ); and death in 10.7% (114) and 9.3% (98), respectively ( $P=0.26$ ). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

### OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approxi-

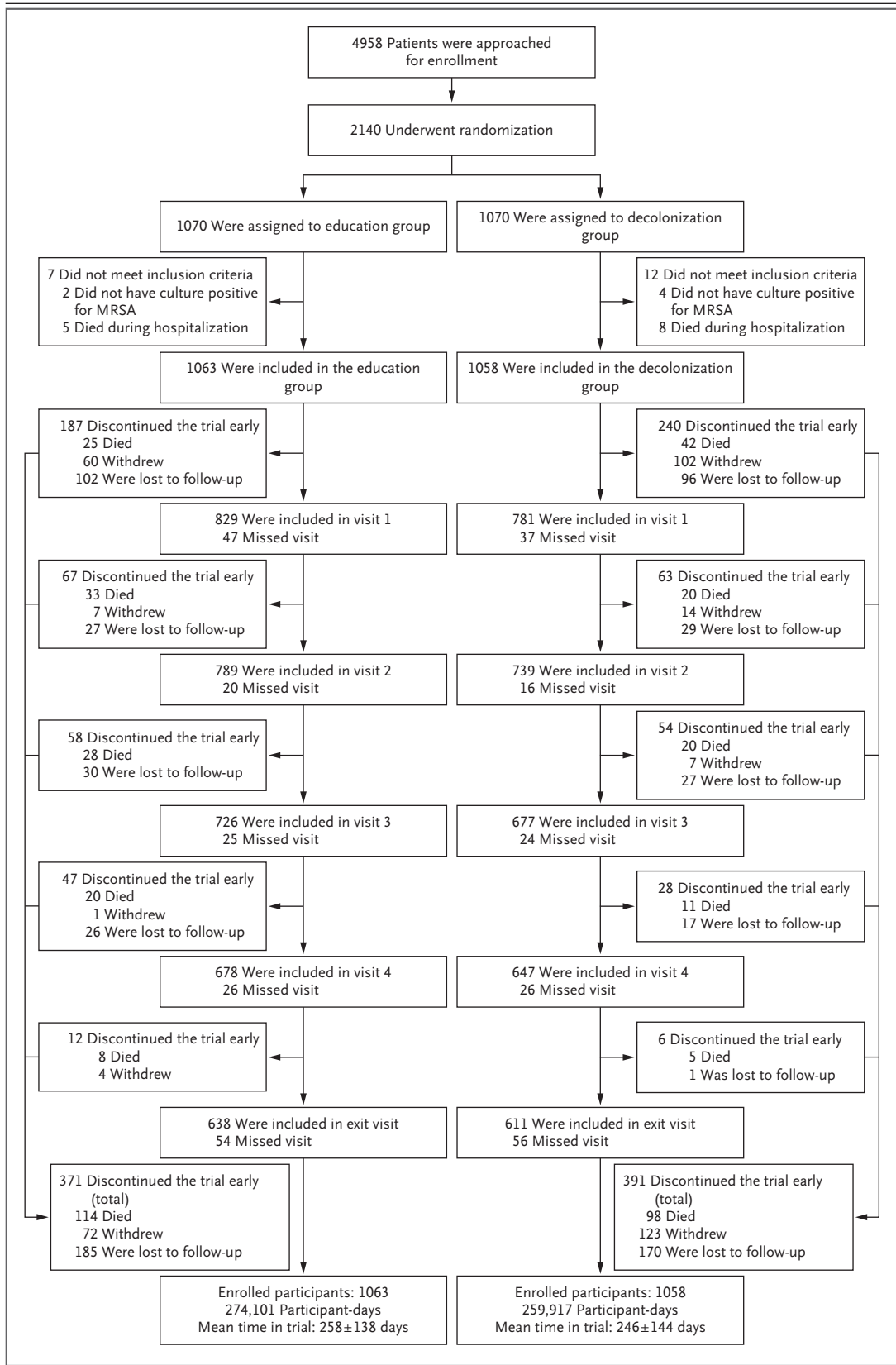
mately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a





**Figure 1 (facing page). Randomization and Follow-up of the Participants.**

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean ( $\pm$ SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI],

0.52 to 0.96;  $P=0.03$ ). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

**EFFECT OF ADHERENCE**

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-



**Table 1. Characteristics of the Participants at Recruitment Hospitalization.\***

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

\* Plus-minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.

† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.

‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.

§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.

¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.

|| By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).

\*\* Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.

†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.

‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

**Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.\***

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
<b>All Participants</b>								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading to hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
<b>Adherent Participants in Decolonization Group‡</b>								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

\* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.

† This was the primary outcome.

‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

**Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.\***

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
<b>Per-protocol analysis</b>				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96) <sup>†</sup>	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI) <sup>‡</sup>	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
<b>As-treated analysis<sup>§</sup></b>				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI) <sup>¶</sup>				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

\* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

<sup>†</sup> A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

<sup>‡</sup> Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

<sup>§</sup> The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

<sup>¶</sup> As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

#### NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infec-

tion was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

#### ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

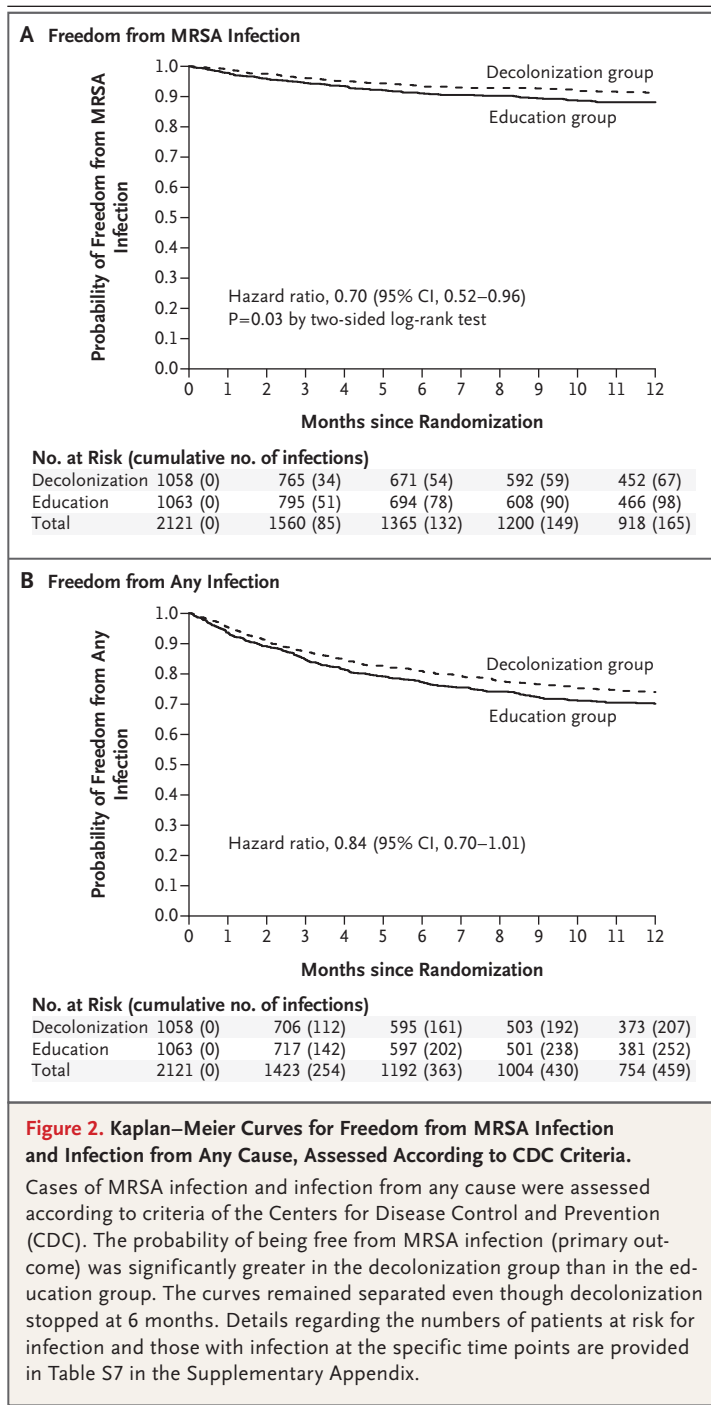
categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group,  $P=0.97$ ). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group,  $P=0.82$ ) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8  $\mu\text{g}$  or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8  $\mu\text{g}$  per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care-associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.<sup>16</sup> MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.<sup>1,17-19</sup> In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.<sup>16</sup>

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),<sup>6-10,19-22</sup> a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.<sup>23-26</sup> In contrast, twice-monthly decolonization



**Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.**

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

ing and mupirocin application.<sup>8,9,22</sup> This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.<sup>8,9,22</sup>

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.<sup>27-30</sup>

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and

reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8  $\mu\text{g}$  per milliliter, although 4% chlorhexidine applies 40,000  $\mu\text{g}$  per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.<sup>31-33</sup> It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive



cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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donated product from Stryker (Sage Products), Mölnlycke, and Medline; Dr. Weinstein, conducting clinical studies in which participating nursing homes and hospitals received donated products from Stryker (Sage Products) and Mölnlycke; Dr. Hayden, conducting clinical studies in which participating nursing homes and hospitals received donated product from Stryker (Sage Products), Mölnlycke, and Medline and donated laboratory services from OpGen and receiving grant support and conducting clinical studies in which participating nursing homes and hospitals received donated product from Clorox; and Dr. Miller, receiving grant support from Gilead Sciences, Merck, Abbott, Cepheid, Genentech, Atox Bio, and Paratek Pharmaceuticals, grant support and fees for serving on an advisory board from Achaogen and grant support, consulting fees, and fees for serving on an advisory board from Tetrphase and conducting clinical studies in which participating nursing homes and hospitals received donated products from Stryker (Sage Products), 3M, Clorox, Xttrium Laboratories, and Medline. No other potential conflict of interest relevant to this article was reported. Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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#### APPENDIX

The authors' full names and academic degrees are as follows: Susan S. Huang, M.D., M.P.H., Raveena Singh, M.A., James A. McKinnell, M.D., Steven Park, M.D., Ph.D., Adrijana Gombosev, M.S., Samantha J. Eells, M.P.H., Daniel L. Gillen, Ph.D., Diane Kim, B.S., Syma Rashid, M.D., Raul Macias-Gil, M.D., Michael A. Bolaris, M.D., Thomas Tjoa, M.P.H., M.S., Chenghua Cao, M.P.H., Suzie S. Hong, M.S., Jennifer Lequieu, B.S., Eric Cui, B.S., Justin Chang, B.S., Jiayi He, M.S., Kaye Evans, B.A., Ellena Peterson, Ph.D., Gail Simpson, M.D., Philip Robinson, M.D., Chester Choi, M.D., Charles C. Bailey, Jr., M.D., James D. Leo, M.D., Alpesh Amin, M.D., Donald Goldmann, M.D., John A. Jernigan, M.D., Richard Platt, M.D., Edward Septimus, M.D., Robert A. Weinstein, M.D., Mary K. Hayden, M.D., and Loren G. Miller, M.D., M.P.H.

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[PUBLIC HEALTH](#)

# Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 2019 5:00 AM ET

ANNA GORMAN



A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics.

*Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly \$8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said [Dr. John Jernigan](#), who directs the CDC's office on health care-acquired infection research.





"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to [15 percent of hospital patients and 65 percent of nursing home residents](#) harbor drug-resistant organisms, though not all of them will develop an infection, says [Dr. Susan Huang](#), who specializes in infectious diseases at the University of California, Irvine.

"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or [CRE](#), often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as [carbapenems](#). CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says [Dr. Michael Lin](#), an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which [has been shown](#) to reduce infections when patients bathe with it.





The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.

*Heidi de Marco/KHN*

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused [rare but severe allergic reactions](#).

In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a [Kaiser Health News analysis](#), and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.

In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says [Dr. Matthew Zahn](#), medical director of epidemiology at the Orange County Health Care Agency

"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.



Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.

*Heidi de Marco/KHN*

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, [published in February](#) in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.



"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator [Shaun Dahl](#) says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says. Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says. "This offers an opportunity to intervene and bend the curve in the right direction."

*Kaiser Health News is a nonprofit news service and editorially independent program of the Kaiser Family Foundation. KHN is not affiliated with Kaiser Permanente.*

# How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | Updated 1:47 p.m. ET April 12, 201

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly \$8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.





Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. (Photo: Heidi de Marco, Kaiser Health News)

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” *E. coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote handwashing and increased communication among hospitals about which patients carry the drug-resistant organisms.

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*Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.*





Centers for Disease Control  
and Prevention (CDC)  
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors  
505 City Parkway West  
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

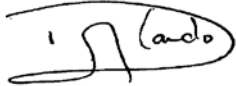
There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,

A handwritten signature in black ink, appearing to read "Denise Cardo". The signature is enclosed within a hand-drawn oval shape.

Denise Cardo, MD  
*Director*, Division of Healthcare Quality Promotion  
Centers for Disease Control and Prevention

## **Attachment 4: IGT Funding Proposals**

### **Proposal 1: Expanded Office Hours**

**Initiative Description:** The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

**Target Population(s):** Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

#### **Plan of Action/Key Milestones:**

High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
  - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
  - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
    - CPT code descriptions:
      - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
      - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
  - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
  - \$125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
  - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
  - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

5. Evaluation

- Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

**Estimated Budget:** Total \$2 million (up to \$500,000 for FY2019/20, remaining amounts from FY2019/20 and \$750,000 for FY2020/21, \$750,000 FY2021/22)

**Project Timeframe:** April 2020 – March 2022

**IGT 9 Focus Area:** Member access and engagement

**Strategic Plan Priority/Objectives:** Expand CalOptima’s Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

**Participating/Collaborating Partners/Vendors/Covered Entities:** Participating providers

## **Proposal 2: Post-Acute Infection Prevention Initiative (PIPOI)**

**Initiative Description:** Expand CalOptima’s program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima’s contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima’s Board of Directors on June 6, 2019.

### **Benefits of the Initiative:**

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
  - Potential improved Star ratings
  - Strengthens community and national partnerships:
    - UCI (Professor Susan Huang -Department of Infectious Diseases)
    - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
    - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
    - contracted nursing facilities
    - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

\*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It’s a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

**Target Member Population(s):** CalOptima Members receiving services at contracted nursing facilities

### **Plan of Action/Key Milestones:**

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

- B. Dedicate two Long Term Support Services Nurses to:
- 1) Provide training for newly participating facilities,
  - 2) Provide ongoing support and compliance monitoring\* at all participating facilities,
  - 3) Develop additional informing, training and monitoring materials.
- C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

\*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

**Estimated Budget:** Total budgeted amount \$3.4 million over 3 fiscal years (\$1 million for FY2019/20, \$1.2 million for FY 2020/21 and \$1.2 million for FY 2021/22)

**Project Timeframe:** Three years FY 2019/20– 2021/22

**IGT 9 Focus Area:** Quality performance and data exchange and support

**Strategic Plan Priority/Objectives:** Innovate and Be Proactive, Expand CalOptima’s Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

**Participating/Collaborating Partners/Vendors/Covered Entities:** University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

### **Proposal 3: Hospital Data Sharing Initiative**

**Initiative Description:** Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

**Target Population(s):** Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

**Plan of Action/Key Milestones:** Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

**Estimated Budget:** \$2 million to be exhausted by end of FY 2020-2021

**Project Timeframe:** Until end of FY 2020-2021

**IGT 9 Focus Area:** Data exchange and support

**Strategic Plan Priority/Objectives:** Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

**Participating/Collaborating Partners/Vendors/Covered Entities:** Hospitals providing the requested data

## **Proposal 4: Intergovernmental Transfer (IGT) Program Administration**

**Initiative Description:** Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

**Target Member Population(s):** NA

**Plan of Action/Key Milestones:** NA

**Estimated Budget:** \$2,000,000

**Project Timeframe:** Five-years

**IGT 9 Focus Area:** Other priority areas

**Strategic Plan Priority/Objectives:** Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

**Participating/Collaborating Partners/Vendors/Covered Entities:** NA



**Proposal 5: Whole Child Model (WCM) Program**

**Initiative Description:** To fund WCM program deficit in year one

**Target Member Population(s):** WCM eligible members (12,000 to 13,000)

**Plan of Action/Key Milestones:** N/A

**Estimated Budget:** Total \$31.1 million for FY 2019-20

**Project Timeframe:** FY 2019-20 (July 1, 2019 to June 30, 2020)

**IGT 9 Focus Area:** Other priority areas

**Strategic Plan Priority/Objectives:**

To Support care delivery for WCM population in FY 2019-20

- 1) Insufficient revenue from DHCS
- 2) Complexity in operation and financial reconciliation

**Participating/Collaborating Partners/Vendors/Covered Entities:** N/A

## CALOPTIMA BOARD ACTION AGENDA REFERRAL

### Action To Be Taken April 2, 2020 Regular Meeting of the CalOptima Board of Directors

#### Report Item

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

#### Contact

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

#### Recommended Actions

1. Authorize expenditure for CalOptima's participation in the following community events:
  - a. Up to \$1,000 and staff participation at the Orange County Women's Health Projects' 8<sup>th</sup> Annual Orange County Women's Health Summit on May 29, 2020 in on-line webinar format;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

#### Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

#### Discussion

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

- **Orange County Women's Health Projects' 8<sup>th</sup> Annual Orange County Women's Health Summit (virtual format)**. Staff recommends the authorization of expenditures for participation in the Orange County Women's Health Projects' 8<sup>th</sup> Annual Orange County Women's Health Summit. This is an educational event that will focus on "Women's Health Across the Lifespan." The event will share information on how Adverse Childhood Experiences (ACEs) result in

associated health conditions and diseases. Additional presentations will examine maternal mental health and concerns and associated health outcomes facing the LGBTQ and individuals, seniors and caregivers living in Orange County. Employee time will be used to participate in this event. A \$1,000 financial commitment for the Orange County Women's Health Projects' 8<sup>th</sup> Annual Orange County Women's Health Summit initially included: One (1) resource booth, CalOptima's name and logo on event promotional materials and social media and two (2) tickets for the event. Due to COVID-19, however, the format has been changed to an on-line webinar. As now proposed the CalOptima sponsorship will include a verbal recognition during welcome remarks and on welcome slides. In lieu of a resource booth, the sponsor plans to include CalOptima information in the electronic program; this will include a written description of programs and services and links to digital literature and resources, and contact information similar to what would be displayed on an exhibit table at an in-person event. Other sponsorship benefits will remain the same. Staff recommends continued support for this event, which is one of few events that focuses primarily on women's health issues and serves as an opportunity to increase CalOptima's visibility in the community. This request is being brought to the Board of Directors for approval to maintain compliance with Policy AA.1223, which requires that requests over \$1,000 per organization per fiscal year be brought to the Board for approval.

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 \$1,000 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 community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in

CalOptima Board Action Agenda Referral  
Consider Authorization of Expenditures in Support of CalOptima's  
Participation in Community Events  
Page 3

CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

**Concurrence**

Gary Crockett, Chief Counsel

**Attachment**

1. Entities Covered by this Recommended Board Action
2. Orange County Women's Health Project's Women's Health Summit Sponsorship Package

/s/ Michael Schrader  
**Authorized Signature**

03/26/2020  
**Date**

*Attachment 1 to April 2, 2020 Board of Directors Meeting – Agenda Item 27*

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Orange County Women's Health Project	4041 MacArthur Blvd., Suite 510	Newport Beach	CA	92660



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8<sup>th</sup> Orange County Women's Health Summit

# WOMEN'S HEALTH ACROSS THE LIFESPAN

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Opportunities for Sponsorship & In-kind Donation for



February 18, 2020

# ABOUT THE ORANGE COUNTY WOMEN'S HEALTH PROJECT

Since 2011, the Orange County Women's Health Project (OCWHP) has worked tirelessly to address gender parity in healthcare. Without it, women's health suffers, and so too does our overall community.

Although women and men have different health needs, healthcare policies have historically been made primarily — or only — with men in mind. Healthcare studies have been predominantly conducted on men and about men. As a result, half of the population's healthcare needs have not been adequately understood or addressed. This has a dramatic impact on the well-being of women, their children, their families, and our overall community. The OCWHP is committed to changing this by ensuring that women have a presence and voice in every important healthcare conversation throughout Orange County.

With a data-informed approach, the OCWHP shines a spotlight on women's health issues as they emerge, bringing attention and resources to bear on critical problems until long-term, sustainable, cross-sectoral solutions have been reached. The OCWHP's methodical process to identify the optimal path to positively impact women's health begins with researching and analyzing data, followed by trend studies, resources and gaps evaluation, and convening regional experts and stakeholders to develop strategies and recommendations. The OCWHP then mobilizes its base of over 90 partners to implement solutions through education, collaboration, and advocacy so that all Orange County women can live longer and thrive.

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# OCWHP CURRENT ISSUE AREAS

Unlike service providers which must focus on particular aspects of women's health, the OCWHP is uniquely positioned to let data drive the process. This is to say, while the organization as a whole exists to improve women's health outcomes in Orange County, the OCWHP is methodical about conducting ongoing needs assessments to understand existing and emerging issues in order to strategically direct resources toward solving critical problems. As a result, the OCWHP helps the community to create sustaining solutions driving toward the vision — to help Orange County women achieve optimal health and wellness — while also responding to new and changing health needs across the landscape.

Based on formal needs assessments, data collected at the annual Health Summits, stakeholder input, and progress made thus far, the OCWHP is currently focused on programming and activities in four key issue areas:

- **Women's Health Overall**
- **Health and Domestic Violence**
- **Teen Health**
- **Mental Health**





# WOMEN'S HEALTH DISPARITIES IN ORANGE COUNTY

- Orange County's **1.6 million women** do not have a county office or any government infrastructure to advocate and represent their health needs.
- Over one in four (26%) women in Orange County have experienced **physical or sexual violence by an intimate partner** and 69% of OC teens experience **dating abuse while in high school**.
- **Teen births** in the low-income cities in Orange County are significantly higher than the county, state, and national averages resulting in significant personal and societal costs. Estimated OC tax payer costs for teen births were \$35 million in 2013.
- Rates of **sexually transmitted infections** among Orange County youth are on the rise. In 2017, the rate of chlamydia rose by 9% among youth 15-24, chlamydia rates among female youth were nearly 3 times higher than among males. Within the same age group, the rate of gonorrhea increased 12% over 2016.
- Nearly 1 in 5 adults live with a **mental illness** with women more likely than men to both have mental illness and to be treated for it.



Orange County

**WOMEN'S HEALTH PROJECT**

The **OC WOMEN'S HEALTH PROJECT** is our region's voice to ensure that women's health remains a top priority so women can live longer, healthier, and happy lives. For when women thrive, so do their children, families, and communities.





## **ALLYSON W. SONENSHINE, JD**

Founding Director

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Allyson Sonenshine is a passionate women's health advocate with over 25 years of nonprofit, legal and volunteer experience. In 2011, she founded the Orange County Women's Health Project to address the lack of coordination around women's health in the county. Prior to the OCWHP, she helped establish the SOS-El Sol Wellness Center in Santa Ana, and before that, she was an attorney with Bingham McCutchen in Los Angeles.

Ms. Sonenshine has chaired the Boards of Directors for Essential Access Health and Planned Parenthood of Orange & San Bernardino Counties. She graduated with honors from the University of Pennsylvania and earned her JD at USC School of Law.

# ADVISORY BOARD

**Anabel Arroyo & Isabel Becerra**  
Coalition of Orange County Community Health Centers

**Candace W. Burton, PhD, RN**  
Sue & Bill Gross School of Nursing, UC Irvine

**DeVera Heard, EdD**  
Delta Sigma Theta Sorority OCAC  
National Council of Negro Women  
Retired Principal, SAUSD

**Carol Kim, MPH**  
Orange County United Way

**Roberta Lessor, PhD, RN**  
Professor Emeritus, Chapman University

**Georgina Maldonado**  
Community Health Initiative of Orange County

**Lisa Nguyen**  
CalOptima

**Ellen Olshansky, PhD, RN**  
Sue & Bill Gross School of Nursing, UC Irvine

**Pamela Pimentel, RN & Michele Silva**  
MOMS Orange County

**Maricela Rios-Faust, MSW**  
Human Options  
[Back to Agenda](#)

**Jennefer Russo, MD, MPH**  
Harbor UCLA Medical Center

**Mona Shah, JD, MPH**  
Independent Healthcare Consultant

**Nichole Quick, MD, MPH**  
OC Health Care Agency

**Sora Park Tanjasiri, DrPH, MPH**  
School of Medicine, UC Irvine

**Jacqueline Tran, DrPH, MPH**  
Independent Consultant





# OCWHPeeps

Peeps are community leaders that make our work possible by contributing financial support and volunteerism in our programs and special events. Peeps ensure that the OCWHP will continue to be Orange County's voice for women's health.

In addition to supporting women, Peeps' contributions makes a difference for all of Orange County; for when we improve women's health we positively impact the health of their children, families, and communities.



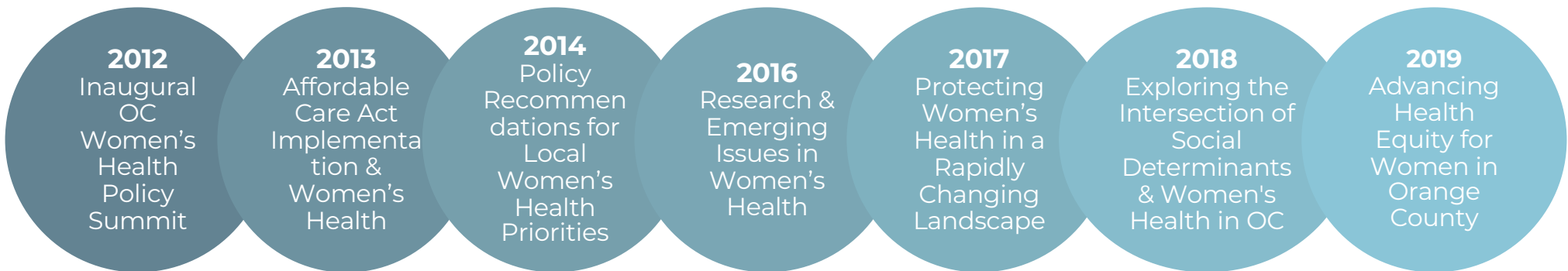
**peeps** pl (plural only)  
Noun. (slang)  
People; one's friends  
or associates.



# ORANGE COUNTY WOMEN'S HEALTH SUMMITS

The OCWHP's annual Orange County Women's Health Summit is the premiere conference for healthcare and social service professionals, researchers, educators, government and nonprofit staff, and advocates dedicated to women's health and well-being.

The Summits feature information about the state of women's health in Orange County, disparities and systems gaps affecting local women, women's health research, and the impact of the Affordable Care Act on women.





8<sup>th</sup> Orange County Women's Health Summit

# WOMEN'S HEALTH ACROSS THE LIFESPAN

**FRIDAY MAY 29, 2020**

9 AM • Beckman Center, UC Irvine

From childhood to older adulthood, girls and women may experience certain health conditions, diseases, and adverse experiences that impact their health differently than boys and men. This Summit will highlight some of the research that exemplifies these differences and will touch on some of the promising efforts that are in place to advance women's health across the lifespan.

Experts featured at this year's Summit will share how Adverse Childhood Experiences (ACEs) result in associated health conditions that impact girls' and women's health and may have long lasting health consequences. Additional presentations will examine maternal mental health, how certain mental health and substance use issues might be impacting women differently from men, and groundbreaking mental health initiatives taking root in OC. An afternoon panel will discuss barriers, concerns and the associated health outcomes facing LGBTQ+ individuals, seniors and caregivers living in Orange County.

Judy Belk, President and CEO of The California Wellness Foundation, will present the keynote address.



# EXCLUSIVE SPONSORSHIP OPPORTUNITIES FOR

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# PRESENTING SPONSOR \$50,000

Sponsorship benefits for 8<sup>th</sup> OC Women's Health Summit

- Exclusivity as Presenting Sponsor with **CalOptima** logo in print materials and signage
- Press Release
- 12 tickets with premier reserved seating to OC Women's Health Summit on Friday, May 29
- Premier logo recognition of **CalOptima** as Presenting Sponsor on all marketing materials and on the OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org)), plus link to corporate website
- **CalOptima** full page Sponsor Spotlight in Summit Program, OCWHP e-newsletter and social media
- Verbal Recognition at Summit
- Brief welcome remarks to open the Summit
- Premier exhibit table and opportunity to distribute **CalOptima** literature and branded takeaway to participants at Summit, cost to be covered by sponsor

# AMBASSADOR SPONSOR \$25,000

Sponsorship benefits for 8th OC Women's Health Summit

- Premium logo recognition of **CalOptima** in print materials and signage
- 12 tickets with premium reserved seating to OC Women's Health Summit on Friday, May 29
- Premium logo recognition of **CalOptima** on all marketing materials and on the OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org)), plus link to corporate website
- **CalOptima** full page Sponsor Spotlight in OCWHP e-newsletter and social media
- Verbal recognition at Film Screening and Summit
- Premium exhibit table and opportunity to distribute **CalOptima** literature and branded takeaway to participants at Summit, cost to be covered by sponsor

# CHAMPION \$10,000

Sponsorship benefits for 8<sup>th</sup> OC Women's Health Summit

- Prominent logo recognition of **CalOptima** in print materials and signage
- 10 tickets with prominent reserved seating to OC Women's Health Summit on Friday, May 29
- Prominent logo recognition of **CalOptima** on all marketing materials and on the OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org)), plus link to corporate website
- **CalOptima** Sponsor Spotlight in OCWHP e-newsletter and social media
- Verbal recognition at Summit
- Prominent exhibit table and opportunity to distribute **CalOptima** literature and branded takeaway to participants at Summit, cost to be covered by sponsor

# GUARDIAN \$5,000

Sponsorship benefits for 8<sup>th</sup> OC Women's Health Summit

- Preferred logo recognition of **CalOptima** in print materials and signage
- 6 tickets with preferred reserved seating to OC Women's Health Summit on Friday, May 29
- Preferred logo recognition of **CalOptima** on all marketing materials and on the OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org))
- **CalOptima** logo in OCWHP e-newsletter and social media
- Preferred exhibit table and opportunity to distribute **CalOptima** literature and branded takeaway to participants at Summit, cost to be covered by sponsor

# ADVOCATE \$2,500

Sponsorship benefits for 8<sup>th</sup> OC Women's Health Summit

- Preferred logo recognition of **CalOptima** in print materials and signage
- 4 tickets with preferred reserved seating to OC Women's Health Summit on Friday, May 29
- Preferred logo recognition of **CalOptima** on all marketing materials and on the OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org))
- **CalOptima** logo in OCWHP e-newsletter and social media
- Preferred exhibit table and opportunity to distribute **CalOptima** literature and branded takeaway to participants at Summit, cost to be covered by sponsor

# ACTIVIST \$1,000

Sponsorship benefits for 8<sup>th</sup> OC Women's Health Summit

- Preferred logo recognition of **CalOptima** in print materials and signage
- 2 tickets with preferred reserved seating to OC Women's Health Summit on Friday, May 29
- Preferred logo recognition of **CalOptima** on all marketing materials and on the OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org))
- **CalOptima** logo in OCWHP e-newsletter and social media
- Preferred exhibit table and opportunity to distribute **CalOptima** literature and branded takeaway to participants at Summit, cost to be covered by sponsor

# IN-KIND DONATION OPPORTUNITIES

In-kind donations will be acknowledged with the following recognition and benefits:

- CalOptima logo recognition on:
  - OCWHP's website ([www.ocwomenshealth.org](http://www.ocwomenshealth.org)) and marketing materials
  - OCWHP social media
  - Printed program

Appreciated in-kind donations include food and beverage items, centerpieces for tables, printing, photography, and rentals.

# SPONSORSHIP DEADLINES

**Tuesday, March 31** for recognition on Summit registration website

**Friday, May 8** for recognition in Summit program

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## CONTACT

### SYDNEY MINCHIN

Program and Events Coordinator

(714) 516 - 8263

[minchin@ocwomenshealth.org](mailto:minchin@ocwomenshealth.org)

4041 MacArthur Blvd., Ste 510  
Newport Beach, CA 92660

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**From:** [Kaaiakamanu, Tiffany](#)  
**To:** [Allyson Sonenshine](#)  
**Cc:** [Minchin Sydney](#)  
**Subject:** RE: CalOptima- Status of the Women's Health Summit  
**Date:** Tuesday, March 17, 2020 3:21:00 PM  
**Attachments:** [image001.png](#)

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Greetings Allyson-

Thanks for clarifying. The update will read:

- Sponsors will be verbally recognized during the welcome remarks and on the welcome slides
- Sponsors can provide a written description, links to digital literature/resources, and contact information in the electronic program, similar to what would be displayed on an exhibit table at an in-person event

I started tele-working today and am working on transferring calls to my cell phone. Thank you for your time!

Take care,

**Tiffany Kaaiakamanu**  
Community Relations Manager



**CalOptima**  
Better. Together.

CalOptima, A Public Agency  
505 City Parkway West, Orange, CA 92868  
Direct: 657.235.6872 | Cell: 714.222.0637 | Fax: 714-338-3141  
[www.caloptima.org](http://www.caloptima.org) | [Facebook](#) | [Twitter](#)

### Leading California in Medi-Cal Quality

—NCQA's Medicaid Health Insurance Plan Ratings 2019–2020

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**From:** Allyson Sonenshine <sonenshine@ocwomenshealth.org>

**Sent:** Tuesday, March 17, 2020 3:12 PM

**To:** Kaaiakamanu, Tiffany <tkaaikamanu@caloptima.org>

**Cc:** Minchin Sydney <minchin@ocwomenshealth.org>

**Subject:** Re: CalOptima- Status of the Women's Health Summit

**WARNING: This email originated outside of CalOptima. Even if this looks like a CalOptima email, it is not. DO NOT provide your username, password, or any other personal information in response to this or any other email.**

**CALOPTIMA WILL NEVER ask you for your username or password via email.**

**DO NOT CLICK links or attachments unless you are positive the content is safe.**

Hi Tiffany,

I just left a voicemail and am following up to clarify - point 1 below is accurate, but points 2 and 3 require some clarification. Sorry for any confusion.

Normally during an in-person Summit we distribute printed Programs that are typically 10-12 pages long and include a front title cover, back cover listing the Advisory Board, a sponsor page, an agenda, bios, substantive content related to the Summit theme, and lined pages for notes. In the sponsor page we list the sponsors according to tiered sponsorship levels and include logos when available.

If we move the Summit online, we would still prepare a Program but it would be electronic, not printed. And to provide some additional benefit to sponsors in lieu of an exhibit table, we could give each sponsor some space (commensurate with the sponsorship level) to provide a written description of your programs, contact info, and links to digital resources/your website. The idea would be to provide a virtual exhibit table inside the electronic Program.

Unfortunately, we are unable to have sponsors provide an oral description of programs during the Summit, whether it is an in-person Summit or an online (digital) Summit.

With this in mind, how about we combine points 2 and 3 to read as follows:

“Sponsors can provide a written description, links to digital literature/resources, and contact information in the electronic program, similar to what would be displayed on an exhibit table at an in-person event.”

I hope this makes sense and am happy to discuss on the phone if that is easier.

Thank you very much,

Allyson W. Sonenshine, JD, Project Director  
Orange County Women's Health Project  
(949) 246-6404 Cell

Sent from my iPhone

On Mar 17, 2020, at 2:36 PM, Kaaiakamanu, Tiffany <[tkaaiakamanu@caloptima.org](mailto:tkaaiakamanu@caloptima.org)> wrote:

Thank you Allyson!

I imagine there are a lot of things to consider given the new format and apologize for the inconvenience. I will update my report to include:

- Sponsors will be verbally recognized during the welcome remarks and on the welcome slides
- Sponsors can provide a description of their services/programs during the digital program
- Links to digital literature/resources, and contact information, similar to what would be displayed on an exhibit table at an in-person event

I would greatly appreciate it if you could confirm these added benefits for our sponsorship. I will update my Board report once confirmed. Thank you again!

I hope you both stay safe and healthy!!!

**Tiffany Kaaiakamanu**  
Community Relations Manager

<image001.png>

CalOptima, A Public Agency  
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Direct: 657.235.6872 | Cell: 714.222.0637 | Fax: 714-338-3141  
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## Leading California in Medi-Cal Quality

—NCQA's Medicaid Health Insurance Plan Ratings 2019–2020

---

**From:** Allyson Sonenshine <[sonenshine@ocwomenshealth.org](mailto:sonenshine@ocwomenshealth.org)>

**Sent:** Tuesday, March 17, 2020 1:47 PM

**To:** Kaaiakamanu, Tiffany <[tkaaiakamanu@caloptima.org](mailto:tkaaiakamanu@caloptima.org)>

**Cc:** Minchin Sydney <[minchin@ocwomenshealth.org](mailto:minchin@ocwomenshealth.org)>

**Subject:** Re: CalOptima- Status of the Women's Health Summit

**Importance:** High

**WARNING: This email originated outside of CalOptima. Even if this looks like a CalOptima email, it is not. DO NOT provide your username, password, or any other personal information in response to this or any other email.**

**CALOPTIMA WILL NEVER ask you for your username or password via email.**



## **Board of Directors Meeting April 2, 2020**

### **Member Advisory Committee (MAC) Update**

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#### **February 25, 2020 Special MAC Meeting**

At the February 25, 2020 special meeting, the MAC members approved the recommendation to forward to the Board, a candidate for the Persons with Disabilities Representative seat for appointment.

Michael Schrader, Chief Executive Officer provided an update on how the recognition CalOptima's Program of All-Inclusive Care to the Elderly (PACE) had received for successfully increasing access to services by the National PACE Association. PACE also received distinctions for having achieved a "Supernova" and "Shooting Stars" status for showing growth of more than 90% in the fourth quarter of 2019.

Ladan Khamseh, Chief Operating Officer, provided An update on the Qualified Medicare Beneficiary (QMB) program and how CalOptima continued to reach out to members who had Medicare Part B to notify them that they may qualify for Medicare Part A. Ms. Khamseh also discussed the recent OneCare/OneCare Connect Behavioral Health transition from Magellan to CalOptima.

David Ramirez, M.D., Chief Medical Officer, explained to the MAC that one of CalOptima's priority areas was member's access to care which included telehealth and after hours care. Funding source would be to use approved Intergovernmental Transfer (IGT) 9 funds. Dr. Ramirez also answered questions regarding the COVID-19 virus.

Betsy Ha, Executive Director, Quality and Population Health Management provided an in-depth and relevant presentation on Trauma-Informed Care and Adverse Childhood Screening (ACE). MAC members asked Ms. Ha to keep the committee updated on any changes to this program.

MAC also received updates from Tracy Hitzeman, Executive Director, Clinical Operations on the Health Homes Program, an IGT 9 presentation from Candice Gomez, Executive Director, Program Implementation, Information on the CalAIM program from Pallavi Patel, Director, Program Excellence and Edwin Poon, Ph.D., Director of Behavioral Health Services provided an update on the Behavioral Health Transition.

MAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the MAC's current activities.

## **Board of Directors Meeting April 2, 2020**

### **Provider Advisory Committee (PAC) Update**

---

#### **March 12, 2020 PAC Meeting**

At the March 12, 2020 Provider Advisory Committee (PAC) meeting, the members welcomed the new Orange County Health Care Agency Representative (OCHCA), Andrew Inglis, M.D.

Michael Schrader, Chief Executive Officer, updated the members on the All Plan CEO Meeting he attended in Sacramento. Mr. Schrader also provided a brief update on the Coronavirus (COVID-19), and the CalAIM Program.

Ladan Khamseh, Chief Operating Officer, updated the members on the Qualified Medicare Beneficiary (QMB) Program outreach to members.

David Ramirez, M.D., Chief Medical Officer, updated the members on CalOptima's incentives for Skilled Nursing Facilities (SNFs) and the Medication Assisted Therapy program's (MAT) pharmacy waiver. Dr. Ramirez noted that CalOptima members will be able to refill prescriptions earlier due to the COVID-19 epidemic.

PAC received a quarterly financial update from Nancy Huang, Chief Financial Officer and an informative presentation on the Coronavirus (COVID-19) update by Miles Masatsugu, M.D., Medical Director, as well as a Whole-Child Model Update from Tracy Hitzeman, Executive Director, Clinical Operations, a Member Advisory Committee (MAC) update from MAC Chair Christine Tolbert, and an Intergovernmental Transfer (IGT) 9 update from Debra Kegel, Director, Strategic Development.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.



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## **Board of Directors Meeting April 2, 2020**

### **OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee Update**

---

At the February 27, 2020 OneCare Connect Member Advisory Committee (OCC MAC) meeting, Michael Schrader, Chief Executive Officer, updated the members on the various awards received by the PACE program.

Ladan Khamseh, Chief Operating Officer, discussed the Qualified Medicare Beneficiary (QMB) Program and provided an overview of the QMB program that allows members to receive assistance from the State to pay their Medicare premiums. This program helps pay for Part A and Part B premiums, deductibles, coinsurance, and copayments. She noted that 69% of members who had received the outreach calls had returned the appropriate form.

David Ramirez, M.D., Chief Medical Officer, discussed the Coronavirus (COVID-19) and how CalOptima will continue to update members as necessary.

OCC MAC received updates on the Health Homes Program, an Intergovernmental Transfer (IGT) 9 verbal report, a presentation on the proposed CalAIM program and a Behavioral Health transition update.

OCC MAC formed a Goals and Objectives Ad Hoc to review the CalOptima 2020-22 Strategic Plan. They will work with the Member Advisory Committee and the Provider Advisory Committee to formulate these goals and objectives for each committee.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.



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# **Coronavirus Disease 2019 (COVID-19) Update**

**CalOptima Board Meeting**  
**April 2, 2020**

**David Ramirez, M.D., Chief Medical Officer**  
**Miles Masatsugu, M.D., Medical Director**

# CalOptima COVID-19 Response

---

- Goals

- Educate members and ensure they have access to needed care while reducing the risk of COVID-19 spread
- Educate and support providers and the local health care system as they respond to COVID-19
- Support and protect CalOptima staff
- Coordinate with county, state and federal public health efforts

# Regulatory Directives

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- The Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) have issued a number of regulatory directives
  - Cover testing, treatment and vaccines without out-of-pocket expenses for members
  - Expand use of telehealth as clinically appropriate
  - Suspend in-person visit requirements
  - Report COVID-19 cases to DHCS daily
  - Implement 1135 Waiver provisions to speed enrollment of members and providers
  - Implement ICD/HCPCS/CPT codes for COVID-19

# CalOptima COVID-19 Response

---

- Completed actions
  - Created COVID-19 response team
  - Transitioned CalOptima meetings to virtual formats
  - Reviewed and updated the Business Continuity Plan
  - Closed the building to external visitors and members
  - Retained COVID-19 medical director consultants
- Ongoing efforts
  - Holding four regular COVID-19 meetings
    - Response team
    - Directors
    - Communications team
    - Executive team
  - Increasing building cleaning to three times per day

# Members: Pharmacy

---

- Authorizing early refills if requested
- Allowing 90-day fills
- Added disinfectants to the formulary
- Added dextromethorphan and acetaminophen to formulary
- Added hydroxychloroquine prior authorization



# Members: Telehealth

---

- Using remote and virtual services to limit person-to-person contact
- Allowing provider visits using telephones and other non-public communications during national emergency
- Distributed provider telehealth FAQs and updated telehealth policy
- Separately seeking Board authority to retain virtual care expert to consult on rapidly expanding telehealth access and options
- Working to update existing nurse advice line agreement to add physician virtual visits as an option for members, per DHCS Director request

# Members: Vulnerable Populations

---

- Clinical Field Teams
  - Three teams continuing to serve homeless population, Homeless Response Team referral phone line remains open, CalOptima staff supporting with remote services, CalOptima encouraging remote visits, collaborating with county and community clinics
- Health Homes Program
  - Suspended face-to-face visit requirement, continuing telephonic care coordination and housing supportive services
- Medi-Cal/OneCare Connect/OneCare Seniors and Persons with Disabilities Model of Care
  - Suspended face-to-face visits, continuing to support members via telephonic and written processes

# Members: Vulnerable Populations (Cont.)

- Community-Based Adult Services (CBAS)
  - DHCS submitted 1135 Waiver request to CMS to permit CBAS centers to modify service delivery
  - CalOptima requesting Board approval to align reimbursement
- Program of All-Inclusive Care for the Elderly (PACE)
  - Day center transitioned to “PACE without walls” by providing services at home, delivering meals and equipment, and performing daily wellness calls
  - Clinic remains open, piloting drive-thru testing but having enough personal protective equipment is an issue
- Long-Term Care Facilities
  - Stopped facility visits by CalOptima staff
  - Approving all continuation requests

# Providers: Reimbursement Changes

---

- Proposing 5% capitation increase for health networks during emergency period
  - Up to \$14 million
  - April 1 to June 30, 2020
- Implementing new procedure codes and provider reimbursement rates for coronavirus testing
- Aligning provider credentialing with Medi-Cal enrollment changes to improve timeliness

# Staff: Temporary Telework

---

- Increased staff working from home in eight days
  - 1,355 employees total
  - Baseline: 27% teleworkers, 73% non-teleworkers
  - Current: 82% teleworkers, 18% non-teleworkers
  - Temporary telework equipment: Up to \$915,000 (April COBAR)
- Categorized staff
  - Positions able to telework
  - Positions not able to telework
- Transitioned positions able to telework based on
  - High-risk individuals
  - Member-facing functions
- Telework is currently voluntary

# COVID-19 Monitoring

---

- CalOptima has created several mechanisms to monitor key areas of activity during the emergency
  - Provider access issues
  - Internal key performance metrics
    - Member call volumes and service levels
    - Authorization volumes and timeliness
    - Claims payment
  - Communications distributed by audience
  - Actions log
  - Regulatory directives

# COVID-19 Communications

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- Members
  - Resource information on website, member portal and social media
- Providers and Health Networks
  - Regular updates in weekly health network newsletter
  - Resource information on CalOptima website and via fax
- Staff
  - All-staff informational webinars
  - Dedicated email boxes for COVID-19 questions and HR issues
- Community-Based Organizations
  - Community alerts via electronic newsletter
- Public
  - COVID-19 updates at public Board and committee meetings

# COVID-19 Collaboration

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- State and County Health Officials
  - Regular calls with Orange County Health Officer Nichole Quick, M.D., and Orange County Health Care Agency
  - California Department of Public Health (CDPH) alerts
  - Weekly CDPH call participation
  - DHCS medical directors and health plan chief medical officer meetings/calls
- State and National Associations
  - Information-sharing calls with California Association of Health Plans, Local Health Plans of California and America's Health Insurance Plans



# CalOptima's Mission

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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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Medi-Cal

## CalOptima

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OneCare (HMO SNP)

## CalOptima

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OneCare Connect

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PACE

## CalOptima

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# **Introduction to the FY 2020-21 CalOptima Budget: Part 1**

**Board of Directors Meeting  
April 2, 2020**





**Nancy Huang  
Chief Financial Officer**

# Overview

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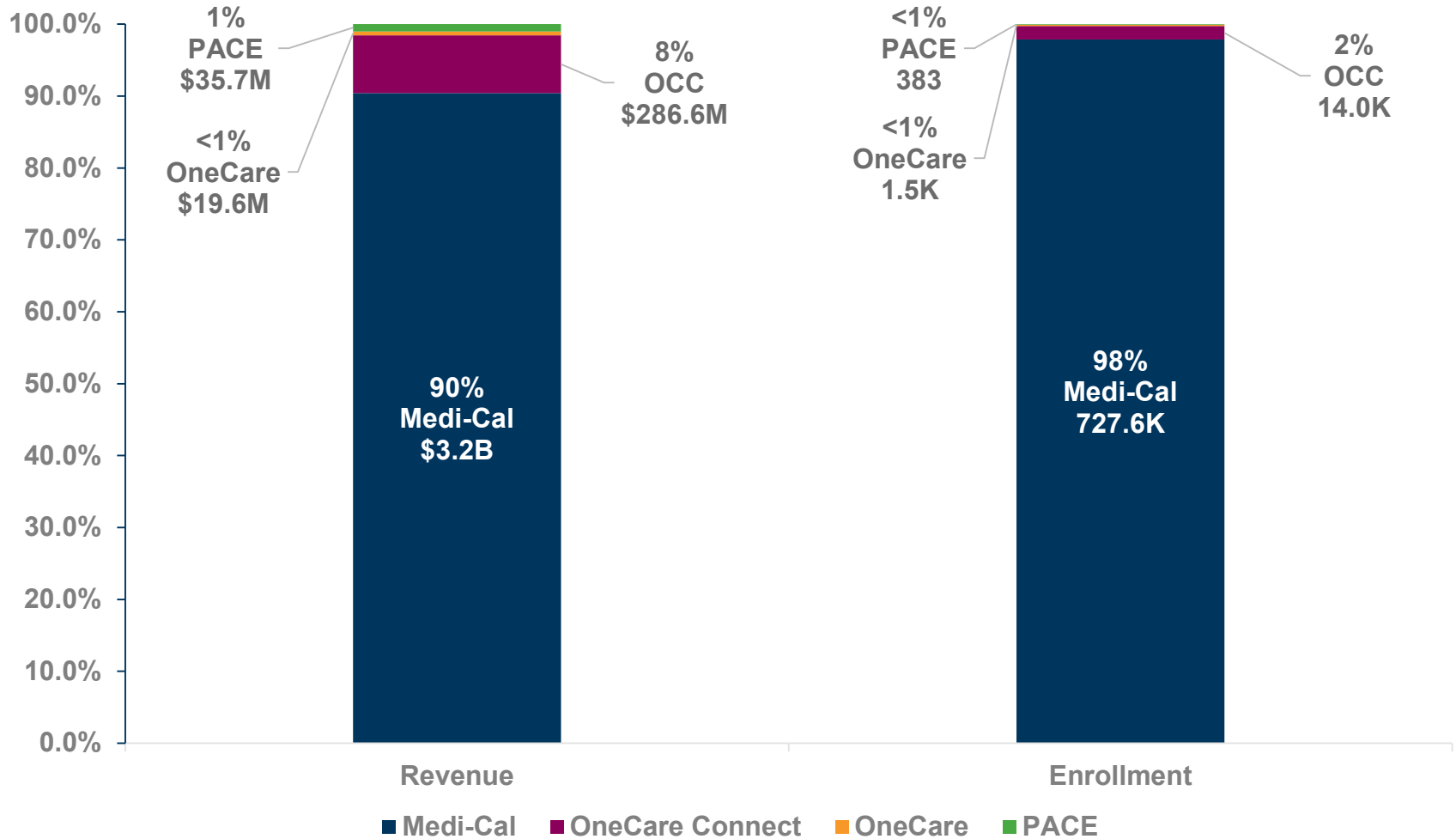
- Lines of Business
- Enrollment and Revenue
- Medical and Administrative Expenses
- Overview
  - Medical Expenses
    - Provider Risk Arrangements
  - Administrative Expenses
  - Capital Budget
- FY 2020-21 Program Updates
- FY 2020-21 Planned Budget Assumptions
- Budget Timeline
- Board Approval Timeline

# Lines of Business

	Start Date	Program Type	Contractor/ Regulator
 <p>Medi-Cal CalOptima A Public Agency Better. Together.</p>	October 1995	California's Medicaid program	California Department of Health Care Services (DHCS)
 <p>OneCare (HMO SNP) CalOptima A Public Agency Better. Together.</p>	October 2005	Medicare Advantage Special Needs Plan (SNP)	Centers for Medicare & Medicaid Services (CMS)
 <p>PACE CalOptima A Public Agency Better. Together.</p>	October 2013	Medicare and Medicaid Program	Three-way contract: CMS, DHCS and CalOptima
 <p>OneCare Connect CalOptima A Public Agency Better. Together.</p>	July 2015	Medicare and Medicaid Duals Demonstration	Three-way contract: CMS, DHCS and CalOptima

- Medi-Cal program includes (1) Classic, (2) Medi-Cal Expansion and (3) Whole Child Model
- MSSP program included under Medi-Cal. Beginning January 2021, MSSP will be carved-out of Medi-Cal

# Enrollment and Revenue



Source: FY 2019-20 Operating Budget (6/6/19 COBAR)

# Enrollment

---

- Medi-Cal enrollment defined by eligibility for aid
  - Adult, Children, Medi-Cal Expansion (MCE), Seniors and Persons with Disabilities, Long Term Care (LTC), Breast and Cervical Cancer Treatment Program, Dual eligible
  - Whole Child Model (WCM) enrollment included in Medi-Cal
- OneCare Connect and OneCare enrollment defined by medical condition
  - Medicare: Aged, End-stage Renal Disease, Hospice
  - Medi-Cal: Institutional, CBAS/MSSP, IHSS, Community Well
- PACE enrollment defined by program eligibility
  - Dual eligible (Medicare and Medi-Cal), Medi-Cal only, and Non-Medi-Cal enrollment

# Medi-Cal Revenue

---

- Enrollment drives revenue
  - Different revenue rates for each aid category
  - Some supplemental revenue for Behavioral Health Treatment, Hepatitis C drugs and Health Homes Program (HHP)
- State provides funding for new programs and benefits
  - Examples: WCM, HHP, Proposition 56, Enhanced Care Management (ECM)
  - Uncertainties/risks associated with new revenue
    - Correct pricing and adequate funding to deliver services
    - Timeliness of funding is unpredictable; will impact cash flow and reserves



# Medi-Cal Revenue

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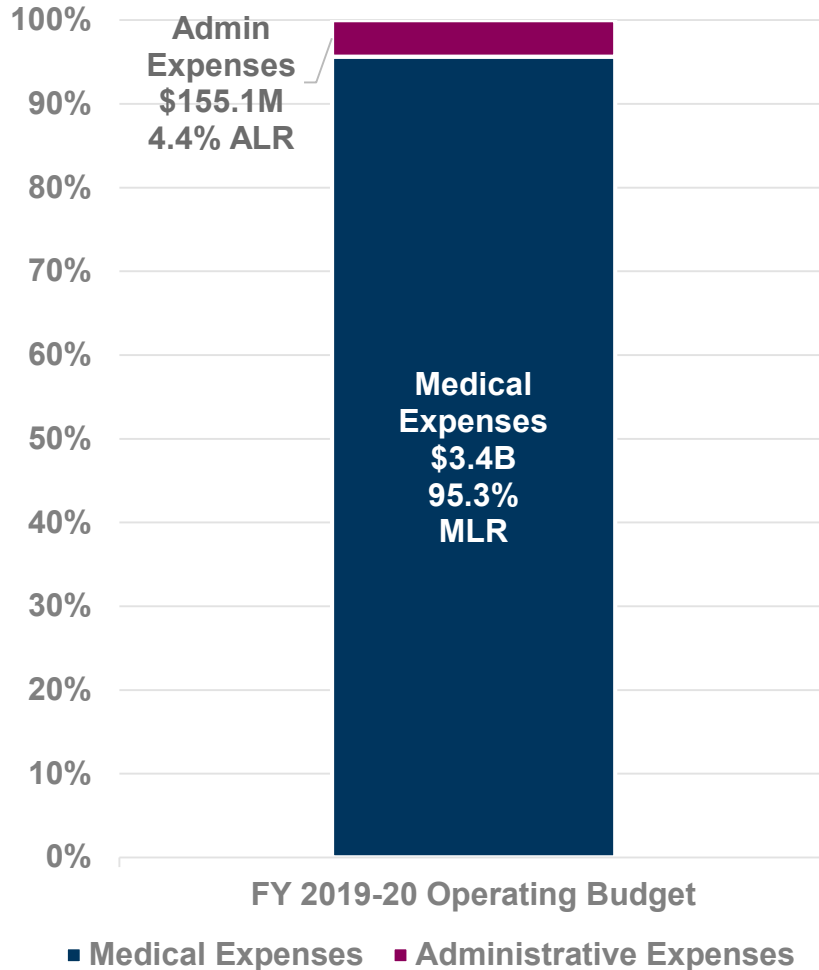
- Timing of rate releases
  - Medi-Cal contract rates now begin January 1<sup>st</sup> (post bridge period)
    - Expect to receive draft rates in October
  - Rates do not become final until they are certified by CMS
  - Budget assumptions
    - 7/1/20 – 12/31/20: Includes current year Bridge Period Rates
    - 1/1/21 – 6/30/21: Will include estimated capitation rates based on information available

# Medicare Revenue

---

- Medicare provides funding for two components
  - Part A/B: Funding for hospital and physician services
  - Part D: Funding for prescription drugs
- Revenue is determined by two primary factors
  - Base rate which is determined via bid or set to fee-for-service benchmark
  - Risk Adjustment Factor applied to the base rate
    - Based on member's medical condition
    - Adjusts funding to match the expected expense of conditions
    - Heavily dependent on Plan's ability to collect and submit data
- Applies to OneCare Connect, OneCare and PACE

# Medical and Administrative Expenses



Source: FY 2019-20 Operating Budget (6/6/19 COBAR)

- Medical Expenses

- Provider capitation payments
- Claims payments to hospitals & providers
- Prescription drugs
- Care management & care coordination activities

- Administrative Expenses

- Salaries & benefits
- Professional fees
- Purchased services
- Printing & postage
- Other Operating expenses

# Medical and Administrative Expenses (cont.)

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- Medical Expenses

- Driven primarily by program, utilization, unit cost, and service mix
- Provider payments are continually evaluated for reasonability and sufficiency
- Goal is to maximize quality and access to care for members

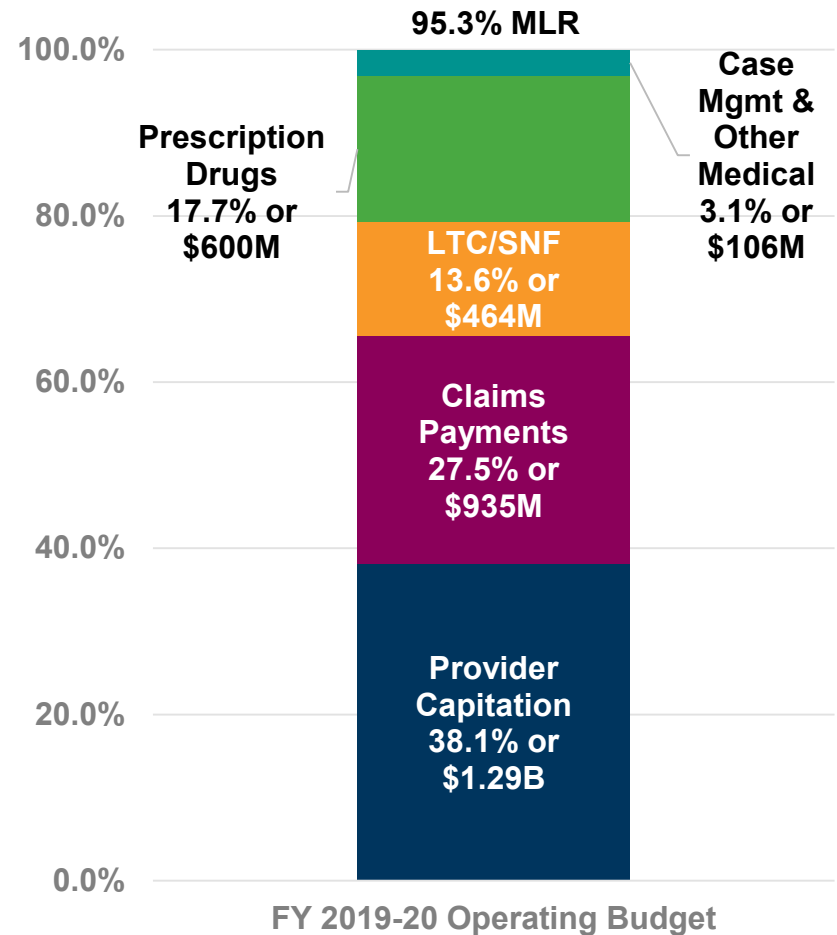
- Administrative Expenses

- Majority of expenses are related to personnel
  - Personnel levels are dependent on membership, utilization level and regulatory requirements
- G&A Budget includes other non-salary expenses

# Overview of Medical Expenses

- 5 categories

- Provider Capitation
- Claims Payments
- LTC/Skilled Nursing Facilities
- Prescription Drugs
- Case Management & Other Medical



# Overview of Provider Risk Arrangements

---

- Capitation
  - Provider paid a per member per month payment for each enrolled member
  - Receives payment regardless of whether or not a member seeks care
  - At-risk arrangement
- Fee-for-Service
  - Provider paid a fee for each particular service rendered
  - Receives payment for each visit
  - No risk arrangement
- Shared Risk
  - Capitation and Fee-for Service arrangement
  - Risk pool shared between CalOptima and health network

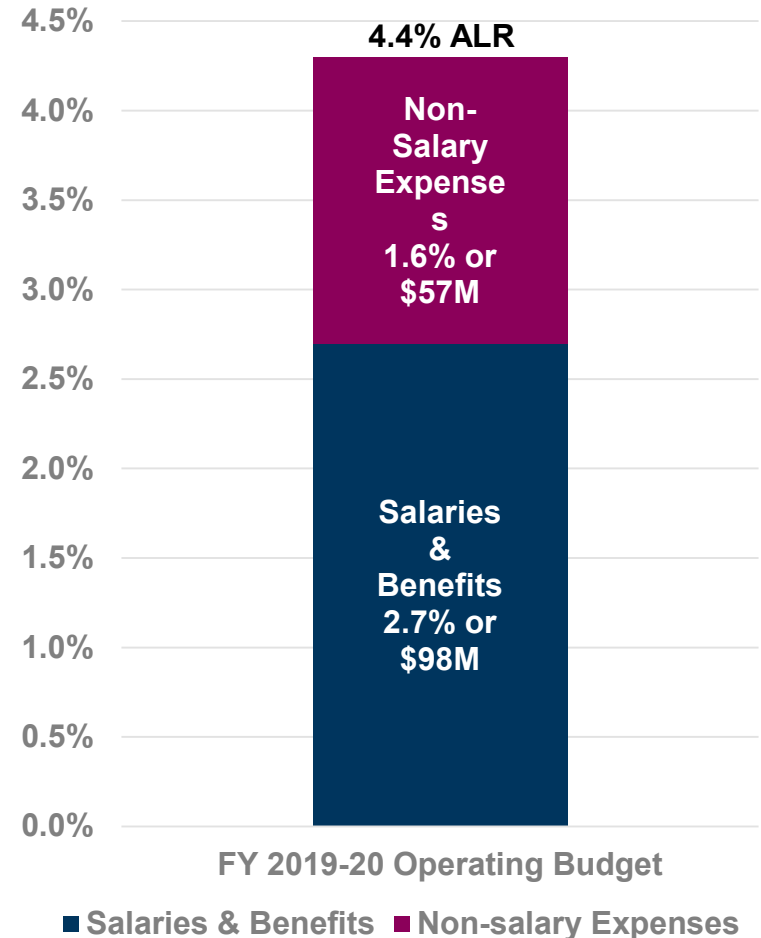
# CalOptima Provider Risk Arrangements

Model	Professional	Hospital	Pharmacy	Other Medical	Membership Distribution*
<b>Kaiser</b>	Capitation	Capitation	Capitation	Capitation	6%
<b>HMO</b>	Capitation	Capitation	Fee-For-Service	Fee-For-Service	16%
<b>PHC</b>	Capitation	Capitation	Fee-For-Service	Fee-For-Service	29%
<b>SRG</b>	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service	24%
<b>CCN/COD</b>	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service	25%

\* Membership Distribution based on March 2020 actuals  
 CCN/COD Member Distribution includes dual eligible and COD-Admin

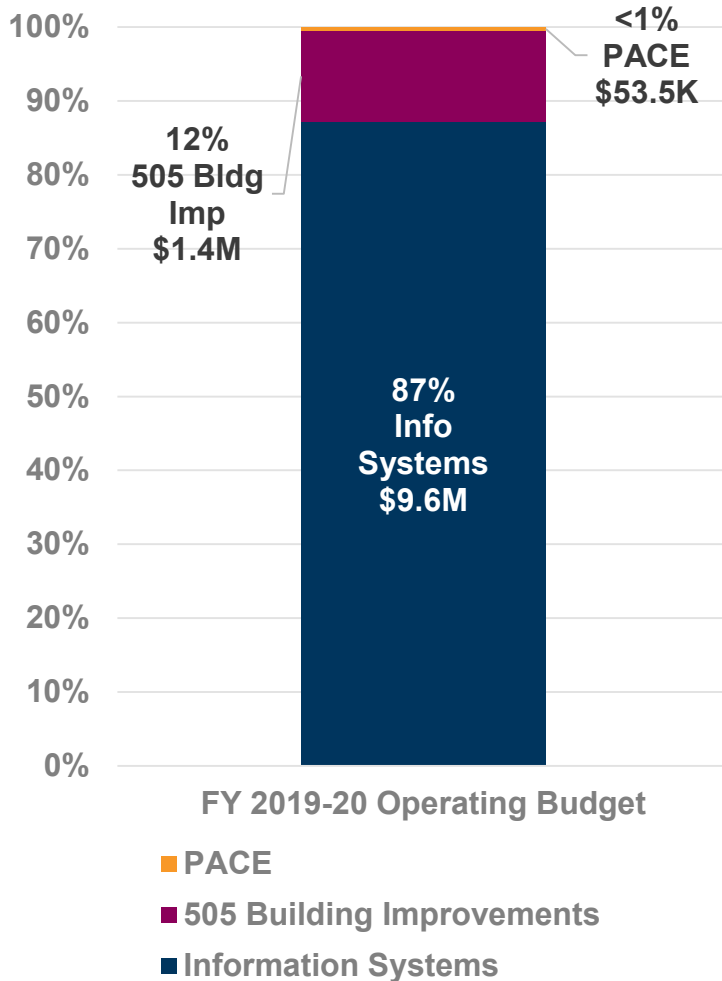
# Overview of Administrative Expenses

- 2 categories
  - Salaries & benefits
  - Non-salary expenses
- Process
  - Purchasing Department reviews all contract obligations
  - Departments identify resource requirements based on service levels, enrollment, regulatory requirements and program needs
  - Sr. Management reviews and approves their departments' budgets





# Overview of Capital Budget



- 3 Categories

- Information Systems: Information technology infrastructure needs
- 505 Building Improvements
- PACE center

- Process

- Departments submit requests for capital projects based on strategic and operational needs
- Information Services Department reviews technology requests

# FY 2020-21 Program Updates

---

- Rate Adjustments
  - Anticipated October 2020 for January 2021 effective date
  - Projected rate decrease to MCE
  - WCM capitation rate
- Program Updates
  - MSSP carve-out: Effective January 2021
  - Pharmacy carve-out: Effective January 2021
  - CalAIM: HHP/WPC transition to ECM and In Lieu of Services: Effective January 2021
- COVID-19 Pandemic

# FY 2020-21 Planned Budget Assumptions

---

- Current Planned Budget Assumptions (effective January 2021)
  - Slight increase to Medi-Cal Classic revenue
  - Continue decrease to MCE revenue
  - Potential increase to WCM revenue
  - Potential reductions due to pharmacy carve-out
- Impact to Providers/Health Networks
  - Potential positive and negative adjustments resulting from Medi-Cal rebasing
  - CDPS risk adjustment implemented for MCE
  - OneCare Connect percent of premium adjustments to hospital capitation

# Budget Timeline

## Budget Preparation

- Late Feb – Early Mar: Departments prepare budgets
- Mid-Mar – End Mar: Finance meets with Departments on budget proposals
- Early Apr: CFO reviews proposed budget
- 4/2: Board Information Item on Budget: Part 1



## Budget Review

- Early Apr – Mid-Apr: Executives review proposed budget; Hold additional department meetings, if needed
- Late Apr: Finalize budget and sign-off from Executives



## Budget Approval

- Late Apr – Mid-May: Prepare May FAC and June BOD materials
- 5/7: Board Information Item on Budget: Part 2
- 5/21: FAC meeting
- 6/4: Board meeting

# Board Approval Timeline

Date	Meeting
April 2, 2020	Present information item to Board of Directors: Introduction to the FY 2020-21 Budget: Part 1
May 7, 2020	Present information item to Board of Directors: Introduction to the FY 2020-21 Budget: Part 2
May 21, 2020	Present FY 2020-21 budgets to Finance and Audit Committee
June 4, 2020	Present FY 2020-21 budgets to Board of Directors
July 1, 2020	Beginning of Fiscal Year 2020-21



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# **Whole Child Model (WCM) Financial Update**

**Board of Directors Meeting  
April 2, 2020**

**Nancy Huang  
Chief Financial Officer**

# WCM in California



Phase I: January 2018

- Included CenCal Health, CCAH, Health Plan of San Mateo
- ~10K members

Phase II: January 2019

- Included Partnership HealthPlan
- ~7.5K members

Phase III: July 2019

- Included CalOptima
- ~11.5K members

# WCM Goals

---

- Combine CCS and Medi-Cal services under one managed care plan
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results and access to care



# WCM Reimbursement Model

- CalOptima takes majority of financial risk
  - Risk to health networks is minimal

<b>Capitated Members</b> (HMO*, PHC and SRG)	<b>CCN</b>	<b>Other Carve-outs</b> (e.g., Prescription drugs, transplants, ESRD, LTC)
<ul style="list-style-type: none"><li>• Monthly Initial Capitation Payment</li><li>• Quarterly Interim Catastrophic Payment</li><li>• Annual Risk Corridor Settlement</li></ul>	<ul style="list-style-type: none"><li>• Fee-for-service</li></ul>	<ul style="list-style-type: none"><li>• Fee-for-service</li></ul>

\*Non-Kaiser HMOs

# Monitoring and Reporting Efforts

---

- Tracking WCM financial performance
  - Monthly internal financial reports and Board information items
    - Provider capitation is estimated based on budgeted rather than actual expenses due to limited information available
    - Lower than budgeted enrollment
    - Estimated cost experience is higher than state revenue assumptions
      - High cost injectables
      - NICU
      - LTC claims
  - WCM Quarterly Financial Report presented to Feb FAC
- Communication with other health plans
  - Other plans are experiencing similar challenges

# Communication with DHCS

---

- Prior to Implementation

- April – Nov 2019: Operational concerns; consistent application of eligibility (i.e., B1 indicator)
- Insufficient data from DHCS
  - DHCS used multiple data sources to develop initial WCM rates
  - Sept 2017 and Sept 2018: CalOptima submitted supplemental data requests to DHCS; data captured utilization for non-CCS services only
  - DHCS relied on other available data sources for CCS services
- Sept 2018: NICU claims; budget assumptions used in base rates
  - Oct 2018: CalOptima submitted WCM utilization report
  - May 2019: DHCS communicated that no revisions to CalOptima's rate development were necessary

# Communication with DHCS (cont.)

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- After Implementation

- July 2019: High cost injectables

- CalOptima began experiencing utilization of Zolgensma (i.e., drug for the treatment of spinal muscular atrophy); asked if DHCS will adjust funding
    - DHCS communicated the drug Zolgensma will not be carved-out from rates; CalOptima is at risk for costs

- July 2019: Other FFS rate increase not built in WCM rates (e.g., shift nursing)

- Aug 2019: DHCS communicated that these costs are for services provided under Pediatric Day Health Care; paid FFS and not covered under managed care

# WCM Rate Considerations

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- DHCS focused on collecting additional updated data to verify appropriateness of rates
- WCM Rate Setting process
  - Prospective: DHCS rates are intended to cover future expenses, not offset incurred deficits
  - Actual WCM cost data (6 months) will be included in the CY 2019 RDT submission
    - Included in the base data for CY 2021 capitation rates
  - No risk mitigation process available for WCM program (i.e., risk corridor, reconciliation, supplemental payment)

# Current Year WCM Deficit

- Estimated current year-end deficit is approximately \$31.1 million
  - Does not include administrative expenses

	February 2020 YTD Financial Summary	Forecasted Annual Financial Summary
Enrollment	92,371 members	137,387 members
Revenue	\$183.8 million	\$273.7 million
Medical Expenses	\$200.1 million	\$304.8 million
Change in Net Assets	(\$16.3) million	(\$31.1) million

# Recommended Action: Current Year WCM Deficit Funding

- Recommend the Board approve use of \$31.1 million in IGT 9 funds for the WCM budget deficit
  - Beginning with IGT 8, DHCS requires IGT funds to be used for covered Medi-Cal services, preferably in the current rate year
  - IGT funds are included in CalOptima's rate development submissions to DHCS; has a direct impact on MLR
  - Anticipated IGT 9 funding will total \$45 million
- Alternatively, if the Board takes no action, the WCM budget deficit would fall to the bottom line
  - Included in the FY 2019-20 operating performance
  - No additional Board action required

# Whole Child Model Financial Highlights

## February 2020

Month				Year to Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
11,254	12,940	(1,686)	(13.0%)	92,371	103,520	(11,149)	(10.8%)
<b>Member Months</b>				<b>Member Months</b>			
<b>Revenues</b>				<b>Revenues</b>			
22,469,096	25,523,466	(3,054,370)	(12.0%)	183,826,029	204,187,730	(20,361,701)	(10.0%)
<b>Capitation Revenue</b>				<b>Capitation Revenue</b>			
<b>22,469,096</b>	<b>25,523,466</b>	<b>(3,054,370)</b>	<b>(12.0%)</b>	<b>183,826,029</b>	<b>204,187,730</b>	<b>(20,361,701)</b>	<b>(10.0%)</b>
<b>Total Operating Revenue</b>				<b>Total Operating Revenue</b>			
<b>Medical Expenses</b>				<b>Medical Expenses</b>			
10,967,718	11,327,365	359,648	3.2%	81,635,318	90,618,822	8,983,504	9.9%
4,341,694	3,590,376	(751,318)	(20.9%)	45,599,674	28,723,008	(16,876,666)	(58.8%)
1,822,257	1,285,104	(537,153)	(41.8%)	11,281,869	10,583,729	(698,140)	(6.6%)
1,602,646	627,696	(974,950)	(155.3%)	14,730,599	5,021,567	(9,709,032)	(193.3%)
6,241,731	6,662,133	420,402	6.3%	44,461,815	53,297,066	8,835,251	16.6%
247,579	718,851	471,271	65.6%	2,100,480	5,750,806	3,650,326	63.5%
31,010	801	(30,209)	(3770.5%)	276,355	6,449	(269,907)	(4185.5%)
<b>25,254,635</b>	<b>24,212,326</b>	<b>(1,042,309)</b>	<b>(4.3%)</b>	<b>200,086,110</b>	<b>194,001,447</b>	<b>(6,084,663)</b>	<b>(3.1%)</b>
<b>Total Medical Expenses</b>				<b>Total Medical Expenses</b>			
<b>(2,785,539)</b>	<b>1,311,140</b>	<b>(4,096,679)</b>	<b>(312.5%)</b>	<b>(16,260,081)</b>	<b>10,186,282</b>	<b>(26,446,363)</b>	<b>(259.6%)</b>
<b>Gross Margin</b>				<b>Gross Margin</b>			
<b>(2,785,539)</b>	<b>1,311,140</b>	<b>(4,096,679)</b>	<b>(312.5%)</b>	<b>(16,260,081)</b>	<b>10,186,282</b>	<b>(26,446,363)</b>	<b>(259.6%)</b>
<b>Change in Net Assets</b>				<b>Change in Net Assets</b>			
<b>112.4%</b>	<b>94.9%</b>	<b>(17.5%)</b>	<b>(18.5%)</b>	<b>108.8%</b>	<b>95.0%</b>	<b>(13.8%)</b>	<b>(14.6%)</b>
<b>Medical Loss Ratio</b>				<b>Medical Loss Ratio</b>			



# FY 2019-20: Whole Child Model Enrollment

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## February 2020 MTD

WCM enrollment was 11,254 members

- Actual lower than budget 1,686 or 13.0%

## February 2020 YTD

WCM enrollment was 92,371 members

- Actual lower than budget 11,149 or 10.8%

# FY 2019-20: Whole Child Model Revenue

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## February 2020 MTD

WCM revenue was \$22.5 million

- Actual lower than budget \$3.1 million or 12.0%
  - Unfavorable volume variance of \$3.3 million
  - Favorable price variance of \$0.3 million

## February 2020 YTD

WCM revenue was \$183.8 million

- Actual lower than budget \$20.4 million or 10.0%
  - Unfavorable volume variance of \$22.0 million
  - Favorable price variance of \$1.6 million

# FY 2019-20: Whole Child Model Expenses

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## February 2020 MTD

WCM expenses were \$25.3 million

- Actual higher than budget \$1.0 million or 4.3%
  - Favorable volume variance of \$3.2 million
  - Unfavorable price variance of \$4.2 million
    - Facilities claims unfavorable variance of \$1.2 million due to claims incurred but not reported (IBNR)
    - Provider Capitation estimated based on budgeted rather than actual expenses due to limited information available; reflects an unfavorable variance of \$1.1 million
    - MLTSS expense unfavorable variance of \$1.1 million due to higher than budgeted utilization

# FY 2019-20: Whole Child Model Expenses

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## February 2020 YTD

WCM expenses were \$200.1 million

- Actual higher than budget \$6.1 million or 3.1%
  - Favorable volume variance of \$20.9 million
  - Unfavorable price variance of \$27.0 million
    - Facilities claims unfavorable variance of \$20.0 million due to NICU estimates, \$2.2 million Zolgensma treatment, and IBNR
    - MLTSS expense unfavorable variance of \$10.2 million due to higher than budgeted utilization
    - Prescription Drug expense favorable variance of \$3.1 million

# CalOptima's Mission

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



A Public Agency

# CalOptima

Better. Together.



A Public Agency

Medi-Cal  
**CalOptima**  
Better. Together.



A Public Agency

OneCare (HMO SNP)  
**CalOptima**  
Better. Together.



A Public Agency

OneCare Connect  
**CalOptima**  
Better. Together.



A Public Agency

PACE  
**CalOptima**  
Better. Together.



A Public Agency

# CalOptima

Better. Together.

# Financial Summary

## February 2020

**Board of Directors Meeting**  
**April 2, 2020**

**Nancy Huang**  
**Chief Financial Officer**

# FY 2019-20: Consolidated Enrollment

## February 2020 MTD

Overall enrollment was 721,228 members

- Actual lower than budget 19,688 or 2.7%
  - Medi-Cal unfavorable to budget 19,797 or 2.7%
    - Medi-Cal Expansion (MCE) unfavorable variance of 14,083
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 5,591
    - Whole Child Model (WCM) unfavorable variance of 1,686
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,458
    - Long-Term Care (LTC) favorable variance of 105
  - OneCare Connect favorable to budget 235 or 1.7%
  - OneCare unfavorable to budget 128 or 8.5%
  - PACE favorable to budget 2 or 0.5%
- 15,672 increase or 2.2% from January
  - Medi-Cal increase of 15,638
  - OneCare Connect increase of 67
  - OneCare decrease of 35
  - PACE increase of 2



# FY 2019-20: Consolidated Enrollment (cont.)

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## February 2020 YTD

Overall enrollment was 5,910,322 member months

- Actual lower than budget 64,365 or 1.1%
  - Medi-Cal unfavorable to budget 64,972 or 1.1%
    - MCE unfavorable variance of 57,432
    - WCM unfavorable variance of 11,149
    - SPD favorable variance of 8,729
    - TANF unfavorable variance 5,712
    - LTC favorable variance of 591
  - OneCare Connect favorable to budget 627 or 0.6%
  - OneCare unfavorable to budget 48 or 0.4%
  - PACE favorable to budget 28 or 1.0%

# FY 2019-20: Consolidated Revenues

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## February 2020 MTD

- Actual higher than budget \$2.8 million or 0.9%
  - Medi-Cal favorable to budget \$1.9 million or 0.7%
    - Unfavorable volume variance of \$7.3 million
    - Favorable price variance of \$9.2 million
      - \$8.0 million of Coordinated Care Initiative (CCI) revenue
      - \$3.0 million of acuity rate adjustment revenue
      - \$2.1 million of Behavioral Health Treatment (BHT) revenue
      - Offset by \$3.9 million of WCM revenue
  - OneCare Connect favorable to budget \$1.1 million or 4.4%
    - Favorable volume variance of \$0.4 million
    - Favorable price variance of \$0.7 million

# FY 2019-20: Consolidated Revenues (cont.)

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## February 2020 MTD (cont.)

- OneCare unfavorable to budget \$299.0 thousand or 17.9%
  - Unfavorable volume variance of \$141.3 thousand
  - Unfavorable price variance of \$157.7 thousand
- PACE favorable to budget \$133.0 thousand or 4.4%
  - Favorable volume variance of \$15.5 thousand
  - Favorable price variance of \$117.5 thousand

# FY 2019-20: Consolidated Revenues (cont.)

## February 2020 YTD

- Actual higher than budget \$146.4 million or 6.2%
  - Medi-Cal favorable to budget \$138.2 million or 6.4%
    - Unfavorable volume variance of \$23.9 million
    - Favorable price variance of \$162.1 million
      - \$104.3 million of directed payment (DP) revenue
      - \$56.2 million of CCI revenue due to updated rate and member mix
      - \$24.0 million due to acuity rate adjustment revenue
      - \$10.7 million of BHT revenue
      - Offset by \$26.5 million of WCM revenue
  - OneCare Connect favorable to budget \$6.6 million or 3.5%
    - Favorable volume variance of \$1.1 million
    - Favorable price variance of \$5.6 million

# FY 2019-20: Consolidated Revenues (cont.)

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## February 2020 YTD (cont.)

- OneCare favorable to budget \$713.3 thousand or 5.4%
  - Unfavorable volume variance of \$52.3 thousand
  - Favorable price variance of \$765.6 thousand
- PACE favorable to budget \$893.4 thousand or 3.9%
  - Favorable volume variance of \$217.5 thousand
  - Favorable price variance of \$675.9 thousand

# FY 2019-20: Consolidated Medical Expenses

## February 2020 MTD

- Actual higher than budget \$8.7 million or 3.2%
  - Medi-Cal unfavorable variance of \$8.5 million or 3.4%
    - Favorable volume variance of \$6.8 million
    - Unfavorable price variance of \$15.3 million
      - Prescription Drug claims unfavorable variance \$9.6 million due to prior period claims
      - Facilities Claims unfavorable variance of \$4.6 million due to increased utilization
      - Professional Claims unfavorable variance of \$3.2 million due to crossover claims
  - OneCare Connect unfavorable variance of \$0.5 million or 2.1%
    - Unfavorable volume variance of \$0.4 million
    - Unfavorable price variance of \$0.1 million

# FY 2019-20: Consolidated Medical Expenses (cont.)

## February 2020 YTD

- Actual higher than budget \$160.9 million or 7.1%
  - Medi-Cal unfavorable variance of \$158.6 million or 7.8%
    - Favorable volume variance of \$22.7 million
    - Unfavorable price variance of \$181.3 million
      - Reinsurance and Other Expense category unfavorable variance of \$93.2 million due to \$104.0 million of DP, offset by favorable variance in homeless health initiative
      - Facilities Claims unfavorable variance of \$39.2 million
      - Professional Claims unfavorable variance of \$26.7 million
      - MLTSS unfavorable variance of \$17.9 million
  - OneCare Connect unfavorable variance of \$3.8 million or 2.0%
    - Unfavorable volume variance of \$1.0 million
    - Unfavorable price variance of \$2.8 million

## Medical Loss Ratio (MLR)

- February 2020 MTD:      Actual: 95.0%      Budget: 93.0%
- February 2020 YTD:      Actual: 95.9%      Budget: 95.0%

# FY 2019-20: Consolidated Administrative Expenses

## February 2020 MTD

- Actual lower than budget \$1.8 million or 14.1%
  - Salaries, wages and benefits: favorable variance of \$0.8 million
  - Other categories: favorable variance of \$0.9 million

## February 2020 YTD

- Actual lower than budget \$14.0 million or 13.5%
  - Salaries, wages and benefits: favorable variance of \$6.1 million
  - Other categories: favorable variance of \$7.9 million

## Administrative Loss Ratio (ALR)

- February 2020 MTD:      Actual: 3.6%      Budget: 4.2%
- February 2020 YTD:      Actual: 3.5%      Budget: 4.3%
  - Actual ALR (excluding DP revenue) is 3.7% YTD



# FY 2019-20: Change in Net Assets

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## February 2020 MTD

- \$10.4 million change in net assets
- \$0.8 million favorable to budget
  - Higher than budgeted revenue of \$2.8 million
  - Higher than budgeted medical expenses of \$8.7 million
  - Lower than budgeted administrative expenses of \$1.8 million
  - Higher than budgeted investment and other income of \$5.0 million

## February 2020 YTD

- \$40.9 million change in net assets
- \$16.2 million favorable to budget
  - Higher than budgeted revenue of \$146.4 million
  - Higher than budgeted medical expenses of \$160.9 million
  - Lower than budgeted administrative expenses of \$14.0 million
  - Higher than budgeted investment and other income of \$16.7 million

# Enrollment Summary: February 2020

Month-to-Date				Enrollment (by Aid Category)	Year-to-Date			
<u>Actual</u>	<u>Budget</u>	<u>\$</u> <u>Variance</u>	<u>%</u> <u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>\$</u> <u>Variance</u>	<u>%</u> <u>Variance</u>
66,380	66,109	271	0.4%	Aged	526,739	525,189	1,550	0.3%
485	615	(130)	(21.1%)	BCCTP	4,271	4,920	(649)	(13.2%)
44,939	43,622	1,317	3.0%	Disabled	357,779	349,951	7,828	2.2%
275,139	277,984	(2,845)	(1.0%)	TANF Child	2,258,069	2,262,182	(4,113)	(0.2%)
81,999	84,745	(2,746)	(3.2%)	TANF Adult	689,744	691,343	(1,599)	(0.2%)
3,509	3,404	105	3.1%	LTC	27,823	27,232	591	2.2%
221,574	235,657	(14,083)	(6.0%)	MCE	1,825,365	1,882,797	(57,432)	(3.1%)
11,254	12,940	(1,686)	(13.0%)	WCM	92,371	103,520	(11,149)	(10.8%)
<b>705,279</b>	<b>725,076</b>	<b>(19,797)</b>	<b>(2.7%)</b>	<b>Medi-Cal Total</b>	<b>5,782,162</b>	<b>5,847,134</b>	<b>(64,972)</b>	<b>(1.1%)</b>
<b>14,171</b>	<b>13,936</b>	<b>235</b>	<b>1.7%</b>	<b>OneCare Connect</b>	<b>113,230</b>	<b>112,603</b>	<b>627</b>	<b>0.6%</b>
<b>1,382</b>	<b>1,510</b>	<b>(128)</b>	<b>(8.5%)</b>	<b>OneCare</b>	<b>11,968</b>	<b>12,016</b>	<b>(48)</b>	<b>(0.4%)</b>
<b>396</b>	<b>394</b>	<b>2</b>	<b>0.5%</b>	<b>PACE</b>	<b>2,962</b>	<b>2,934</b>	<b>28</b>	<b>1.0%</b>
<b>721,228</b>	<b>740,916</b>	<b>(19,688)</b>	<b>(2.7%)</b>	<b>CalOptima Total</b>	<b>5,910,322</b>	<b>5,974,687</b>	<b>(64,365)</b>	<b>(1.1%)</b>

# Financial Highlights: February 2020

Month-to-Date					Year-to-Date			
Actual	Budget	\$ Budget	% Budget		Actual	Budget	\$ Budget	% Budget
721,228	740,916	(19,688)	(2.7%)	Member Months	5,910,322	5,974,687	(64,365)	(1.1%)
300,202,018	297,388,165	2,813,852	0.9%	Revenues	2,524,518,675	2,378,080,674	146,438,001	6.2%
285,339,143	276,608,340	(8,730,804)	(3.2%)	Medical Expenses	2,421,011,950	2,260,075,965	(160,935,985)	(7.1%)
10,734,765	12,494,493	1,759,728	14.1%	Administrative Expenses	89,288,986	103,248,541	13,959,555	13.5%
<b>4,128,109</b>	<b>8,285,333</b>	<b>(4,157,223)</b>	<b>(50.2%)</b>	<b>Operating Margin</b>	<b>14,217,739</b>	<b>14,756,168</b>	<b>(538,429)</b>	<b>(3.6%)</b>
6,235,120	1,250,000	4,985,120	398.8%	Non Operating Income (Loss)	26,688,785	10,000,000	16,688,785	166.9%
<b>10,363,229</b>	<b>9,535,333</b>	<b>827,897</b>	<b>8.7%</b>	<b>Change in Net Assets</b>	<b>40,906,524</b>	<b>24,756,168</b>	<b>16,150,356</b>	<b>65.2%</b>
95.0%	93.0%	(2.0%)		Medical Loss Ratio	95.9%	95.0%	(0.9%)	
3.6%	4.2%	0.6%		Administrative Loss Ratio	3.5%	4.3%	0.8%	
<u>1.4%</u>	<u>2.8%</u>	(1.4%)		Operating Margin Ratio	<u>0.6%</u>	<u>0.6%</u>	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.3%	0.6%	

\*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

# Consolidated Performance Actual vs. Budget: February 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
3.4	8.4	(5.0)	Medi-Cal	15.9	24.4	(8.4)
0.3	(0.5)	0.7	OCC	(5.4)	(10.2)	4.7
(0.2)	(0.0)	(0.2)	OneCare	0.8	(0.9)	1.6
<u>0.6</u>	<u>0.4</u>	<u>0.3</u>	<u>PACE</u>	<u>3.0</u>	<u>1.5</u>	<u>1.5</u>
<b>4.1</b>	<b>8.3</b>	<b>(4.2)</b>	<b>Operating</b>	<b>14.2</b>	<b>14.8</b>	<b>(0.5)</b>
<u>6.2</u>	<u>1.3</u>	<u>5.0</u>	<u>Inv./Rental Inc, MCO tax</u>	<u>26.7</u>	<u>10.0</u>	<u>16.7</u>
<b>6.2</b>	<b>1.3</b>	<b>5.0</b>	<b>Non-Operating</b>	<b>26.7</b>	<b>10.0</b>	<b>16.7</b>
<b>10.4</b>	<b>9.5</b>	<b>0.8</b>	<b>TOTAL</b>	<b>40.9</b>	<b>24.8</b>	<b>16.2</b>

# Consolidated Revenue & Expense:

## February 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
<b>MEMBER MONTHS</b>	472,451	221,574	11,254	705,279	14,171	1,382	396	721,228
<b>REVENUES</b>								
Capitation Revenue	145,598,779	\$ 102,298,191	\$ 22,469,096	\$ 270,366,067	\$ 25,280,051	\$ 1,368,401	\$ 3,187,499	\$ 300,202,018
Other Income	-	-	-	-	-	-	-	-
<b>Total Operating Revenue</b>	<u>145,598,779</u>	<u>102,298,191</u>	<u>22,469,096</u>	<u>270,366,067</u>	<u>25,280,051</u>	<u>1,368,401</u>	<u>3,187,499</u>	<u>300,202,018</u>
<b>MEDICAL EXPENSES</b>								
Provider Capitation	38,741,390	40,277,099	10,827,278	89,845,768	10,550,133	488,152	-	100,884,053
Facilities	23,985,484	21,714,691	4,341,694	50,041,869	3,099,820	295,146	681,563	54,118,399
Ancillary	-	-	-	-	-	-	-	-
Professional Claims	16,183,837	6,802,760	1,822,257	24,808,854	998,569	79,623	477,547	26,364,593
Prescription Drugs	18,695,116	25,625,489	6,241,731	50,562,337	6,218,457	497,050	270,042	57,547,886
MLTSS	31,791,697	2,353,087	1,602,646	35,747,431	1,295,930	26,695	37,825	37,107,880
Medical Management	1,860,488	1,190,897	247,579	3,298,965	910,214	31,987	697,360	4,938,526
Quality Incentives	1,473,800	443,664	140,439	2,057,903	198,265	-	4,588	2,260,756
Reinsurance & Other	892,836	810,358	31,010	1,734,204	190,341	-	192,505	2,117,051
<b>Total Medical Expenses</b>	<u>133,624,649</u>	<u>99,218,046</u>	<u>25,254,635</u>	<u>258,097,330</u>	<u>23,461,729</u>	<u>1,418,653</u>	<u>2,361,431</u>	<u>285,339,143</u>
<b>Medical Loss Ratio</b>	91.8%	97.0%	112.4%	95.5%	92.8%	103.7%	74.1%	95.0%
<b>GROSS MARGIN</b>	<b>11,974,130</b>	<b>3,080,145</b>	<b>(2,785,539)</b>	<b>12,268,737</b>	<b>1,818,321</b>	<b>(50,252)</b>	<b>826,068</b>	<b>14,862,874</b>
<b>ADMINISTRATIVE EXPENSES</b>								
Salaries & Benefits				6,041,509	693,262	67,393	136,033	6,938,197
Professional fees				170,797	4,000	15,000	123	189,921
Purchased services				914,299	119,516	9,354	9,072	1,052,241
Printing & Postage				510,721	111,600	9,241	21,217	652,780
Depreciation & Amortization				283,048	-	-	2,057	285,105
Other expenses				1,271,968	57,547	263	4,443	1,334,222
Indirect cost allocation & Occupancy				(308,736)	548,726	38,274	4,036	282,299
<b>Total Administrative Expenses</b>				<u>8,883,606</u>	<u>1,534,651</u>	<u>139,526</u>	<u>176,981</u>	<u>10,734,765</u>
<b>Admin Loss Ratio</b>				3.3%	6.1%	10.2%	5.6%	3.6%
<b>INCOME (LOSS) FROM OPERATIONS</b>				3,385,131	283,670	(189,778)	649,086	4,128,109
<b>INVESTMENT INCOME</b>								6,802,965
<b>TOTAL MCO TAX</b>				(567,820)				(567,820)
<b>TOTAL GRANT INCOME</b>				(25)				(25)
<b>CHANGE IN NET ASSETS</b>				<u>\$ 2,817,285</u>	<u>\$ 283,670</u>	<u>\$ (189,778)</u>	<u>\$ 649,086</u>	<u>\$ 10,363,229</u>
<b>BUDGETED CHANGE IN NET ASSETS</b>				8,412,553	(459,528)	(26,259)	358,567	9,535,333
<b>VARIANCE TO BUDGET - FAV (UNFAV)</b>				<u>\$ (5,595,267)</u>	<u>\$ 743,198</u>	<u>\$ (163,519)</u>	<u>\$ 290,519</u>	<u>\$ 827,897</u>

# Consolidated Revenue & Expense: February 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
<b>MEMBER MONTHS</b>	3,864,425	1,825,365	92,371	5,782,161	113,230	11,968	2,962	5,910,321
<b>REVENUES</b>								
Capitation Revenue	1,231,553,286	\$ 873,962,444	\$ 183,826,029	\$ 2,289,341,760	\$ 197,683,360	\$ 13,807,011	\$ 23,686,545	\$ 2,524,518,675
Other Income	-	-	-	-	-	-	-	-
<b>Total Operating Revenue</b>	<u>1,231,553,286</u>	<u>873,962,444</u>	<u>183,826,029</u>	<u>2,289,341,760</u>	<u>197,683,360</u>	<u>13,807,011</u>	<u>23,686,545</u>	<u>2,524,518,675</u>
<b>MEDICAL EXPENSES</b>								
Provider Capitation	311,234,489	351,980,979	80,505,569	743,721,037	87,921,518	3,842,695	-	835,485,251
Facilities	202,275,127	172,684,144	45,599,674	420,558,945	29,623,026	3,132,248	5,246,068	458,560,288
Ancillary	-	-	-	-	-	-	-	-
Professional Claims	141,904,967	55,918,860	11,281,869	209,105,696	6,051,569	390,030	4,298,198	219,845,493
Prescription Drugs	134,435,490	177,103,851	44,461,815	356,001,157	44,972,194	4,133,304	1,872,571	406,979,226
MLTSS	274,707,958	20,979,360	14,730,599	310,417,916	10,826,133	101,275	296,626	321,641,951
Medical Management	16,809,216	9,834,731	2,100,480	28,744,427	8,168,696	305,660	5,714,661	42,933,444
Quality Incentives	7,318,407	3,699,714	1,129,749	12,147,870	1,619,090	-	191,235	13,958,195
Reinsurance & Other	67,828,448	50,362,499	276,355	118,467,303	1,464,349	-	1,676,451	121,608,103
<b>Total Medical Expenses</b>	<u>1,156,514,102</u>	<u>842,564,139</u>	<u>200,086,110</u>	<u>2,199,164,351</u>	<u>190,646,576</u>	<u>11,905,213</u>	<u>19,295,810</u>	<u>2,421,011,950</u>
<b>Medical Loss Ratio</b>	93.9%	96.4%	108.8%	96.1%	96.4%	86.2%	81.5%	95.9%
<b>GROSS MARGIN</b>	<b>75,039,184</b>	<b>31,398,306</b>	<b>(16,260,081)</b>	<b>90,177,409</b>	<b>7,036,784</b>	<b>1,901,798</b>	<b>4,390,735</b>	<b>103,506,725</b>
<b>ADMINISTRATIVE EXPENSES</b>								
Salaries & Benefits				51,275,630	5,696,728	519,785	1,119,353	58,611,495
Professional fees				1,572,340	456,485	159,371	1,383	2,189,579
Purchased services				6,383,657	1,183,248	110,905	66,707	7,744,517
Printing & Postage				2,752,156	473,674	37,546	82,490	3,345,867
Depreciation & Amortization				2,733,320	-	-	16,656	2,749,976
Other expenses				11,537,951	221,451	2,237	32,546	11,794,186
Indirect cost allocation & Occupancy				(2,006,745)	4,448,560	319,465	92,085	2,853,365
<b>Total Administrative Expenses</b>				<u>74,248,309</u>	<u>12,480,147</u>	<u>1,149,310</u>	<u>1,411,220</u>	<u>89,288,986</u>
<b>Admin Loss Ratio</b>				3.2%	6.3%	8.3%	6.0%	3.5%
<b>INCOME (LOSS) FROM OPERATIONS</b>				15,929,100	(5,443,364)	752,488	2,979,514	14,217,739
<b>INVESTMENT INCOME</b>								29,670,624
<b>TOTAL MCO TAX</b>				(2,982,247)				(2,982,247)
<b>TOTAL GRANT INCOME</b>				(86)				(86)
<b>OTHER INCOME</b>				494				494
<b>CHANGE IN NET ASSETS</b>				<u>\$ 12,947,261</u>	<u>\$ (5,443,364)</u>	<u>\$ 752,488</u>	<u>\$ 2,979,514</u>	<u>\$ 40,906,524</u>
<b>BUDGETED CHANGE IN NET ASSETS</b>				24,363,845	(10,183,404)	(881,059)	1,456,786	24,756,168
<b>VARIANCE TO BUDGET - FAV (UNFAV)</b>				<u>\$ (11,416,584)</u>	<u>\$ 4,740,040</u>	<u>\$ 1,633,547</u>	<u>\$ 1,522,728</u>	<u>\$ 16,150,356</u>

# Balance Sheet:

## As of February 2020

### ASSETS

Current Assets	
Operating Cash	\$489,245,301
Investments	603,526,985
Capitation receivable	431,771,211
Receivables - Other	35,353,301
Prepaid expenses	7,568,030
<b>Total Current Assets</b>	<b>1,567,464,828</b>
Capital Assets	
Furniture & Equipment	37,266,060
Building/Leasehold Improvements	11,166,259
505 City Parkway West	50,489,717
	98,922,036
Less: accumulated depreciation	(50,951,175)
Capital assets, net	47,970,861
Other Assets	
Restricted Deposit & Other	300,000
Homeless Health Reserve	58,198,913
Board-designated assets:	
Cash and Cash Equivalents	6,769,010
Long-term Investments	568,851,831
Total Board-designated Assets	575,620,841
<b>Total Other Assets</b>	<b>634,119,754</b>
<b>TOTAL ASSETS</b>	<b>2,249,555,443</b>
Deferred Outflows	
Contributions	686,962
Difference in Experience	3,419,328
Excess Earning	-
Changes in Assumptions	6,428,159
Pension Contributions	556,000
<b>TOTAL ASSETS &amp; DEFERRED OUTFLOWS</b>	<b>2,260,645,892</b>

### LIABILITIES & NET POSITION

Current Liabilities	
Accounts Payable	\$118,224,858
Medical Claims liability	913,223,141
Accrued Payroll Liabilities	12,907,342
Deferred Revenue	54,025,966
Deferred Lease Obligations	170,710
Capitation and Withholds	128,765,322
<b>Total Current Liabilities</b>	<b>1,227,317,338</b>
Other (than pensions) post employment benefits liability	
	25,683,620
Net Pension Liabilities	23,788,705
Bldg 505 Development Rights	-
<b>TOTAL LIABILITIES</b>	<b>1,276,789,664</b>
Deferred Inflows	
Excess Earnings	156,330
Change in Assumptions	4,747,505
OPEB Changes in Assumptions	2,503,000
Net Position	
TNE	97,174,161
Funds in Excess of TNE	879,275,232
<b>TOTAL NET POSITION</b>	<b>976,449,394</b>
<b>TOTAL LIABILITIES, DEFERRED INFLOWS &amp; NET POSITION</b>	<b>2,260,645,892</b>

# Board Designated Reserve and TNE Analysis

## As of February 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	157,659,267				
	Tier 1 - Logan Circle	156,404,603				
	Tier 1 - Wells Capital	156,906,818				
Board-designated Reserve						
		470,970,688	323,409,639	503,659,839	147,561,049	(32,689,151)
TNE Requirement	Tier 2 - Logan Circle	104,650,153	97,174,161	97,174,161	7,475,992	7,475,992
<b>Consolidated:</b>		<b>575,620,841</b>	<b>420,583,800</b>	<b>600,834,001</b>	<b>155,037,041</b>	<b>(25,213,159)</b>
<i>Current reserve level</i>		<i>1.92</i>	<i>1.40</i>	<i>2.00</i>		





# CalOptima

Better. Together.



Medi-Cal

# CalOptima

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OneCare (HMO SNP)

# CalOptima

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OneCare Connect

# CalOptima

Better. Together.



PACE

# CalOptima

Better. Together.



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## **UNAUDITED FINANCIAL STATEMENTS**

**February 2020**

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## February 29, 2020 Unaudited Financial Statements

### SUMMARY

#### MONTHLY RESULTS:

- Change in Net Assets is \$10.4 million, \$0.8 million favorable to budget
- Operating surplus is \$4.1 million, with a surplus in non-operating income of \$6.2 million

#### YEAR TO DATE RESULTS:

- Change in Net Assets is \$40.9 million, \$16.2 million favorable to budget
- Operating surplus is \$14.2 million, with a surplus in non-operating income of \$26.7 million

#### Change in Net Assets by Line of Business (LOB) (\$ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
3.4	8.4	(5.0)	Medi-Cal	15.9	24.4	(8.4)
0.3	(0.5)	0.7	OCC	(5.4)	(10.2)	4.7
(0.2)	(0.0)	(0.2)	OneCare	0.8	(0.9)	1.6
<u>0.6</u>	<u>0.4</u>	<u>0.3</u>	<u>PACE</u>	<u>3.0</u>	<u>1.5</u>	<u>1.5</u>
<b>4.1</b>	<b>8.3</b>	<b>(4.2)</b>	<b>Operating</b>	<b>14.2</b>	<b>14.8</b>	<b>(0.5)</b>
<u>6.2</u>	<u>1.3</u>	<u>5.0</u>	<u>Inv./Rental Inc, MCO tax</u>	<u>26.7</u>	<u>10.0</u>	<u>16.7</u>
<b>6.2</b>	<b>1.3</b>	<b>5.0</b>	<b>Non-Operating</b>	<b>26.7</b>	<b>10.0</b>	<b>16.7</b>
<b>10.4</b>	<b>9.5</b>	<b>0.8</b>	<b>TOTAL</b>	<b>40.9</b>	<b>24.8</b>	<b>16.2</b>

**CalOptima - Consolidated  
Financial Highlights  
For the Eight Months Ended February 29, 2020**

Month-to-Date				Year-to-Date				
Actual	Budget	\$ Budget	% Budget		Actual	Budget	\$ Budget	% Budget
721,228	740,916	(19,688)	(2.7%)	Member Months	5,910,322	5,974,687	(64,365)	(1.1%)
300,202,018	297,388,165	2,813,852	0.9%	Revenues	2,524,518,675	2,378,080,674	146,438,001	6.2%
285,339,143	276,608,340	(8,730,804)	(3.2%)	Medical Expenses	2,421,011,950	2,260,075,965	(160,935,985)	(7.1%)
10,734,765	12,494,493	1,759,728	14.1%	Administrative Expenses	89,288,986	103,248,541	13,959,555	13.5%
<b>4,128,109</b>	<b>8,285,333</b>	<b>(4,157,223)</b>	<b>(50.2%)</b>	<b>Operating Margin</b>	<b>14,217,739</b>	<b>14,756,168</b>	<b>(538,429)</b>	<b>(3.6%)</b>
6,235,120	1,250,000	4,985,120	398.8%	Non Operating Income (Loss)	26,688,785	10,000,000	16,688,785	166.9%
<b>10,363,229</b>	<b>9,535,333</b>	<b>827,897</b>	<b>8.7%</b>	<b>Change in Net Assets</b>	<b>40,906,524</b>	<b>24,756,168</b>	<b>16,150,356</b>	<b>65.2%</b>
95.0%	93.0%	(2.0%)		Medical Loss Ratio	95.9%	95.0%	(0.9%)	
3.6%	4.2%	0.6%		Administrative Loss Ratio	3.5%	4.3%	0.8%	
<u>1.4%</u>	<u>2.8%</u>	(1.4%)		Operating Margin Ratio	<u>0.6%</u>	<u>0.6%</u>	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.3%	0.6%	

\*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

**CalOptima**  
**Financial Dashboard**  
**For the Eight Months Ended February 29, 2020**

**MONTH - TO - DATE**

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	705,279	725,076 ↓	(19,797)	(2.7%)
OneCare Connect	14,171	13,936 ↑	235	1.7%
OneCare	1,382	1,510 ↓	(128)	(8.5%)
PACE	396	394 ↑	2	0.5%
<b>Total</b>	<b>721,228</b>	<b>740,916 ↓</b>	<b>(19,688)</b>	<b>(2.7%)</b>

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 2,817	\$ 8,413 ↓	\$ (5,596)	(66.5%)
OneCare Connect	284	(460) ↑	744	161.7%
OneCare	(190)	(26) ↓	(164)	(630.8%)
PACE	649	359 ↑	290	80.8%
505 Bldg.	-	- ↑	-	0.0%
Investment Income & Other	6,803	1,250 ↑	5,553	444.2%
<b>Total</b>	<b>\$ 10,363</b>	<b>\$ 9,536 ↑</b>	<b>\$ 827</b>	<b>8.7%</b>

MLR	Actual	Budget	% Point Var
Medi-Cal	95.5%	93.0% ↓	(2.5)
OneCare Connect	92.8%	94.8% ↑	2.0
OneCare	103.7%	92.9% ↓	(10.8)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 8,884	\$ 10,465 ↑	\$ 1,581	15.1%
OneCare Connect	1,535	1,709 ↑	175	10.2%
OneCare	140	145 ↑	5	3.6%
PACE	177	176 ↓	(1)	(0.8%)
<b>Total</b>	<b>\$ 10,735</b>	<b>\$ 12,494 ↑</b>	<b>\$ 1,760</b>	<b>14.1%</b>

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,054	1,183	129
OneCare Connect	192	211	18
OneCare	11	9	(2)
PACE	77	93	15
<b>Total</b>	<b>1,335</b>	<b>1,496</b>	<b>161</b>

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	669	613	56
OneCare Connect	74	66	8
OneCare	121	162	(41)
PACE	5	4	1
<b>Total</b>	<b>869</b>	<b>846</b>	<b>24</b>

**YEAR - TO - DATE**

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,782,162	5,847,134 ↓	(64,972)	(1.1%)
OneCare Connect	113,230	112,603 ↑	627	0.6%
OneCare	11,968	12,016 ↓	(48)	(0.4%)
PACE	2,962	2,934 ↑	28	1.0%
<b>Total</b>	<b>5,910,322</b>	<b>5,974,687 ↓</b>	<b>(64,365)</b>	<b>(1.1%)</b>

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 12,947	\$ 24,364 ↓	\$ (11,417)	(46.9%)
OneCare Connect	(5,443)	(10,183) ↑	4,740	46.5%
OneCare	752	(881) ↑	1,633	185.4%
PACE	2,980	1,457 ↑	1,523	104.5%
505 Bldg.	-	- ↑	-	0.0%
Investment Income & Other	29,671	10,000 ↑	19,671	196.7%
<b>Total</b>	<b>\$ 40,907</b>	<b>\$ 24,757 ↑</b>	<b>\$ 16,150</b>	<b>65.2%</b>

MLR	Actual	Budget	% Point Var
Medi-Cal	96.1%	94.9% ↓	(1.2)
OneCare Connect	96.4%	97.8% ↑	1.3
OneCare	86.2%	97.8% ↑	11.5

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	\$ 74,248	\$ 86,199 ↑	\$ 11,950	13.9%
OneCare Connect	12,480	14,420 ↑	1,940	13.5%
OneCare	1,149	1,175 ↑	25	2.2%
PACE	1,411	1,455 ↑	43	3.0%
<b>Total</b>	<b>\$ 89,289</b>	<b>\$ 103,249 ↑</b>	<b>\$ 13,960</b>	<b>13.5%</b>

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,313	9,314	1,000
OneCare Connect	1,533	1,640	107
OneCare	75	74	(0)
PACE	575	736	161
<b>Total</b>	<b>10,496</b>	<b>11,764</b>	<b>1,268</b>

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	696	628	68
OneCare Connect	74	69	5
OneCare	160	162	(2)
PACE	5	4	1
<b>Total</b>	<b>934</b>	<b>862</b>	<b>72</b>

**CalOptima - Consolidated**  
**Statement of Revenues and Expenses**  
**For the One Month Ended February 29, 2020**

	Actual		Budget		Variance	
	\$	PMPM	\$	PMPM	\$	PMPM
<b>MEMBER MONTHS</b>	721,228		740,916		(19,688)	
<b>REVENUE</b>						
Medi-Cal	\$ 270,366,067	\$ 383.35	\$ 268,448,434	\$ 370.23	\$ 1,917,633	\$ 13.12
OneCare Connect	25,280,051	1,783.93	24,217,845	1,737.67	1,062,206	46.26
OneCare	1,368,401	990.16	1,667,399	1,104.24	(298,998)	(114.08)
PACE	3,187,499	8,049.24	3,054,487	7,752.51	133,012	296.73
Total Operating Revenue	<u>300,202,018</u>	<u>416.24</u>	<u>297,388,165</u>	<u>401.38</u>	<u>2,813,852</u>	<u>14.86</u>
<b>MEDICAL EXPENSES</b>						
Medi-Cal	258,097,330	365.95	249,571,039	344.20	(8,526,292)	(21.75)
OneCare Connect	23,461,729	1,655.62	22,968,065	1,647.99	(493,664)	(7.63)
OneCare	1,418,653	1,026.52	1,548,863	1,025.74	130,210	(0.78)
PACE	2,361,431	5,963.21	2,520,373	6,396.89	158,942	433.68
Total Medical Expenses	<u>285,339,143</u>	<u>395.63</u>	<u>276,608,340</u>	<u>373.33</u>	<u>(8,730,804)</u>	<u>(22.30)</u>
<b>GROSS MARGIN</b>	14,862,874	20.61	20,779,826	28.05	(5,916,952)	(7.44)
<b>ADMINISTRATIVE EXPENSES</b>						
Salaries and benefits	6,938,197	9.62	7,748,287	10.46	810,090	0.84
Professional fees	189,921	0.26	481,001	0.65	291,080	0.39
Purchased services	1,052,241	1.46	1,136,276	1.53	84,035	0.07
Printing & Postage	652,780	0.91	565,630	0.76	(87,150)	(0.15)
Depreciation & Amortization	285,105	0.40	457,866	0.62	172,761	0.22
Other expenses	1,334,222	1.85	1,726,234	2.33	392,012	0.48
Indirect cost allocation & Occupancy expense	282,299	0.39	379,199	0.51	96,900	0.12
Total Administrative Expenses	<u>10,734,765</u>	<u>14.88</u>	<u>12,494,493</u>	<u>16.86</u>	<u>1,759,728</u>	<u>1.98</u>
<b>INCOME (LOSS) FROM OPERATIONS</b>	4,128,109	5.72	8,285,333	11.18	(4,157,223)	(5.46)
<b>INVESTMENT INCOME</b>						
Interest income	2,687,736	3.73	1,250,000	1.69	1,437,736	2.04
Realized gain/(loss) on investments	346,014	0.48	-	-	346,014	0.48
Unrealized gain/(loss) on investments	3,769,215	5.23	-	-	3,769,215	5.23
Total Investment Income	<u>6,802,965</u>	<u>9.43</u>	<u>1,250,000</u>	<u>1.69</u>	<u>5,552,965</u>	<u>7.74</u>
<b>TOTAL MCO TAX</b>	(567,820)	(0.79)	-	-	(567,820)	(0.79)
<b>TOTAL GRANT INCOME</b>	(25)	-	-	-	(25)	-
<b>CHANGE IN NET ASSETS</b>	<u><b>10,363,229</b></u>	<u><b>14.37</b></u>	<u><b>9,535,333</b></u>	<u><b>12.87</b></u>	<u><b>827,897</b></u>	<u><b>1.50</b></u>
<b>MEDICAL LOSS RATIO</b>	<b>95.0%</b>		<b>93.0%</b>		<b>(2.0%)</b>	
<b>ADMINISTRATIVE LOSS RATIO</b>	<b>3.6%</b>		<b>4.2%</b>		<b>0.6%</b>	

**CalOptima - Consolidated**  
**Statement of Revenues and Expenses**  
**For the Eight Months Ended February 29, 2020**

	Actual		Budget		Variance	
	\$	PMPM	\$	PMPM	\$	PMPM
<b>MEMBER MONTHS</b>	5,910,322		5,974,687		(64,365)	
<b>REVENUE</b>						
Medi-Cal	\$ 2,289,341,760	\$ 395.93	\$ 2,151,130,613	\$ 367.89	\$ 138,211,147	\$ 28.04
OneCare Connect	197,683,360	1,745.86	191,063,222	1,696.77	6,620,138	49.09
OneCare	13,807,011	1,153.66	13,093,732	1,089.69	713,279	63.97
PACE	23,686,545	7,996.81	22,793,107	7,768.61	893,438	228.20
Total Operating Revenue	<u>2,524,518,675</u>	<u>427.14</u>	<u>2,378,080,674</u>	<u>398.03</u>	<u>146,438,001</u>	<u>29.11</u>
<b>MEDICAL EXPENSES</b>						
Medi-Cal	2,199,164,351	380.34	2,040,568,022	348.99	(158,596,329)	(31.35)
OneCare Connect	190,646,576	1,683.71	186,826,206	1,659.14	(3,820,370)	(24.57)
OneCare	11,905,213	994.75	12,800,001	1,065.25	894,788	70.50
PACE	19,295,810	6,514.45	19,881,736	6,776.32	585,926	261.87
Total Medical Expenses	<u>2,421,011,950</u>	<u>409.62</u>	<u>2,260,075,965</u>	<u>378.28</u>	<u>(160,935,985)</u>	<u>(31.34)</u>
<b>GROSS MARGIN</b>	103,506,725	17.52	118,004,709	19.75	(14,497,984)	(2.23)
<b>ADMINISTRATIVE EXPENSES</b>						
Salaries and benefits	58,611,495	9.92	64,685,425	10.83	6,073,930	0.91
Professional fees	2,189,579	0.37	3,800,977	0.64	1,611,398	0.27
Purchased services	7,744,517	1.31	9,669,208	1.62	1,924,691	0.31
Printing & Postage	3,345,867	0.57	4,533,726	0.76	1,187,859	0.19
Depreciation & Amortization	2,749,976	0.47	3,662,928	0.61	912,952	0.14
Other expenses	11,794,186	2.00	13,830,886	2.31	2,036,700	0.31
Indirect cost allocation & Occupancy expense	2,853,365	0.48	3,065,391	0.51	212,026	0.03
Total Administrative Expenses	<u>89,288,986</u>	<u>15.11</u>	<u>103,248,541</u>	<u>17.28</u>	<u>13,959,555</u>	<u>2.17</u>
<b>INCOME (LOSS) FROM OPERATIONS</b>	14,217,739	2.41	14,756,168	2.47	(538,429)	(0.06)
<b>INVESTMENT INCOME</b>						
Interest income	22,367,150	3.78	10,000,000	1.67	12,367,150	2.11
Realized gain/(loss) on investments	1,857,218	0.31	-	-	1,857,218	0.31
Unrealized gain/(loss) on investments	5,446,256	0.92	-	-	5,446,256	0.92
Total Investment Income	<u>29,670,624</u>	<u>5.02</u>	<u>10,000,000</u>	<u>1.67</u>	<u>19,670,624</u>	<u>3.35</u>
<b>TOTAL MCO TAX</b>	(2,982,247)	(0.50)	-	-	(2,982,247)	(0.50)
<b>TOTAL GRANT INCOME</b>	(86)	-	-	-	(86)	-
<b>OTHER INCOME</b>	494	-	-	-	494	-
<b>CHANGE IN NET ASSETS</b>	<u><b>40,906,524</b></u>	<u><b>6.92</b></u>	<u><b>24,756,168</b></u>	<u><b>4.14</b></u>	<u><b>16,150,356</b></u>	<u><b>2.78</b></u>
<b>MEDICAL LOSS RATIO</b>	<b>95.9%</b>		<b>95.0%</b>		<b>(0.9%)</b>	
<b>ADMINISTRATIVE LOSS RATIO</b>	<b>3.5%</b>		<b>4.3%</b>		<b>0.8%</b>	



**CalOptima - Consolidated - Month to Date  
Statement of Revenues and Expenses by LOB  
For the One Month Ended February 29, 2020**

	<u>Medi-Cal Classic</u>	<u>Medi-Cal Expansion</u>	<u>Whole Child Model</u>	<u>Total Medi-Cal</u>	<u>OneCare Connect</u>	<u>OneCare</u>	<u>PACE</u>	<u>Consolidated</u>
<b>MEMBER MONTHS</b>	472,451	221,574	11,254	705,279	14,171	1,382	396	721,228
<b>REVENUES</b>								
Capitation Revenue	145,598,779	\$ 102,298,191	\$ 22,469,096	\$ 270,366,067	\$ 25,280,051	\$ 1,368,401	\$ 3,187,499	\$ 300,202,018
Other Income	-	-	-	-	-	-	-	-
<b>Total Operating Revenue</b>	<u>145,598,779</u>	<u>102,298,191</u>	<u>22,469,096</u>	<u>270,366,067</u>	<u>25,280,051</u>	<u>1,368,401</u>	<u>3,187,499</u>	<u>300,202,018</u>
<b>MEDICAL EXPENSES</b>								
Provider Capitation	38,741,390	40,277,099	10,827,278	89,845,768	10,550,133	488,152		100,884,053
Facilities	23,985,484	21,714,691	4,341,694	50,041,869	3,099,820	295,146	681,563	54,118,399
Professional Claims	16,183,837	6,802,760	1,822,257	24,808,854	998,569	79,623	477,547	26,364,593
Prescription Drugs	18,695,116	25,625,489	6,241,731	50,562,337	6,218,457	497,050	270,042	57,547,886
MLTSS	31,791,697	2,353,087	1,602,646	35,747,431	1,295,930	26,695	37,825	37,107,880
Medical Management	1,860,488	1,190,897	247,579	3,298,965	910,214	31,987	697,360	4,938,526
Quality Incentives	1,473,800	443,664	140,439	2,057,903	198,265		4,588	2,260,756
Reinsurance & Other	892,836	810,358	31,010	1,734,204	190,341		192,505	2,117,051
<b>Total Medical Expenses</b>	<u>133,624,649</u>	<u>99,218,046</u>	<u>25,254,635</u>	<u>258,097,330</u>	<u>23,461,729</u>	<u>1,418,653</u>	<u>2,361,431</u>	<u>285,339,143</u>
<b>Medical Loss Ratio</b>	91.8%	97.0%	112.4%	95.5%	92.8%	103.7%	74.1%	95.0%
<b>GROSS MARGIN</b>	<b>11,974,130</b>	<b>3,080,145</b>	<b>(2,785,539)</b>	<b>12,268,737</b>	<b>1,818,321</b>	<b>(50,252)</b>	<b>826,068</b>	<b>14,862,874</b>
<b>ADMINISTRATIVE EXPENSES</b>								
Salaries & Benefits				6,041,509	693,262	67,393	136,033	6,938,197
Professional fees				170,797	4,000	15,000	123	189,921
Purchased services				914,299	119,516	9,354	9,072	1,052,241
Printing & Postage				510,721	111,600	9,241	21,217	652,780
Depreciation & Amortization				283,048			2,057	285,105
Other expenses				1,271,968	57,547	263	4,443	1,334,222
Indirect cost allocation & Occupancy				(308,736)	548,726	38,274	4,036	282,299
<b>Total Administrative Expenses</b>				<u>8,883,606</u>	<u>1,534,651</u>	<u>139,526</u>	<u>176,981</u>	<u>10,734,765</u>
<b>Admin Loss Ratio</b>				3.3%	6.1%	10.2%	5.6%	3.6%
<b>INCOME (LOSS) FROM OPERATIONS</b>				3,385,131	283,670	(189,778)	649,086	4,128,109
<b>INVESTMENT INCOME</b>								6,802,965
<b>TOTAL MCO TAX</b>				(567,820)				(567,820)
<b>TOTAL GRANT INCOME</b>				(25)				(25)
<b>CHANGE IN NET ASSETS</b>				<u>\$ 2,817,285</u>	<u>\$ 283,670</u>	<u>\$ (189,778)</u>	<u>\$ 649,086</u>	<u>\$ 10,363,229</u>
<b>BUDGETED CHANGE IN NET ASSETS</b>				8,412,553	(459,528)	(26,259)	358,567	9,535,333
<b>VARIANCE TO BUDGET - FAV (UNFAV)</b>				<u>\$ (5,595,267)</u>	<u>\$ 743,198</u>	<u>\$ (163,519)</u>	<u>\$ 290,519</u>	<u>\$ 827,897</u>

**CalOptima - Consolidated - Year to Date  
Statement of Revenues and Expenses by LOB  
For the Eight Months Ended February 29, 2020**

	<u>Medi-Cal Classic</u>	<u>Medi-Cal Expansion</u>	<u>Whole Child Model</u>	<u>Total Medi-Cal</u>	<u>OneCare Connect</u>	<u>OneCare</u>	<u>PACE</u>	<u>Consolidated</u>
<b>MEMBER MONTHS</b>	3,864,425	1,825,365	92,371	5,782,161	113,230	11,968	2,962	5,910,321
<b>REVENUES</b>								
Capitation Revenue	1,231,553,286	\$ 873,962,444	\$ 183,826,029	\$ 2,289,341,760	\$ 197,683,360	\$ 13,807,011	\$ 23,686,545	\$ 2,524,518,675
Other Income	-	-	-	-	-	-	-	-
<b>Total Operating Revenue</b>	<u>1,231,553,286</u>	<u>873,962,444</u>	<u>183,826,029</u>	<u>2,289,341,760</u>	<u>197,683,360</u>	<u>13,807,011</u>	<u>23,686,545</u>	<u>2,524,518,675</u>
<b>MEDICAL EXPENSES</b>								
Provider Capitation	311,234,489	351,980,979	80,505,569	743,721,037	87,921,518	3,842,695		835,485,251
Facilities	202,275,127	172,684,144	45,599,674	420,558,945	29,623,026	3,132,248	5,246,068	458,560,288
Professional Claims	141,904,967	55,918,860	11,281,869	209,105,696	6,051,569	390,030	4,298,198	219,845,493
Prescription Drugs	134,435,490	177,103,851	44,461,815	356,001,157	44,972,194	4,133,304	1,872,571	406,979,226
MLTSS	274,707,958	20,979,360	14,730,599	310,417,916	10,826,133	101,275	296,626	321,641,951
Medical Management	16,809,216	9,834,731	2,100,480	28,744,427	8,168,696	305,660	5,714,661	42,933,444
Quality Incentives	7,318,407	3,699,714	1,129,749	12,147,870	1,619,090		191,235	13,958,195
Reinsurance & Other	67,828,448	50,362,499	276,355	118,467,303	1,464,349		1,676,451	121,608,103
<b>Total Medical Expenses</b>	<u>1,156,514,102</u>	<u>842,564,139</u>	<u>200,086,110</u>	<u>2,199,164,351</u>	<u>190,646,576</u>	<u>11,905,213</u>	<u>19,295,810</u>	<u>2,421,011,950</u>
<b>Medical Loss Ratio</b>	93.9%	96.4%	108.8%	96.1%	96.4%	86.2%	81.5%	95.9%
<b>GROSS MARGIN</b>	<b>75,039,184</b>	<b>31,398,306</b>	<b>(16,260,081)</b>	<b>90,177,409</b>	<b>7,036,784</b>	<b>1,901,798</b>	<b>4,390,735</b>	<b>103,506,725</b>
<b>ADMINISTRATIVE EXPENSES</b>								
Salaries & Benefits				51,275,630	5,696,728	519,785	1,119,353	58,611,495
Professional fees				1,572,340	456,485	159,371	1,383	2,189,579
Purchased services				6,383,657	1,183,248	110,905	66,707	7,744,517
Printing & Postage				2,752,156	473,674	37,546	82,490	3,345,867
Depreciation & Amortization				2,733,320			16,656	2,749,976
Other expenses				11,537,951	221,451	2,237	32,546	11,794,186
Indirect cost allocation & Occupancy				(2,006,745)	4,448,560	319,465	92,085	2,853,365
<b>Total Administrative Expenses</b>				<u>74,248,309</u>	<u>12,480,147</u>	<u>1,149,310</u>	<u>1,411,220</u>	<u>89,288,986</u>
<b>Admin Loss Ratio</b>				3.2%	6.3%	8.3%	6.0%	3.5%
<b>INCOME (LOSS) FROM OPERATIONS</b>				15,929,100	(5,443,364)	752,488	2,979,514	14,217,739
<b>INVESTMENT INCOME</b>								29,670,624
<b>TOTAL MCO TAX</b>				(2,982,247)				(2,982,247)
<b>TOTAL GRANT INCOME</b>				(86)				(86)
<b>OTHER INCOME</b>				494				494
<b>CHANGE IN NET ASSETS</b>				<u>\$ 12,947,261</u>	<u>\$ (5,443,364)</u>	<u>\$ 752,488</u>	<u>\$ 2,979,514</u>	<u>\$ 40,906,524</u>
<b>BUDGETED CHANGE IN NET ASSETS</b>				24,363,845	(10,183,404)	(881,059)	1,456,786	24,756,168
<b>VARIANCE TO BUDGET - FAV (UNFAV)</b>				<u>\$ (11,416,584)</u>	<u>\$ 4,740,040</u>	<u>\$ 1,633,547</u>	<u>\$ 1,522,728</u>	<u>\$ 16,150,356</u>

**Enrollment Summary**  
**For the Eight Months Ended February 29, 2020**

Month-to-Date										Year-to-Date					
		\$	%					\$	%			\$	%		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Variance</u>	Enrollment (by Aid Category)		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Variance</u>			<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Variance</u>
66,380	66,109	271	0.4%	Aged		526,739	525,189	1,550	0.3%						
485	615	(130)	(21.1%)	BCCTP		4,271	4,920	(649)	(13.2%)						
44,939	43,622	1,317	3.0%	Disabled		357,779	349,951	7,828	2.2%						
275,139	277,984	(2,845)	(1.0%)	TANF Child		2,258,069	2,262,182	(4,113)	(0.2%)						
81,999	84,745	(2,746)	(3.2%)	TANF Adult		689,744	691,343	(1,599)	(0.2%)						
3,509	3,404	105	3.1%	LTC		27,823	27,232	591	2.2%						
221,574	235,657	(14,083)	(6.0%)	MCE		1,825,365	1,882,797	(57,432)	(3.1%)						
11,254	12,940	(1,686)	(13.0%)	WCM		92,371	103,520	(11,149)	(10.8%)						
<b>705,279</b>	<b>725,076</b>	<b>(19,797)</b>	<b>(2.7%)</b>	<b>Medi-Cal Total</b>		<b>5,782,162</b>	<b>5,847,134</b>	<b>(64,972)</b>	<b>(1.1%)</b>						
<b>14,171</b>	<b>13,936</b>	<b>235</b>	<b>1.7%</b>	<b>OneCare Connect</b>		<b>113,230</b>	<b>112,603</b>	<b>627</b>	<b>0.6%</b>						
<b>1,382</b>	<b>1,510</b>	<b>(128)</b>	<b>(8.5%)</b>	<b>OneCare</b>		<b>11,968</b>	<b>12,016</b>	<b>(48)</b>	<b>(0.4%)</b>						
<b>396</b>	<b>394</b>	<b>2</b>	<b>0.5%</b>	<b>PACE</b>		<b>2,962</b>	<b>2,934</b>	<b>28</b>	<b>1.0%</b>						
<b>721,228</b>	<b>740,916</b>	<b>(19,688)</b>	<b>(2.7%)</b>	<b>CalOptima Total</b>		<b>5,910,322</b>	<b>5,974,687</b>	<b>(64,365)</b>	<b>(1.1%)</b>						
<b>Enrollment (by Network)</b>															
154,360	160,942	(6,582)	(4.1%)	HMO		1,273,688	1,297,298	(23,610)	(1.8%)						
199,417	206,504	(7,087)	(3.4%)	PHC		1,646,722	1,672,654	(25,932)	(1.6%)						
165,077	185,606	(20,529)	(11.1%)	Shared Risk Group		1,417,948	1,498,001	(80,053)	(5.3%)						
186,425	172,024	14,401	8.4%	Fee for Service		1,443,803	1,379,181	64,622	4.7%						
<b>705,279</b>	<b>725,076</b>	<b>(19,797)</b>	<b>(2.7%)</b>	<b>Medi-Cal Total</b>		<b>5,782,162</b>	<b>5,847,134</b>	<b>(64,972)</b>	<b>(1.1%)</b>						
<b>14,171</b>	<b>13,936</b>	<b>235</b>	<b>1.7%</b>	<b>OneCare Connect</b>		<b>113,230</b>	<b>112,603</b>	<b>627</b>	<b>0.6%</b>						
<b>1,382</b>	<b>1,510</b>	<b>(128)</b>	<b>(8.5%)</b>	<b>OneCare</b>		<b>11,968</b>	<b>12,016</b>	<b>(48)</b>	<b>(0.4%)</b>						
<b>396</b>	<b>394</b>	<b>2</b>	<b>0.5%</b>	<b>PACE</b>		<b>2,962</b>	<b>2,934</b>	<b>28</b>	<b>1.0%</b>						
<b>721,228</b>	<b>740,916</b>	<b>(19,688)</b>	<b>(2.7%)</b>	<b>CalOptima Total</b>		<b>5,910,322</b>	<b>5,974,687</b>	<b>(64,365)</b>	<b>(1.1%)</b>						

**CalOptima  
Enrollment Trend by Network  
Fiscal Year 2020**

MEDI-CAL		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	YTD Actual	YTD Budget	Variance
<b>HMOs</b>												
02.Aged	Aged	3,723	3,740	3,754	3,821	3,827	3,743	3,768	3,625	30,001	30,379	(378)
03.BCCTP	BCCTP	1	1	2	2	1	1	1	1	10	8	2
04.Disabled	Disabled	6,539	6,547	6,572	6,613	6,633	6,546	6,468	6,612	52,530	52,923	(393)
05.TANF Child	TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	50,877	50,743	419,491	422,371	(2,880)
06.TANF Adult	TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	25,104	25,208	214,901	221,721	(6,820)
08.LTC	LTC	2	1	3	3	2	4	5	5	20	16	4
10.MCE	MCE	68,973	69,077	68,729	68,881	68,361	68,256	62,418	66,229	540,924	550,976	(10,052)
11.WCM	WCM	2,026	2,087	2,052	1,987	2,006	2,024	1,692	1,937	15,811	18,904	(3,093)
<b>Total</b>		<b>163,254</b>	<b>162,896</b>	<b>161,178</b>	<b>161,655</b>	<b>160,633</b>	<b>159,384</b>	<b>150,328</b>	<b>154,360</b>	<b>1,273,688</b>	<b>1,297,298</b>	<b>(23,610)</b>
<b>PHCs</b>												
02.Aged	Aged	1,548	1,540	1,524	1,542	1,577	1,579	1,516	1,448	12,274	12,201	73
03.BCCTP	BCCTP											0
04.Disabled	Disabled	5,416	5,499	5,323	5,425	5,500	5,474	5,244	5,422	43,303	42,658	645
05.TANF Child	TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	143,833	140,195	1,157,179	1,172,774	(15,595)
06.TANF Adult	TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	9,797	9,907	85,993	82,061	3,932
08.LTC	LTC	1	1	1	1	1	1	2	2	7	7	0
10.MCE	MCE	37,510	37,479	37,084	37,037	36,728	36,708	33,716	35,640	291,902	301,488	(9,586)
11.WCM	WCM	7,209	7,276	7,190	7,151	7,070	6,994	6,371	6,803	56,064	61,472	(5,408)
<b>Total</b>		<b>211,497</b>	<b>211,247</b>	<b>206,041</b>	<b>208,410</b>	<b>207,353</b>	<b>202,278</b>	<b>200,479</b>	<b>199,417</b>	<b>1,646,722</b>	<b>1,672,654</b>	<b>(25,932)</b>
<b>Shared Risk Groups</b>												
02.Aged	Aged	3,569	3,523	3,470	3,501	3,527	3,364	3,301	3,225	27,480	29,002	(1,522)
03.BCCTP	BCCTP						1	(1)	1	1	1	1
04.Disabled	Disabled	7,275	7,294	7,144	7,177	7,200	7,139	6,724	7,092	57,045	54,542	2,503
05.TANF Child	TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	56,508	54,614	468,835	492,147	(23,312)
06.TANF Adult	TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	24,473	24,861	215,890	227,918	(12,028)
08.LTC	LTC	1	3	3	2	1	1	1	1	12	8	4
10.MCE	MCE	84,595	83,922	82,492	81,749	80,096	79,714	69,637	73,826	636,031	678,648	(42,617)
11.WCM	WCM	1,732	1,706	1,620	1,598	1,581	1,593	1,367	1,457	12,654	15,736	(3,082)
<b>Total</b>		<b>189,144</b>	<b>187,219</b>	<b>179,572</b>	<b>181,034</b>	<b>178,041</b>	<b>175,852</b>	<b>162,009</b>	<b>165,077</b>	<b>1,417,948</b>	<b>1,498,001</b>	<b>(80,053)</b>
<b>Fee for Service (Dual)</b>												
02.Aged	Aged	51,730	52,454	52,097	52,050	52,649	51,770	54,711	52,919	420,380	417,492	2,888
03.BCCTP	BCCTP	15	18	17	18	19	20	13	10	130	144	(14)
04.Disabled	Disabled	20,752	20,053	20,586	20,577	20,781	20,848	20,986	20,729	165,312	164,209	1,103
05.TANF Child	TANF Child		19	1	1	1	1	1	1	25	25	0
06.TANF Adult	TANF Adult	964	1,923	949	941	963	938	1,528	917	9,123	7,093	2,030
08.LTC	LTC	3,044	3,097	3,061	3,161	3,204	2,971	3,389	3,142	25,069	24,392	677
10.MCE	MCE	2,116	2,171	1,935	1,717	1,737	2,255	876	1,084	13,891	16,520	(2,629)
11.WCM	WCM	15	15	15	16	15	16	15	14	121	128	(7)
<b>Total</b>		<b>78,636</b>	<b>79,750</b>	<b>78,661</b>	<b>78,481</b>	<b>79,369</b>	<b>78,819</b>	<b>81,519</b>	<b>78,816</b>	<b>634,051</b>	<b>629,978</b>	<b>4,073</b>
<b>Fee for Service (Non-Dual - Total)</b>												
02.Aged	Aged	4,682	4,211	4,370	4,583	4,890	3,841	4,864	5,163	36,604	36,115	489
03.BCCTP	BCCTP	550	542	484	532	525	518	506	473	4,130	4,768	(638)
04.Disabled	Disabled	4,928	5,692	4,374	4,930	5,428	8,670	483	5,084	39,589	35,619	3,970
05.TANF Child	TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	32,748	29,586	212,539	174,890	37,649
06.TANF Adult	TANF Adult	19,658	19,951	19,854	19,854	23,011	22,542	18,203	21,106	163,837	152,550	11,287
08.LTC	LTC	328	326	331	347	364	302	358	359	2,715	2,816	(101)
10.MCE	MCE	40,680	41,152	40,342	41,308	48,994	48,138	37,208	44,795	342,617	335,165	7,452
11.WCM	WCM	843	960	978	1,008	1,079	874	936	1,043	7,721	7,280	441
<b>Total</b>		<b>97,240</b>	<b>104,940</b>	<b>86,516</b>	<b>97,857</b>	<b>114,205</b>	<b>106,079</b>	<b>95,306</b>	<b>107,609</b>	<b>809,752</b>	<b>749,203</b>	<b>60,549</b>
<b>Grand Totals</b>												
02.Aged	Aged	65,252	65,468	65,215	65,497	66,470	64,297	68,160	66,380	526,739	525,189	1,550
03.BCCTP	BCCTP	566	561	503	552	545	540	519	485	4,271	4,920	(649)
04.Disabled	Disabled	44,910	45,085	43,999	44,722	45,542	48,677	39,905	44,939	357,779	349,951	7,828
05.TANF Child	TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	283,967	275,139	2,258,069	2,262,182	(4,113)
06.TANF Adult	TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	79,105	81,999	689,744	691,343	(1,599)
08.LTC	LTC	3,375	3,399	3,513	3,427	3,572	3,279	3,749	3,509	27,823	27,232	591
10.MCE	MCE	233,874	233,801	230,582	230,692	235,916	235,071	203,855	221,574	1,825,365	1,882,797	(57,432)
11.WCM	WCM	11,825	12,044	11,855	11,760	11,751	11,501	10,381	11,254	92,371	103,520	(11,149)
<b>Total MediCal MM</b>		<b>739,771</b>	<b>746,052</b>	<b>711,968</b>	<b>727,437</b>	<b>739,601</b>	<b>722,412</b>	<b>689,641</b>	<b>705,279</b>	<b>5,782,162</b>	<b>5,847,134</b>	<b>(64,972)</b>
<b>OneCare Connect</b>		<b>14,257</b>	<b>14,090</b>	<b>14,186</b>	<b>14,093</b>	<b>14,065</b>	<b>14,264</b>	<b>14,104</b>	<b>14,171</b>	<b>113,230</b>	<b>112,603</b>	<b>627</b>
<b>OneCare</b>		<b>1,530</b>	<b>1,545</b>	<b>1,564</b>	<b>1,567</b>	<b>1,498</b>	<b>1,465</b>	<b>1,417</b>	<b>1,382</b>	<b>11,968</b>	<b>12,016</b>	<b>(48)</b>
<b>PACE</b>		<b>335</b>	<b>345</b>	<b>356</b>	<b>368</b>	<b>375</b>	<b>393</b>	<b>394</b>	<b>396</b>	<b>2,962</b>	<b>2,934</b>	<b>28</b>
<b>Grand Total</b>		<b>755,893</b>	<b>762,032</b>	<b>728,074</b>	<b>743,465</b>	<b>755,539</b>	<b>738,534</b>	<b>705,556</b>	<b>721,228</b>	<b>5,910,322</b>	<b>5,974,687</b>	<b>(64,365)</b>

## **ENROLLMENT:**

**Overall** February enrollment was 721,228

- Unfavorable to budget 19,688 or 2.7%
- Increased 15,672 or 2.2% from prior month (PM) (January 2020)
- Decreased 39,974 or 5.3% from prior year (PY) (February 2019)

**Medi-Cal** enrollment was 705,279

- Unfavorable to budget 19,797 or 2.7%
  - Medi-Cal Expansion (MCE) unfavorable 14,083
  - Temporary Assistance for Needy Families (TANF) unfavorable 5,591
  - Whole Child Model (WCM) unfavorable 1,686
  - Seniors and Persons with Disabilities (SPD) favorable 1,458
  - Long-Term Care (LTC) favorable 105
- Increased 15,638 from PM

**OneCare Connect** enrollment was 14,171

- Favorable to budget 235 or 1.7%
- Increased 67 from PM

**OneCare** enrollment was 1,382

- Unfavorable to budget 128 or 8.5%
- Decreased 35 from PM

**PACE** enrollment was 396

- Favorable to budget 2 or 0.5%
- Increased 2 from PM

**CalOptima  
Medi-Cal Total  
Statement of Revenues and Expenses  
For the Eight Months Ending February 29, 2020**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
705,279	725,076	(19,797)	(2.7%)	<b>Member Months</b>	5,782,162	5,847,134	(64,972)	(1.1%)
				<b>Revenues</b>				
270,366,067	268,448,434	1,917,633	0.7%	Capitation Revenue	2,289,341,760	2,151,130,613	138,211,147	6.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
<b>270,366,067</b>	<b>268,448,434</b>	<b>1,917,633</b>	<b>0.7%</b>	<b>Total Operating Revenue</b>	<b>2,289,341,760</b>	<b>2,151,130,613</b>	<b>138,211,147</b>	<b>6.4%</b>
				<b>Medical Expenses</b>				
91,903,671	95,031,507	3,127,836	3.3%	Provider Capitation	755,868,907	760,945,725	5,076,818	0.7%
50,041,869	46,710,089	(3,331,780)	(7.1%)	Facilities Claims	420,558,945	385,634,237	(34,924,708)	(9.1%)
24,808,854	22,177,011	(2,631,842)	(11.9%)	Professional Claims	209,105,696	184,452,248	(24,653,448)	(13.4%)
50,562,337	42,106,025	(8,456,311)	(20.1%)	Prescription Drugs	356,001,157	350,907,878	(5,093,278)	(1.5%)
35,747,431	35,351,234	(396,197)	(1.1%)	MLTSS	310,417,916	295,851,927	(14,565,989)	(4.9%)
3,298,965	4,998,254	1,699,289	34.0%	Medical Management	28,744,427	37,179,506	8,435,079	22.7%
1,734,204	3,196,918	1,462,714	45.8%	Reinsurance & Other	118,467,303	25,596,500	(92,870,804)	(362.8%)
<b>258,097,330</b>	<b>249,571,039</b>	<b>(8,526,292)</b>	<b>(3.4%)</b>	<b>Total Medical Expenses</b>	<b>2,199,164,351</b>	<b>2,040,568,022</b>	<b>(158,596,329)</b>	<b>(7.8%)</b>
<b>12,268,737</b>	<b>18,877,396</b>	<b>(6,608,659)</b>	<b>(35.0%)</b>	<b>Gross Margin</b>	<b>90,177,409</b>	<b>110,562,591</b>	<b>(20,385,182)</b>	<b>(18.4%)</b>
				<b>Administrative Expenses</b>				
6,041,509	6,762,602	721,093	10.7%	Salaries, Wages & Employee Benefits	51,275,630	56,586,031	5,310,401	9.4%
170,797	381,572	210,775	55.2%	Professional Fees	1,572,340	3,005,546	1,433,206	47.7%
914,299	957,253	42,954	4.5%	Purchased Services	6,383,657	7,637,026	1,253,369	16.4%
510,721	442,570	(68,151)	(15.4%)	Printing and Postage	2,752,156	3,549,244	797,088	22.5%
283,048	455,750	172,702	37.9%	Depreciation & Amortization	2,733,320	3,646,000	912,680	25.0%
1,271,968	1,645,473	373,505	22.7%	Other Operating Expenses	11,537,951	13,184,790	1,646,839	12.5%
(308,736)	(180,377)	128,359	71.2%	Indirect Cost Allocation, Occupancy Expense	(2,006,745)	(1,409,891)	596,854	42.3%
<b>8,883,606</b>	<b>10,464,843</b>	<b>1,581,237</b>	<b>15.1%</b>	<b>Total Administrative Expenses</b>	<b>74,248,309</b>	<b>86,198,746</b>	<b>11,950,437</b>	<b>13.9%</b>
				<b>Operating Tax</b>				
13,543,285	11,180,942	2,362,343	21.1%	Tax Revenue	110,080,526	90,152,409	19,928,117	22.1%
14,111,106	11,180,942	(2,930,164)	(26.2%)	Premium Tax Expense	113,062,774	90,152,409	(22,910,365)	(25.4%)
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(567,820)	-	(567,820)	0.0%	<b>Total Net Operating Tax</b>	(2,982,247)	-	(2,982,247)	0.0%
				<b>Grant Income</b>				
16,930	-	16,930	0.0%	Grant Revenue	100,192	-	100,192	0.0%
4,888	-	(4,888)	0.0%	Grant expense - Service Partner	15,513	-	(15,513)	0.0%
12,068	-	(12,068)	0.0%	Grant expense - Administrative	84,765	-	(84,765)	0.0%
(25)	-	(25)	0.0%	<b>Total Grant Income</b>	(86)	-	(86)	0.0%
-	-	-	0.0%	<b>Other income</b>	494	-	494	0.0%
<b>2,817,285</b>	<b>8,412,553</b>	<b>(5,595,267)</b>	<b>(66.5%)</b>	<b>Change in Net Assets</b>	<b>12,947,261</b>	<b>24,363,845</b>	<b>(11,416,584)</b>	<b>(46.9%)</b>
95.5%	93.0%	(2.5%)	(2.7%)	<b>Medical Loss Ratio</b>	96.1%	94.9%	(1.2%)	(1.3%)
3.3%	3.9%	0.6%	15.7%	<b>Admin Loss Ratio</b>	3.2%	4.0%	0.8%	19.1%

## **MEDI-CAL INCOME STATEMENT - FEBRUARY MONTH:**

**REVENUES** of \$270.4 million are favorable to budget \$1.9 million driven by:

- Unfavorable volume related variance of \$7.3 million
- Favorable price related variance of \$9.2 million due to:
  - \$8.0 million of Coordinated Care Initiative (CCI) revenue
  - \$3.0 million of acuity rate adjustment revenue
  - \$2.1 million of Behavioral Health Treatment (BHT) revenue
  - Offset by \$3.9 million of WCM revenue

**MEDICAL EXPENSES** of \$258.1 million are unfavorable to budget \$8.5 million driven by:

- Favorable volume related variance of \$6.8 million
- Unfavorable price related variance of \$15.3 million due to:
  - Prescription Drugs unfavorable variance of \$9.6 million due to prior period claims
  - Facilities Claims unfavorable variance of \$4.6 million due to increased utilization
  - Professional Claims unfavorable variance of \$3.2 million due to crossover claims

**ADMINISTRATIVE EXPENSES** of \$8.9 million are favorable to budget \$1.6 million driven by:

- Salaries & Benefit expenses are favorable to budget \$0.7 million
- Other Non-Salary expenses are favorable to budget \$0.9 million

**CHANGE IN NET ASSETS** is \$2.8 million for the month, unfavorable to budget \$5.6 million

**CalOptima**  
**OneCare Connect Total**  
**Statement of Revenue and Expenses**  
**For the Eight Months Ending February 29, 2020**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
14,171	13,936	235	1.7%	<b>Member Months</b>	113,230	112,603	627	0.6%
				Revenues				
2,824,630	2,735,912	88,718	3.2%	Medi-Cal Capitation Revenue	19,721,738	22,202,908	(2,481,170)	(11.2%)
16,916,991	16,658,151	258,840	1.6%	Medicare Capitation Revenue Part C	134,791,828	130,505,264	4,286,564	3.3%
5,538,430	4,823,782	714,648	14.8%	Medicare Capitation Revenue Part D	43,169,794	38,355,050	4,814,744	12.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
<b>25,280,051</b>	<b>24,217,845</b>	<b>1,062,206</b>	<b>4.4%</b>	<b>Total Operating Revenue</b>	<b>197,683,360</b>	<b>191,063,222</b>	<b>6,620,138</b>	<b>3.5%</b>
				Medical Expenses				
10,748,398	11,007,896	259,498	2.4%	Provider Capitation	89,540,608	87,420,081	(2,120,527)	(2.4%)
3,099,820	3,441,226	341,406	9.9%	Facilities Claims	29,623,026	27,973,066	(1,649,960)	(5.9%)
998,569	663,352	(335,217)	(50.5%)	Ancillary	6,051,569	5,460,038	(591,531)	(10.8%)
1,295,930	1,447,066	151,136	10.4%	MLTSS	10,826,133	12,332,041	1,505,908	12.2%
6,218,457	5,100,168	(1,118,289)	(21.9%)	Prescription Drugs	44,972,194	43,021,127	(1,951,067)	(4.5%)
910,214	1,087,360	177,146	16.3%	Medical Management	8,168,696	8,873,964	705,268	7.9%
190,341	220,997	30,656	13.9%	Other Medical Expenses	1,464,349	1,745,889	281,540	16.1%
<b>23,461,729</b>	<b>22,968,065</b>	<b>(493,664)</b>	<b>(2.1%)</b>	<b>Total Medical Expenses</b>	<b>190,646,576</b>	<b>186,826,206</b>	<b>(3,820,370)</b>	<b>(2.0%)</b>
<b>1,818,321</b>	<b>1,249,780</b>	<b>568,541</b>	<b>45.5%</b>	<b>Gross Margin</b>	<b>7,036,784</b>	<b>4,237,016</b>	<b>2,799,768</b>	<b>66.1%</b>
				Administrative Expenses				
693,262	800,983	107,721	13.4%	Salaries, Wages & Employee Benefits	5,696,728	6,553,819	857,091	13.1%
4,000	77,796	73,796	94.9%	Professional Fees	456,485	622,367	165,882	26.7%
119,516	142,989	23,473	16.4%	Purchased Services	1,183,248	1,743,910	560,662	32.1%
111,600	95,860	(15,740)	(16.4%)	Printing and Postage	473,674	766,882	293,208	38.2%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
57,547	71,888	14,341	19.9%	Other Operating Expenses	221,451	575,106	353,655	61.5%
548,726	519,792	(28,934)	(5.6%)	Indirect Cost Allocation	4,448,560	4,158,336	(290,224)	(7.0%)
<b>1,534,651</b>	<b>1,709,308</b>	<b>174,657</b>	<b>10.2%</b>	<b>Total Administrative Expenses</b>	<b>12,480,147</b>	<b>14,420,420</b>	<b>1,940,273</b>	<b>13.5%</b>
<b>283,670</b>	<b>(459,528)</b>	<b>743,198</b>	<b>161.7%</b>	<b>Change in Net Assets</b>	<b>(5,443,364)</b>	<b>(10,183,404)</b>	<b>4,740,040</b>	<b>46.5%</b>
<b>92.8%</b>	<b>94.8%</b>	<b>2.0%</b>	<b>2.1%</b>	<b>Medical Loss Ratio</b>	<b>96.4%</b>	<b>97.8%</b>	<b>1.3%</b>	<b>1.4%</b>
<b>6.1%</b>	<b>7.1%</b>	<b>1.0%</b>	<b>14.0%</b>	<b>Admin Loss Ratio</b>	<b>6.3%</b>	<b>7.5%</b>	<b>1.2%</b>	<b>16.4%</b>



**ONECARE CONNECT INCOME STATEMENT - FEBRUARY MONTH:**

**REVENUES** of \$25.3 million are favorable to budget \$1.1 million driven by:

- Favorable volume related variance of \$0.4 million
- Favorable price related variance of \$0.7 million

**MEDICAL EXPENSES** of \$23.5 million are unfavorable to budget \$0.5 million driven by:

- Unfavorable volume related variance of \$0.4 million
- Unfavorable price related variance of \$0.1 million

**ADMINISTRATIVE EXPENSES** of \$1.5 million are favorable to budget \$0.2 million

**CHANGE IN NET ASSETS** is \$0.3 million, favorable to budget \$0.7 million

**CalOptima  
OneCare  
Statement of Revenues and Expenses  
For the Eight Months Ending February 29, 2020**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
1,382	1,510	(128)	(8.5%)	<b>Member Months</b>	11,968	12,016	(48)	(0.4%)
				<b>Revenues</b>				
1,224,069	1,143,116	80,953	7.1%	Medicare Part C revenue	9,731,978	8,937,256	794,722	8.9%
144,332	524,283	(379,951)	(72.5%)	Medicare Part D revenue	4,075,033	4,156,476	(81,443)	(2.0%)
<b>1,368,401</b>	<b>1,667,399</b>	<b>(298,998)</b>	<b>(17.9%)</b>	<b>Total Operating Revenue</b>	<b>13,807,011</b>	<b>13,093,732</b>	<b>713,279</b>	<b>5.4%</b>
				<b>Medical Expenses</b>				
488,152	442,720	(45,432)	(10.3%)	Provider Capitation	3,842,695	3,521,251	(321,444)	(9.1%)
295,146	480,878	185,732	38.6%	Inpatient	3,132,248	4,027,536	895,288	22.2%
79,623	52,619	(27,004)	(51.3%)	Ancillary	390,030	439,969	49,939	11.4%
26,695	43,184	16,489	38.2%	Skilled Nursing Facilities	101,275	361,403	260,128	72.0%
497,050	472,329	(24,721)	(5.2%)	Prescription Drugs	4,133,304	3,981,207	(152,097)	(3.8%)
31,987	46,235	14,248	30.8%	Medical Management	305,660	381,910	76,250	20.0%
-	10,898	10,898	100.0%	Other Medical Expenses	-	86,725	86,725	100.0%
<b>1,418,653</b>	<b>1,548,863</b>	<b>130,210</b>	<b>8.4%</b>	<b>Total Medical Expenses</b>	<b>11,905,213</b>	<b>12,800,001</b>	<b>894,788</b>	<b>7.0%</b>
<b>(50,252)</b>	<b>118,536</b>	<b>(168,788)</b>	<b>(142.4%)</b>	<b>Gross Margin</b>	<b>1,901,798</b>	<b>293,731</b>	<b>1,608,067</b>	<b>547.5%</b>
				<b>Administrative Expenses</b>				
67,393	49,258	(18,135)	(36.8%)	Salaries, wages & employee benefits	519,785	410,494	(109,291)	(26.6%)
15,000	21,480	6,480	30.2%	Professional fees	159,371	171,840	12,469	7.3%
9,354	17,063	7,709	45.2%	Purchased services	110,905	136,504	25,599	18.8%
9,241	16,667	7,426	44.6%	Printing and postage	37,546	133,336	95,790	71.8%
263	4,738	4,475	94.4%	Other operating expenses	2,237	37,904	35,667	94.1%
38,274	35,589	(2,685)	(7.5%)	Indirect cost allocation, occupancy expense	319,465	284,712	(34,753)	(12.2%)
<b>139,526</b>	<b>144,795</b>	<b>5,269</b>	<b>3.6%</b>	<b>Total Administrative Expenses</b>	<b>1,149,310</b>	<b>1,174,790</b>	<b>25,480</b>	<b>2.2%</b>
<b>(189,778)</b>	<b>(26,259)</b>	<b>(163,519)</b>	<b>(622.7%)</b>	<b>Change in Net Assets</b>	<b>752,488</b>	<b>(881,059)</b>	<b>1,633,547</b>	<b>185.4%</b>
<b>103.7%</b>	<b>92.9%</b>	<b>(10.8%)</b>	<b>(11.6%)</b>	<b>Medical Loss Ratio</b>	<b>86.2%</b>	<b>97.8%</b>	<b>11.5%</b>	<b>11.8%</b>
<b>10.2%</b>	<b>8.7%</b>	<b>(1.5%)</b>	<b>(17.4%)</b>	<b>Admin Loss Ratio</b>	<b>8.3%</b>	<b>9.0%</b>	<b>0.6%</b>	<b>7.2%</b>

**CalOptima  
PACE  
Statement of Revenues and Expenses  
For the Eight Months Ending February 29, 2020**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
396	394	2	0.5%	<b>Member Months</b>	2,962	2,934	28	1.0%
				<b>Revenues</b>				
2,533,182	2,368,216	164,966	7.0%	Medi-Cal Capitation Revenue	18,504,247	17,640,696	863,551	4.9%
570,846	540,800	30,046	5.6%	Medicare Part C Revenue	4,096,847	4,070,227	26,620	0.7%
83,471	145,471	(62,000)	(42.6%)	Medicare Part D Revenue	1,085,450	1,082,184	3,266	0.3%
<b>3,187,499</b>	<b>3,054,487</b>	<b>133,012</b>	<b>4.4%</b>	<b>Total Operating Revenue</b>	<b>23,686,545</b>	<b>22,793,107</b>	<b>893,438</b>	<b>3.9%</b>
				<b>Medical Expenses</b>				
697,360	850,641	153,281	18.0%	Medical Management	5,714,661	6,975,478	1,260,817	18.1%
681,563	550,589	(130,974)	(23.8%)	Facilities Claims	5,246,068	4,283,511	(962,557)	(22.5%)
477,547	602,022	124,475	20.7%	Professional Claims	4,298,198	4,694,997	396,799	8.5%
192,505	247,014	54,509	22.1%	Patient Transportation	1,676,451	1,880,950	204,499	10.9%
270,042	229,569	(40,473)	(17.6%)	Prescription Drugs	1,872,571	1,786,237	(86,334)	(4.8%)
37,825	33,871	(3,954)	(11.7%)	MLTSS	296,626	207,229	(89,397)	(43.1%)
4,588	6,667	2,079	31.2%	Other Expenses	191,235	53,334	(137,901)	(258.6%)
<b>2,361,431</b>	<b>2,520,373</b>	<b>158,942</b>	<b>6.3%</b>	<b>Total Medical Expenses</b>	<b>19,295,810</b>	<b>19,881,736</b>	<b>585,926</b>	<b>2.9%</b>
<b>826,068</b>	<b>534,114</b>	<b>291,954</b>	<b>54.7%</b>	<b>Gross Margin</b>	<b>4,390,735</b>	<b>2,911,371</b>	<b>1,479,364</b>	<b>50.8%</b>
				<b>Administrative Expenses</b>				
136,033	135,444	(589)	(0.4%)	Salaries, wages & employee benefits	1,119,353	1,135,081	15,728	1.4%
123	153	30	19.4%	Professional fees	1,383	1,224	(159)	(13.0%)
9,072	18,971	9,899	52.2%	Purchased services	66,707	151,768	85,061	56.0%
21,217	10,533	(10,684)	(101.4%)	Printing and postage	82,490	84,264	1,774	2.1%
2,057	2,116	59	2.8%	Depreciation & amortization	16,656	16,928	272	1.6%
4,443	4,135	(308)	(7.4%)	Other operating expenses	32,546	33,086	540	1.6%
4,036	4,195	159	3.8%	Indirect Cost Allocation, Occupancy Expense	92,085	32,234	(59,851)	(185.7%)
<b>176,981</b>	<b>175,547</b>	<b>(1,434)</b>	<b>(0.8%)</b>	<b>Total Administrative Expenses</b>	<b>1,411,220</b>	<b>1,454,585</b>	<b>43,365</b>	<b>3.0%</b>
				<b>Operating Tax</b>				
5,877	-	5,877	0.0%	Tax Revenue	43,956	-	43,956	0.0%
5,877	-	(5,877)	0.0%	Premium Tax Expense	43,956	-	(43,956)	0.0%
<b>-</b>	<b>-</b>	<b>-</b>	<b>0.0%</b>	<b>Total Net Operating Tax</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.0%</b>
<b>649,086</b>	<b>358,567</b>	<b>290,519</b>	<b>81.0%</b>	<b>Change in Net Assets</b>	<b>2,979,514</b>	<b>1,456,786</b>	<b>1,522,728</b>	<b>104.5%</b>
<b>74.1%</b>	<b>82.5%</b>	<b>8.4%</b>	<b>10.2%</b>	<b>Medical Loss Ratio</b>	<b>81.5%</b>	<b>87.2%</b>	<b>5.8%</b>	<b>6.6%</b>
<b>5.6%</b>	<b>5.7%</b>	<b>0.2%</b>	<b>3.4%</b>	<b>Admin Loss Ratio</b>	<b>6.0%</b>	<b>6.4%</b>	<b>0.4%</b>	<b>6.6%</b>

**CalOptima**  
**BUILDING 505 - CITY PARKWAY**  
**Statement of Revenues and Expenses**  
**For the Eight Months Ending February 29, 2020**

Month				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
				<b>Revenues</b>				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	<b>0.0%</b>	<b>Total Operating Revenue</b>	-	-	-	<b>0.0%</b>
				<b>Administrative Expenses</b>				
47,284	23,101	(24,183)	(104.7%)	Purchase services	387,292	184,809	(202,483)	(109.6%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	1,315,950	1,397,800	81,850	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	139,812	126,928	(12,884)	(10.2%)
88,093	140,162	52,069	37.1%	Repair and maintenance	822,874	1,121,296	298,422	26.6%
31,368	46,432	15,064	32.4%	Other Operating Expense	351,044	371,456	20,412	5.5%
(348,716)	(400,286)	(51,570)	(12.9%)	Indirect allocation, Occupancy	(3,016,973)	(3,202,289)	(185,316)	(5.8%)
<b>(1)</b>	<b>-</b>	<b>1</b>	<b>0.0%</b>	<b>Total Administrative Expenses</b>	<b>(0)</b>	<b>-</b>	<b>0</b>	<b>0.0%</b>
				<b>Change in Net Assets</b>				
<b>1</b>	<b>-</b>	<b>1</b>	<b>0.0%</b>		<b>0</b>	<b>-</b>	<b>0</b>	<b>0.0%</b>

**OTHER INCOME STATEMENTS – FEBRUARY MONTH:**

**ONECARE INCOME STATEMENT**

**CHANGE IN NET ASSETS** is (\$189.8) thousand, unfavorable to budget \$163.5 thousand

**PACE INCOME STATEMENT**

**CHANGE IN NET ASSETS** is \$649.1 thousand, favorable to budget \$290.5 thousand

**CalOptima  
Balance Sheet  
February 29, 2020**

**ASSETS**

Current Assets	
Operating Cash	\$489,245,301
Investments	603,526,985
Capitation receivable	431,771,211
Receivables - Other	35,353,301
Prepaid expenses	7,568,030
<b>Total Current Assets</b>	<b><u>1,567,464,828</u></b>

Capital Assets	
Furniture & Equipment	37,266,060
Building/Leasehold Improvements 505 City Parkway West	11,166,259
	<u>50,489,717</u>
	98,922,036
Less: accumulated depreciation	<u>(50,951,175)</u>
Capital assets, net	<u>47,970,861</u>

Other Assets	
Restricted Deposit & Other	300,000
Homeless Health Reserve	58,198,913
Board-designated assets:	
Cash and Cash Equivalents	6,769,010
Long-term Investments	<u>568,851,831</u>
Total Board-designated Assets	<u>575,620,841</u>
<b>Total Other Assets</b>	<b><u>634,119,754</u></b>

**TOTAL ASSETS** **2,249,555,443**

Deferred Outflows	
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** **2,260,645,892**

**LIABILITIES & NET POSITION**

Current Liabilities	
Accounts Payable	\$118,224,858
Medical Claims liability	913,223,141
Accrued Payroll Liabilities	12,907,342
Deferred Revenue	54,025,966
Deferred Lease Obligations	170,710
Capitation and Withholds	128,765,322
<b>Total Current Liabilities</b>	<b><u>1,227,317,338</u></b>

Other (than pensions) post employment benefits liability	25,683,620
Net Pension Liabilities	23,788,705
Bldg 505 Development Rights	-

**TOTAL LIABILITIES** **1,276,789,664**

Deferred Inflows	
Excess Earnings	156,330
Change in Assumptions	4,747,505
OPEB Changes in Assumptions	2,503,000

Net Position	
TNE	97,174,161
Funds in Excess of TNE	<u>879,275,232</u>

**TOTAL NET POSITION** **976,449,394**

**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION** **2,260,645,892**

**CalOptima**  
**Board Designated Reserve and TNE Analysis**  
**as of February 29, 2020**

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	157,659,267				
	Tier 1 - Logan Circle	156,404,603				
	Tier 1 - Wells Capital	156,906,818				
<b>Board-designated Reserve</b>						
		470,970,688	323,409,639	503,659,839	147,561,049	(32,689,151)
TNE Requirement	Tier 2 - Logan Circle	104,650,153	97,174,161	97,174,161	7,475,992	7,475,992
<b>Consolidated:</b>		<b>575,620,841</b>	<b>420,583,800</b>	<b>600,834,001</b>	<b>155,037,041</b>	<b>(25,213,159)</b>
<i>Current reserve level</i>		<i>1.92</i>	<i>1.40</i>	<i>2.00</i>		

**CalOptima**  
**Statement of Cash Flows**  
**February 29, 2020**

	<b>Month Ended</b>	<b>Year-To-Date</b>
<b>CASH FLOWS FROM OPERATING ACTIVITIES:</b>		
Change in net assets	10,363,229	40,906,524
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	449,599	4,065,927
Changes in assets and liabilities:		
Prepaid expenses and other	833,216	(1,780,289)
Catastrophic reserves		
Capitation receivable	(25,834,022)	(115,182,745)
Medical claims liability	164,551,852	160,912,189
Deferred revenue	177,494	2,991,202
Payable to health networks	(8,417,938)	19,862,181
Accounts payable	14,075,615	75,558,131
Accrued payroll	958,587	3,065,131
Other accrued liabilities	170,710	126,198
Net cash provided by/(used in) operating activities	157,328,342	190,524,450
 GASB 68 CalPERS Adjustments	-	-
<b>CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:</b>		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Change in Investments	(183,652,729)	(29,820,688)
Change in Property and Equipment	(355,290)	(5,411,899)
Change in Board designated reserves	(4,835,791)	(15,475,434)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	(188,843,810)	(48,906,934)
 NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(31,515,468)	141,617,517
 CASH AND CASH EQUIVALENTS, beginning of period	\$520,760,769	347,627,784
 <b>CASH AND CASH EQUIVALENTS, end of period</b>	<b>489,245,301</b>	<b>489,245,301</b>



## **BALANCE SHEET – FEBRUARY MONTH:**

**ASSETS** of \$2.3 billion increased \$181.9 million from January or 8.7%

- Investments increased \$183.7 million due to Hospital Quality Assurance Fee (HQAF) funding received for payment to facilities in March
- Operating Cash decreased \$31.5 million due to the timing of month end cut-off and cash flow requirements
- Capitation Receivables increased \$23.9 million due to timing of capitation received

**LIABILITIES** of \$1.3 billion increased \$171.5 million from January or 15.5%

- Claims Liabilities increased \$164.6 million due to timing of HQAF payment
- Accounts Payable increased \$14.1 million due to Managed Care Organization (MCO) tax accruals
- Capitation and Withhold decreased \$8.4 million due to disbursement of shared risk pool, offset by increase in capitation payables

**NET ASSETS** total \$976.4 million

**Budget Allocation Changes  
Reporting Changes for February 2020**

Transfer Month	Line of Business	From	To	Amount	Expense Description
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)
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)
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)
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.
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 Upgrades to Capital Project Replace Conference Room AV Equipment.
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.
January	Medi-Cal	Member Survey - CG CAHPS	Inovalon Contract for HEDIS Software Training and Support hours	\$40,000	To reallocate funds from Member Survey - CG CAHPS to Inovalon Contract for HEDIS Software Training and Support hours.

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.

**Homeless Health Initiative and Allocated Funds  
as of February 29, 2020**

	<b>Amount</b>
<b>Program Commitment</b>	<b>\$ 100,000,000</b>
<b>Funds Allocation, approved initiatives:</b>	
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	<u>570,000</u>
<b>Funds Allocation Total</b>	<b><u>41,801,087</u></b>
<b>Program Commitment Balance, available for new initiatives</b>	<b>\$ 58,198,913</b>

**On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.  
This report only lists Board approved projects.**

## Board of Directors Meeting April 2, 2020

### Monthly Compliance Report

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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

- CY2018 Medicare Part D Prescription Drug Event Validation (OneCare and OneCare Connect):

On January 10, 2020, CMS informed CalOptima that its OneCare and OneCare Connect programs have been selected to participate in the Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (PEPV) audit.

CMS conducts the audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2018 payments. CMS released the contract-specific documentation for both programs on January 24, 2020. CalOptima submitted supporting documentation for this audit on February 20, 2020. On February 25, 2020, CMS issued the Element Check Results. All submissions by CalOptima were deemed complete. No additional actions are required at this time.

- Timeliness Monitoring Project:

On October 8, 2019, CMS announced that it will conduct an industry-wide monitoring project in 2020, to evaluate the timeliness of processing Medicare Advantage (Part C) organization determinations and reconsiderations and Medicare Prescription Drug (Part D) coverage determinations and redeterminations. The review period for this monitoring effort 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. The CMS validation webinars were conducted on February 7, 2020. CalOptima is pending audit results from CMS.

- 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 January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit. CalOptima is working to provide the requested medical record documentation to CMS by the regulatory deadline of July 10, 2020.

- 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. The validation audit is expected to take place from March through 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

The webinar validation is expected to take place in April 2020.

## 2. OneCare Connect

- National 2018 Risk Adjustment Data Validation (RADV) Audit:

On January 13, 2020, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the CY 2018 Medicare Part C Improper Payment Measurement, known as the National Risk Adjustment Data Validation (RADV) audit. CMS will be conducting medical record reviews to validate the accuracy of the CY 2018 Medicare Part C risk adjustment data. The results of this review will be used to calculate a program-wide improper payment rate for Medicare Part C. On February 14, 2020, the CMS submission window opened and CalOptima was notified that only one (1) enrollee with three (3) hierarchical condition categories (HCCs) was selected for validation. The final deadline for submission of medical records to CMS is June 8, 2020.

## 3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

The Department of Health Care Services' (DHCS) onsite audit of CalOptima took place from January 27, 2020 to February 7, 2020. The audit covered the review period of

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2 | 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.

February 1, 2019 to January 31, 2020, and pertained to CalOptima’s Medi-Cal program as well as elements of its OneCare Connect Medicaid-based services. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare.

In light of the COVID-19 pandemic, the DHCS has indicated that remaining audit activities will be delayed, which may also impact the delivery of the draft audit report, originally slated to be released in May 2020.

- Rate Development Template (RDT) Audit:

On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which focused 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.

## B. Regulatory Notices of Non-Compliance

On February 14, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a Notice of Non-Compliance to CalOptima’s OneCare Connect program, for failure to meet call center standards for the CY2019 Part D prospective beneficiary customer service phone lines.

CMS’ Accuracy and Accessibility Study measures Part C and Part D prospective beneficiary call center phone lines to determine (1) the availability of interpreters for individuals, (2) TTY functionality, and (3) the accuracy of plan information provided by customer service representatives (CSRs) in all languages. The 2019 Accuracy and Accessibility Study – TTY Functionality measure monitoring results are as follows:

- OneCare Connect
  - Part C TTY Functionality: Compliant
  - Part D TTY Functionality: 68.75% (passing score is 75%)

CMS will continue to monitor Part C and Part D prospective beneficiary customer service call centers on an annual basis. CalOptima’s Office of Compliance has issued a corrective action plan to the Customer Service department, and continues to work with the department to remediate the issue.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal <sup>a\</sup>

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2019	100%	100%	100%	97%
November 2019	100%	100%	100%	100%
December 2019	100%	100%	100%	100%

➤ For the December 2019 file review of Medi-Cal claims, CalOptima’s Claims department received a compliance score of 100% for timeliness based on a focused review of sixty (60) 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
October 2019	100%	100%	93%	100%	50%
November 2019	98%	100%	93%	100%	98%
December 2019	97%	100%	100%	100%	100%

➤ For the December 2019 file review of Medi-Cal PDRs, CalOptima’s Claims department received a compliance score of 99% for timeliness based on a focused review of forty (40) PDRs.

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4 | 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.

2. Internal Monitoring: OneCare <sup>a\</sup>

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2019	100%	100%	100%	100%
November 2019	100%	100%	100%	60%
December 2019	100%	100%	100%	80%

- For the December 2019 file review of PACE claims, CalOptima’s Claims department received a compliance score of 95% for timeliness based on a focused review of thirty (30) paid and denied claims selected for review.
- The lower compliance score of 80% for denied claims accuracy for December 2019 was due to three (3) inaccurate claims.
- 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.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
October 2019	100%	100%	100%
November 2019	100%	100%	100%
December 2019	100%	100%	100%

5 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.



- For the December 2019 file review of OneCare PDRs, CalOptima’s Claims department received a compliance score of 100% for timeliness based on a focused review of two (2) PDRs selected for review.

3. Internal Monitoring: OneCare Connect <sup>a\</sup>

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2019	90%	100%	100%	100%
November 2019	100%	100%	100%	100%
December 2019	100%	100%	100%	100%

- For the December 2019 file review of OneCare Connect claims, CalOptima’s Claims department received a compliance score of 100% for timeliness based on a focused review of thirty (30) paid and denied claims selected for review.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
October 2019	100%	100%	100%
November 2019	95%	100%	100%
December 2019	100%	100%	100%

- For the December 2019 file review of OneCare Connect PDRs, CalOptima’s Claims department received a compliance score of 100% for timeliness based on a focused review of nine (9) PDRs selected for review.

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6 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.

4. Internal Monitoring: PACE <sup>a\</sup>

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
October 2019	100%	100%	100%	100%
November 2019	100%	100%	100%	100%
December 2019	100%	100%	100%	100%

- For the December 2019 file review of PACE claims, CalOptima’s Claims department received a compliance score of 100% for timeliness based on a focused review of thirty (30) paid and denied claims selected for review.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
October 2019	100%	100%	100%	N/A
November 2019	100%	100%	100%	N/A
December 2019	100%	100%	100%	N/A

- For the December 2019 file review of PACE PDRs, CalOptima’s Claims department received a score of 100% for timeliness based on a focused review of twenty (20) PDRs selected for review.

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7 | 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.

- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
October 2019	100%	100%
November 2019	0%	100%
December 2019	NTR	100%

➤ For the December 2019 file review of PACE SDRs, CalOptima’s PACE department received a score of 100% for timeliness based on a focused review of three (3) SDRs selected for review.

5. Health Network Monitoring: Medi-Cal <sup>a\</sup>

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
October 2019	69%	80%	90%	67%	72%	83%	97%	71%	83%	92%	100%	84%	96%
November 2019	83%	80%	94%	89%	91%	72%	93%	84%	77%	93%	100%	61%	87%
December 2019	76%	84%	89%	72%	61%	86%	89%	68%	74%	83%	50%	53%	74%

➤ Based on a focused review of select files, nine (9) health networks drove the lower compliance score for timeliness. Eighty-four (84) of the one hundred eighty-five (185) files received from the nine (9) 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)
- Failure to meet timeframe for member notification (2 business days)
- Failure to meet timeframe for provider initial notification (24 hours)
- Failure to meet timeframe for provider written notification (2 business days)
- Failure to meet timeframe for member delay notification (5 business days)

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8 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.

- Based on a focused review of select files, eight (8) health networks drove the lower compliance score for clinical decision making (CDM). Forty-six (46) of the fifty-one (51) files received from the eight (8) health networks were deficient. Deficiencies for the lower scores for CDM include the following:
    - Failure to have appropriate professional make decision
    - Failure to obtain adequate clinical information
    - Failure to cite criteria for decision
  
  - Based on a focused review of select files, four (4) health networks drove the lower compliance letter score. Forty-one (41) of the sixty-eight (68) files received from the four (4) health networks were deficient. Deficiencies for the lower letter scores include the following:
    - Failure to describe why the request did not meet criteria in lay language
    - Failure to provide letter in member’s primary language
    - Failure to provide letter with description of services in lay language
    - Failure to provide peer-to-peer discussion of the decision with medical reviewer
    - Failure to provide referral back to primary care provider (PCP) on denial letter
    - Failure to include name and contact information for health care professional responsible for the decision to deny or modify
  
  - Based on the overall universe of Medi-Cal authorizations for November 2019, CalOptima’s health networks received an overall compliance score of 96% for timely processing of routine authorization requests and a compliance score of 97% 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 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 within regulatory requirements.
- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2019	89%	93%	94%	92%
November 2019	98%	95%	99%	92%
December 2019	98%	97%	99%	95%

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9 a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

- Based on the overall universe of Medi-Cal claims for November 2019, CalOptima’s health networks received an overall compliance score of 96% for timely processing of claims.
- CalOptima’s Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

6. Health Network Monitoring: OneCare <sup>a\</sup>

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
October 2019	100%	100%	100%	93%	97%	100%	84%	96%
November 2019	100%	NTR	100%	100%	91%	100%	75%	95%
December 2019	75%	100%	91%	87%	91%	100%	82%	88%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. Eight (8) files of the sixteen (16) files received from the two (2) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
- Based on a focused review of select files, three (3) health networks drove the lower compliance letter score. Six (6) files of the ten (10) files received from the three (3) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter with description of services in lay language
- Based on the overall universe of OneCare authorization requests for CalOptima’s health networks for November 2019, CalOptima’s health networks received an overall compliance score of 100% for timely processing of standard Part C authorization requests and 92% for timely processing of expedited Part C authorization requests.

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.

- 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 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 within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2019	100%	100%	96%	82%
November 2019	100%	100%	89%	100%
December 2019	100%	100%	100%	98%

- Based on the overall universe of OneCare claims for CalOptima’s health networks for November 2019, CalOptima’s health networks received the following overall compliance scores for timely processing of claims:
  - 98% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 100% 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 --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

7. Health Network Monitoring: OneCare Connect <sup>a\</sup>

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
October 2019	88%	100%	99%	90%	92%	70%	60%	73%	100%	89%	95%
November 2019	91%	100%	93%	81%	82%	96%	73%	96%	57%	84%	95%
December 2019	95%	100%	89%	91%	84%	68%	87%	85%	100%	100%	100%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. Two (2) of the six (6) files received from the two (2) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision (Urgent – 72 hours)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
- Based on a focused review of select files, four (4) health networks drove the lower compliance letter score. Fifteen (15) of the thirty-one (31) files received from the four (4) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide language assistance program (LAP) insert in approved threshold languages
  - Failure to provide member with information on how to file a grievance
  - Failure to provide letter in member’s primary language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify
- Based on the overall universe of OneCare Connect authorization requests for CalOptima’s health networks for November 2019, CalOptima’s health networks received an overall compliance score of 96% for timely processing of routine authorization requests and 94% 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 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 within regulatory requirements.

- OneCare Connect Claims: Professional Claims

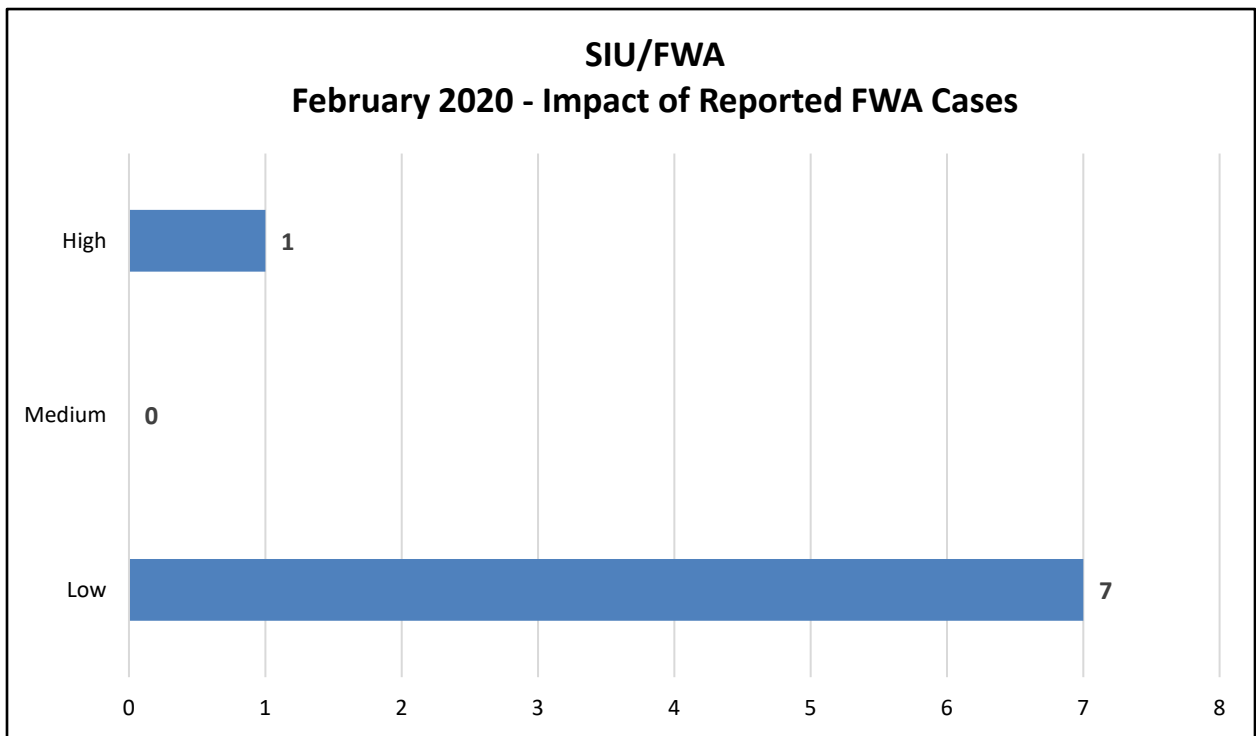
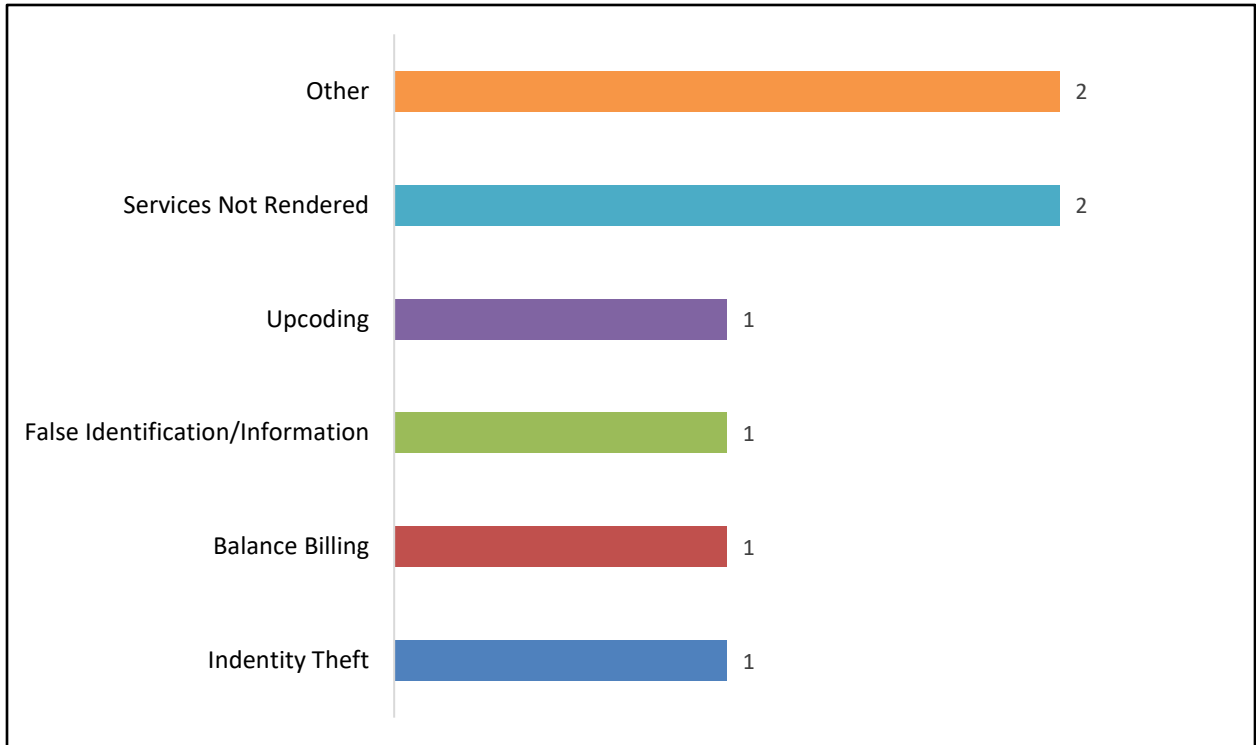
Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2019	88%	88%	94%	85%
November 2019	97%	98%	98%	97%
December 2019	95%	99%	99%	98%

- Based on the overall universe of OneCare Connect claims for CalOptima’s health networks for November 2019, CalOptima’s health networks received the following overall compliance scores:
  - 99% 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
  - 100% 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 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.

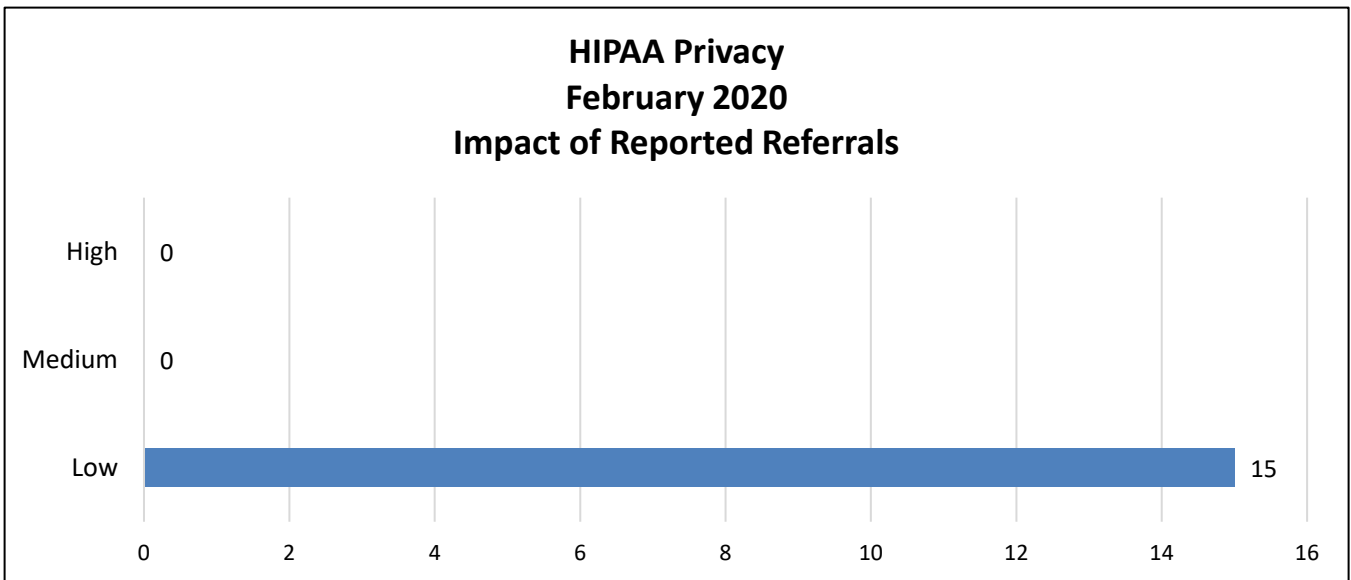
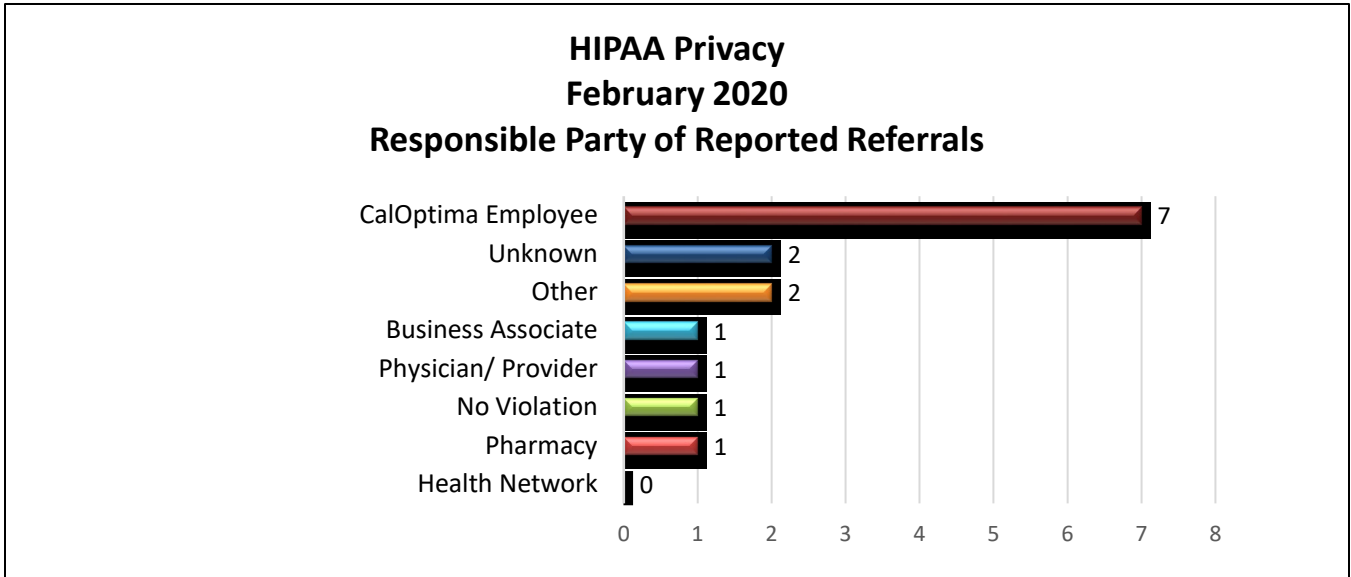


D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in February 2020)



E. Privacy Update (February 2020)



Total Number of Referrals Reported to DHCS (State)	15
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
<b>Total Number of Referrals Reported</b>	<b>15</b>

**15** 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.



March 19, 2020

**CalOptima Legislative Report  
By Don Gilbert, Trent Smith and Bridget McGowen**

**UPDATE ON STATUS OF THE LEGISLATURE AND RESPONSE TO COVID-19**

On March 16th the Legislature convened to unanimously pass two budget bills intended to appropriate funding for the state's immediate response to the COVID-19 pandemic.

SB 89 appropriates \$500 million to be used by the Governor for disaster relief including funding for increased hospital capacity and any activities included in the Governor's March 4th proclamation declaring a state of emergency. An additional \$500 million may be appropriated for the same purpose upon notification to the Joint Legislative Budget Committee.

Important for all residents and small businesses, SB 89 also includes language stating the Legislature's intent that the Administration work with stakeholders to develop strategies to provide assistance to individuals, small businesses, and nonprofits experiencing economic hardship as a result of the pandemic. This language merely notes the Legislature's desire to address issues in substantive legislation in the coming weeks. In discussing this language on their respective floors, the Assembly and Senate Budget Chairs noted that the Legislature would be reviewing how Federal relief legislation would impact the state.

SB 117 provides for the continued support for schools in the state including \$100 million for cleaning and protective equipment.

Finally, the Senate adopted a resolution that, among other things, amended their House Rules to allow Senators to participate in Legislative proceedings remotely. In presenting the resolution, Pro Tem Atkins stated that she hoped the new authority would only be used rarely. The legality of remote voting and exactly how this would be implemented in practice are open questions.

Just before adjournment, the Senate and Assembly adopted a joint resolution sending the Legislature into recess until April 13th unless leadership from each house call them back into session sooner. There was some discussion of potentially extending the recess depending on how things develop. It remains to be seen what this will mean for the Legislature's schedule and the several thousand bills introduced at the beginning of the year.

On March 18th the Governor in an executive order waived eligibility re-determinations for 90 days for Californians who participate in the following programs:

- Medi-Cal health coverage
- CalFresh food assistance
- CalWORKS
- Cash Assistance for Immigrants; and
- In-Home Supportive Services

On March 19th Governor Newsom sent a letter to the leaders of the US Congress asking for an immediate and initial \$1 billion in federal funding to deal with immediate state needs related to the COVID-19 pandemic.

Specifically, the Governor has requested:

- An increase in federal funds for unemployment insurance and to extend benefits beyond the normal 26 weeks. This is a request that has been granted in previous emergencies.
- Funding to support safety net programs such as the state's Medicaid program providing healthcare to the poor, and food assistance program for the poor and elderly.
- Direct assistance to local governments and schools to maintain services.
- Assistance to small businesses.

He also requested the creation of a guaranteed loan program for small and medium businesses, direct cash assistance to small businesses, and rental assistance for small businesses.

We expect the Governor to continue issuing emergency proclamations in the coming days and weeks. We will keep you apprised as we learn more.

## M E M O R A N D U M

March 9, 2020

**To:** CalOptima  
**From:** Akin Gump Strauss Hauer & Feld, LLP  
**Re:** March Board of Directors Report

In spite of the partisan tension that reigns in Washington, lawmakers this month quickly rallied to pass a bipartisan funding package for coronavirus response. The outbreak continues to dominate headlines and the congressional hearing schedule, though work continues behind closed doors on other issues, such as surprise billing and drug pricing. This report covers legislative activity through March 9, 2020.

### **Coronavirus Response**

As the novel coronavirus (COVID-19) continues to spread around the world and within the United States, Congress and the federal government have intensified their focus on the outbreak. Congress took up and swiftly passed an \$8.3 billion supplemental funding package, which the President signed into law on March 6. The emergency spending measure provides more than \$3 billion for research and development related to potential treatments, testing, and vaccines. While Democrats had sought to include language that would have given the federal government more authority to regulate prices of COVID-19 drugs and vaccines, the final bill reiterates existing policy regarding the Federal Acquisition Regulation's "fair and reasonable" pricing requirement.

The supplemental includes provisions that allow qualified Medicare providers to offer telehealth services during a public health emergency, waiving originating site requirements and restrictions on using telephones as long as the phones have audio and video capabilities. The Congressional Budget Office (CBO) scored the telehealth provisions as costing \$490 million in fiscal years 2020 through 2022. The supplemental also provides \$950 million to the Centers for Disease Control and Prevention (CDC) to distribute to states, localities, territories, and tribes to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response efforts. Half of that money must be allocated within 30 days. In addition, the package allocates \$100 million to Community Health Centers to respond to the outbreak.

Appropriators made clear that they would provide additional funding for COVID-19 response if needed. Further legislation could focus on coverage expansions for COVID-19 testing and care; supply chain and drug shortage proposals; and broader telehealth allowances. Senate Finance Committee Chairman Chuck Grassley (R-IA) also has said he is exploring "targeted tax relief

March 9, 2020

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measures” to support specific industries. House Speaker Nancy Pelosi (D-CA) and Senate Minority Leader Chuck Schumer (D-NY), meanwhile, are discussing an economic relief package that would expand medical and family leave, food stamps, school lunches, and unemployment benefits. The White House is expected to meet with business leaders to discuss stimulus options and support for hourly workers who may be affected by self- or mandatory quarantines.

Numerous congressional committees have held hearings on the government’s response to the outbreak, with Democrats offering sharp criticism of the Administration’s early messaging around the crisis and the slow rollout of testing kits. In response to the criticism, Vice President Pence was tapped to coordinate the Administration’s response efforts, while Health and Human Services (HHS) Secretary Alex Azar has taken a more behind-the-scenes role.

### **Surprise Billing and Drug Pricing**

The House Education & Labor, Energy & Commerce, and Ways & Means Committees continue to negotiate a compromise surprise billing package, with the goal of reaching a bipartisan consensus before the May 22 expiration of a number of health “extender” provisions. With all eyes on COVID-19 and the Congressional response, however, there is reduced bandwidth for everything else. Thus, final action on surprise billing, drug pricing, and other health care priorities could be pushed to the “lame duck” period following the election.

Concerns over the access to and affordability of potential COVID-19 treatments and vaccines have kept drug pricing issues at the forefront. Senate Finance Committee Chairman Chuck Grassley (R-IA), has yet to reveal modifications to his drug pricing legislation, the Prescription Drug Pricing Reduction Act (S. 2543), but reports indicate the updated bill has the support of at least 24 Republicans in the Senate. In addition, Sen. Grassley stated that new estimates from CBO show that Part D beneficiaries would save \$50 billion over 10 years under the bill. Meanwhile, the Administration’s collaboration with the pharmaceutical industry on the development of COVID-19 therapeutics, diagnostics, and vaccine candidates could prompt the White House to soften its approach to drug pricing reforms and delay policies such as the International Pricing Index (IPI) Model.

### **Medicaid Fiscal Accountability Regulation**

Sen. Grassley is urging the Administration to finalize the Medicaid Fiscal Accountability Regulation (MFAR) proposed rule, even as other members of his Committee, including Sen. John Cornyn (R-TX), raise concerns about the regulation. There is particular concern on both sides of the aisle that the state financing aspects of the rule could strain state budgets and threaten access to care and benefits. Hospital leaders have warned that the proposed rule could

March 9, 2020

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have a disproportionate impact on children's hospitals, possibly leading to staffing reductions and benefit cuts. With the prospect for legislation dimming, advocates are hopeful that pressure from Republican senators and governors may prompt the Administration to strike a deal including a delay of the state financing reforms.

### **Affordable Care Act Litigation**

The U.S. Supreme Court announced March 2 that will hear the *Texas v. United States* case during the term beginning October 2020. Oral arguments have not yet been scheduled but could take place before the November election. A final decision would be handed down before the end of the term in June 2021.

The lawsuit was brought by Republican state attorneys general who argue that the Affordable Care Act (ACA) is no longer constitutional after the so-called individual mandate penalty was zeroed out in 2017. If the Court does invalidate the law, tens of millions of Americans could lose their health coverage and the ACA's Medicaid expansion would be eliminated. Democratic lawmakers pressed HHS Secretary Azar on this point during hearings on the President's Fiscal Year (FY) 2021 Budget Request this past month, noting the Administration's support for the plaintiffs in *Texas v. United States*. Secretary Azar refused to say whether the White House has developed a contingency plan in the event that the law is struck down, but insisted that the President's priority would be to protect individuals with pre-existing conditions.

# 2019–20 Legislative Tracking Matrix

## COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>H.R. 6201</b> <b>Lowey</b>	<b>Families First Coronavirus Response Act:</b> Would include billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of \$8.3 billion for treating and preventing the spread of COVID-19.	<b>03/18/2020</b> Signed into law  <b>03/17/2020</b> Passed the Senate  <b>03/14/2020</b> Passed the House  <b>03/11/2020</b> Introduced	CalOptima: Watch
<b>AB 89</b> <b>Ting</b>	<b>Emergency Budget Response to COVID-19:</b> Similar to SB 89, would appropriate \$500 million General Fund by amending the Budget Act of 2019. Funds are to be allocated to any use related to Governor Newsom’s March 4, 2020 State of Emergency regarding COVID-19. Additionally, would authorize additional appropriations related to COVID-19 in increments of \$50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed \$1 billion.	<b>03/16/2020</b> Amended and referred to the Senate Committee on Budget and Fiscal Review  <b>12/03/2018</b> Introduced	CalOptima: Watch
<b>AB 117</b> <b>Ting</b>	<b>Emergency Budget Response to COVID-19 at Schools:</b> Similar to SB 117, appropriate \$100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds would be distributed by the Superintendent of Public Instruction.	<b>03/16/2020</b> Amended and referred to the Senate Committee on Budget and Fiscal Review  <b>12/03/2018</b> Introduced	CalOptima: Watch
<b>SB 89</b> <b>Committee on Budget and Fiscal Review</b>	<b>Emergency Budget Response to COVID-19:</b> Similar to AB 89, appropriates \$500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom’s March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of \$50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed \$1 billion.	<b>03/17/2020</b> Signed into law  <b>03/16/2020</b> Enrolled with the Governor  <b>01/10/2019</b> Introduced	CalOptima: Watch
<b>SB 117</b> <b>Committee on Budget and Fiscal Review</b>	<b>Emergency Budget Response to COVID-19 at Schools:</b> Similar to AB 117, appropriates \$100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	<b>03/17/2020</b> Signed into law  <b>03/16/2020</b> Enrolled with the Governor  <b>01/10/2019</b> Introduced	CalOptima: Watch



## BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 910 Wood</b>	<b>Mental Health Services Dispute Resolution:</b> Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	<b>01/30/2020</b> Passed Assembly floor; Referred to Senate floor  <b>02/20/2020</b> Introduced	CalOptima: Watch
<b>AB 2265 Quirk-Silva</b>	<b>Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:</b> Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state.	<b>02/24/2020</b> Referred to Committee on Health  <b>02/14/2020</b> Introduced	CalOptima: Watch
<b>AB 2266 Quirk-Silva</b>	<b>Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:</b> Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	<b>02/24/2020</b> Referred to Committee on Health  <b>02/14/2020</b> Introduced	CalOptima: Watch
<b>SB 803 Beall</b>	<b>Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:</b> Would create the Certified Support Specialist (CSS) certificate program. Would allow parents, peers, and family, 18 years of age or older and who have experienced a mental illness and/or a substance use disorder, to become a CSS. A CSS would be able to provide non-medical mental health and substance abuse support services. Additionally, would require the Department of Health Care Services to include CSS as a provider type, covered by Medi-Cal, no sooner than July 1, 2021. If federally approved, the peer-support program would be funded through Medi-Cal reimbursement.	<b>01/15/2020</b> Referred to Committee on Health  <b>01/08/2020</b> Introduced	CalOptima: Watch

## BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2276 Reyes</b>	<b>Blood Lead Screening Tests Age Guidelines:</b> Would require the Medi-Cal managed care plan (MCP) to conduct blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age. Additionally, if a child 2 to 6 years of age does not have medical records stating the completion of a blood lead screening test, the MCP would be required to provide that test. This bill would also require the Department of Health Care Services to notify the beneficiary's parent or guardian that the beneficiary is eligible for blood lead screening tests.	<b>02/24/2020</b> Referred to Committee on Health  <b>02/14/2020</b> Introduced	CalOptima: Watch

## 2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2277</b> <b>Salas</b>	<b>Blood Lead Screening Tests Contracted Providers:</b> Would require the Medi-Cal managed care plan (MCP) to impose requirements of the contracted provider to conduct blood lead screenings tests and for the provider to identify patients eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screenings tests and identify eligible beneficiaries on a monthly basis.	<b>02/24/2020</b> Referred to Committee on Health  <b>02/14/2020</b> Introduced	CalOptima: Watch
<b>AB 2278</b> <b>Quirk</b>	<b>Childhood Lead Poisoning Prevention Health Plan Identification:</b> Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screen tests.	<b>02/24/2020</b> Referred to Committee on Health  <b>02/14/2020</b> Introduced	CalOptima: Watch
<b>AB 2279</b> <b>Garcia</b>	<b>Childhood Lead Poisoning Prevention Risk Factors:</b> Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: <ul style="list-style-type: none"> <li>■ A child's residency or visit to a foreign country</li> <li>■ A child's residency in a high-risk ZIP Code</li> <li>■ A child's relative who has been exposed to lead poisoning</li> <li>■ The likelihood of a child placing nonfood items in the mouth</li> <li>■ A child's proximity to current or former lead-producing facilities</li> <li>■ The likelihood of a child using food, medicine, or dishes from other countries</li> </ul>	<b>02/24/2020</b> Referred to Committees on Health; Environmental Safety and Toxic Materials  <b>02/14/2020</b> Introduced	CalOptima: Watch
<b>AB 2422</b> <b>Grayson</b>	<b>Blood Lead Screening Tests Medi-Cal Identification Number:</b> Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	<b>02/27/2020</b> Referred to Committee on Health  <b>02/19/2020</b> Introduced	CalOptima: Watch
<b>SB 1008</b> <b>Leyva</b>	<b>Childhood Lead Poisoning Prevention Act Online Registry:</b> Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	<b>03/05/2020</b> Referred to Committees on Health; Judiciary  <b>02/14/2020</b> Introduced	CalOptima: Watch

## CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2042</b> <b>Wood</b>	<b>CalAIM Enhanced Care Management and In-Lieu-Of Services:</b> Similar to SB 916, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	<b>03/12/2020</b> Referred to Committee on Health  <b>02/03/2020</b> Introduced	CalOptima: Watch

## 2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2055 Wood</b>	<b>CalAIM Drug Medi-Cal and Behavioral Health:</b> Would require the Department of Health Care Services to establish the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program would be responsible for providing support to entities managing the Drug Medi-Cal program as they prepare for any changes directed by the CalAIM initiative. Additionally, would establish a voluntary intergovernmental transfer (IGT) program relating to substance use disorder treatment provided by counties under the Drug Medi-Cal program. The IGT program would fund the nonfederal share of supplemental payments and to replace claims based on certified public expenditures.	<b>03/12/2020</b> Referred to Committee on Health  <b>02/03/2020</b> Introduced	CalOptima: Watch
<b>AB 2170 Blanco Rubio</b>	<b>CalAIM Medi-Cal Eligibility for Juveniles Who are Incarcerated:</b> Would require the county welfare department to conduct a redetermination of eligibility for juveniles who are incarcerated so that, if eligible, their Medi-Cal would be reinstated immediately upon release.	<b>02/20/2020</b> Referred to Committee on Health  <b>02/11/2020</b> Introduced	CalOptima: Watch
<b>SB 910 Pan</b>	<b>CalAIM Population Health Management:</b> Would require Medi-Cal managed care plans (MCPs) to implement the population health management program for those deemed eligible, effective January 1, 2022. Would require the Department of Health Care Services to utilize an external quality review organization (EQRO) to evaluate the effectiveness of the enhanced care management and in-lieu-of services provided to beneficiaries by each MCP. Additionally, would require each MCP to consult with stakeholders, including, but not limited to, county behavioral health departments, public health departments, providers, community-based organizations, consumer advocates, and Medi-Cal beneficiaries, on developing and implementing the population health management program.	<b>02/03/2020</b> Introduced	CalOptima: Watch
<b>SB 916 Pan</b>	<b>CalAIM Enhanced Care Management and In-Lieu-Of Services:</b> Similar to AB 2042, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	<b>02/03/2020</b> Introduced	CalOptima: Watch

## COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>H.R. 4618 McBath</b>	<b>Medicare Hearing Act of 2019:</b> 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.	<b>10/17/2019</b> Passed the Committee on Energy and Commerce  <b>10/08/2019</b> Introduced	CalOptima: Watch
<b>H.R. 4650 Kelly</b>	<b>Medicare Dental Act of 2019:</b> 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.	<b>10/17/2019</b> Passed the Committee on Energy and Commerce  <b>10/11/2019</b> Introduced	CalOptima: Watch

## 2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>H.R. 4665 Schrier</b>	<b>Medicare Vision Act of 2019:</b> 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.	<b>10/17/2019</b> Passed the Committee on Energy and Commerce  <b>10/11/2019</b> Introduced	CalOptima: Watch
<b>AB 1904 Boerner Horvath</b>	<b>Maternal Physical Therapy:</b> Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	<b>01/17/2020</b> Referred to Committee on Health  <b>01/08/2020</b> Introduced	CalOptima: Watch
<b>AB 1965 Aguiar-Curry</b>	<b>Human Papillomavirus (HPV) Vaccine:</b> Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	<b>01/30/2020</b> Referred to Committee on Health  <b>01/21/2020</b> Introduced	CalOptima: Watch
<b>AB 2258 Reyes</b>	<b>Doula Care:</b> Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	<b>02/20/2020</b> Referred to Committee on Health  <b>02/13/2020</b> Introduced	CalOptima: Watch
<b>AB 3118 Bonta</b>	<b>Medically Supportive Food and Nutrition Services:</b> Would include medically supportive food and nutrition services as a Medi-Cal Benefit. Would also include transportation services for a beneficiary to access healthy food as a way to help prevent or manage chronic illnesses.	<b>03/09/2020</b> Referred to Committee on Health  <b>02/21/2020</b> Introduced	CalOptima: Watch

## DENTAL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2535 Mathis</b>	<b>Denti-Cal Education Pilot Program:</b> Would establish a 5-year pilot program to provide education and training to Denti-Cal providers providing care to individuals who attend a regional center and are living with a developmental disability. Additionally, Denti-Cal providers who participate in the pilot program and complete the required continuing education units would be eligible for a supplemental provider payment. The supplemental provider payment amount has yet to be defined by the Department of Health Care Services.	<b>02/27/2020</b> Referred to Committee on Health  <b>02/19/2020</b> Introduced	CalOptima: Watch

**ELIGIBILITY**

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 4</b> <b>Arambula</b>	<b>Medi-Cal Eligibility Expansion:</b> 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.	<b>07/02/2019</b> Hearing canceled at the request of the author  <b>06/06/2019</b> Referred to Senate Committee on Health  <b>05/28/2019</b> Passed Assembly floor  <b>12/03/2018</b> Introduced	CalOptima: Watch CAHP: Support LHPC: Support
<b>AB 526</b> <b>Petrie-Norris</b>	<b>Women, Infants, and Children (WIC) to Medi-Cal Express Lane:</b> Similar to SB 1073, 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, 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.	<b>08/30/2019</b> Senate Committee on Appropriations; Held under submission  <b>06/27/2019</b> Passed Senate Committee on Health  <b>05/23/2019</b> Passed Assembly floor  <b>02/13/2019</b> Introduced	CalOptima: Watch
<b>AB 683</b> <b>Carrillo</b>	<b>Adjusting the Assets Test for Medi-Cal Eligibility:</b> Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment.	<b>05/16/2019</b> Committee on Appropriations; Hearing postponed at the request of the Committee  <b>04/02/2019</b> Passed Committee on Health  <b>02/15/2019</b> Introduced	CalOptima: Watch
<b>SB 29</b> <b>Durazo</b>	<b>Medi-Cal Eligibility Expansion:</b> 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 is estimated to cost \$13 million General Fund.	<b>09/13/2019</b> Held in Assembly  <b>05/29/2019</b> Passed Senate floor  <b>12/03/2018</b> Introduced	CalOptima: Watch

## 2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>SB 1073 Gonzalez</b>	<p><b>Women, Infants, and Children (WIC) to Medi-Cal Express Lane:</b> Similar to AB 526, 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, 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.</p>	<b>02/18/2020</b> Introduced	CalOptima: Watch

## HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>H.R. 1978 Correa/Lieu</b>	<p><b>Fighting Homelessness Through Services and Housing Act:</b> 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.</p> <p>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.</p>	<b>03/28/2019</b> Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch

## 2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>S. 923 Feinstein</b>	<p><b>Fighting Homelessness Through Services and Housing Act:</b> 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.</p> <p>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.</p>	<p><b>03/28/2019</b> Introduced; Referred to Committee on Health, Education, Labor, and Pensions</p>	CalOptima: Watch
<b>AB 1907 Santiago, Gipson, Quirk-Silva</b>	<p><b>California Environmental Quality Act (CEQA) Exemption for Emergency Shelters and Supportive Housing:</b> Would exempt the development of emergency shelters, supportive housing or affordable housing by a public agency from CEQA regulations, expiring on December 31, 2028.</p>	<p><b>01/30/2020</b> Referred to Committees on Natural Resources; Housing and Community Development</p> <p><b>01/08/2020</b> Introduced</p>	CalOptima: Watch
<b>AB 2295 Quirk-Silva</b>	<p>Fairview Developmental Center: Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA.</p> <p>Of note, the Governor’s Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center.</p> <p>This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.</p>	<p><b>02/14/2020</b> Introduced</p>	CalOptima: Watch



## MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>SB 936 Pan</b>	<b>Medi-Cal Managed Care Plans Contract Procurement:</b> Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	<b>02/20/2020</b> Referred to Committee on Health  <b>02/06/2020</b> Introduced	CalOptima: Watch

## PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 1084 Umberg</b>	<b>Secure Dispensing of a Controlled Substance:</b> Would require a pharmacist who dispenses a controlled substance in a pill form to dispense the controlled substance in a lockable vial. Would require the manufacturer of the controlled substance to reimburse the pharmacy dispensing the medication the cost of using a lockable vial. Would also require the pharmacy to provide educational pamphlets to the patient regarding the use of a controlled substance.	<b>03/05/2020</b> Referred to Committees on Business, Professions and Economic Development; Judiciary  <b>02/19/2020</b> Introduced	CalOptima: Watch
<b>AB 2100 Wood</b>	<b>Pharmacy Carve-Out Benefit:</b> Would require the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act. Would require the IPDMRS to review disputed health care service of any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed or to a finding that the service is not medically necessary. Additionally, would establish prior authorization requirements, such as a 24-hour response, a 72-hour supply during emergency situations, and a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list.	<b>02/20/2020</b> Referred to Committee on Health  <b>02/05/2020</b> Introduced	CalOptima: Watch
<b>SB 852 Pan</b>	<b>California Affordable Drug Manufacturing Act of 2020:</b> Would establish the Office of Drug Contracting and Manufacturing (Office) to reduce the cost of prescription drugs. No later than January 1, 2022, would require the Office to contract or partner with no less than one drug company or generic drug manufacturer, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs.	<b>01/13/2020</b> Introduced	CalOptima: Watch



## PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2492</b> <b>Choi</b>	<b>Program of All-Inclusive Care for the Elderly (PACE) Enrollment:</b> Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	<b>03/12/2020</b> Referred to Committees on Aging; Long-Term Care  <b>02/19/2019</b> Introduced	CalOptima: Watch

## PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 890</b> <b>Wood</b>	<b>Nurse Practitioners:</b> Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would create the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs to certify nurse practitioners wanting to practice without direct, ongoing supervision of one or more physicians.	<b>01/27/2019</b> Passed Assembly floor  <b>02/20/2019</b> Introduced	CalOptima: Watch LHPC: Support

## REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>SB 66</b> <b>Atkins/</b> <b>McGuire</b>	<b>Federally Qualified Health Center (FQHC) Reimbursement:</b> 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.	<b>09/13/2019</b> Carry-over bill; Moved to inactive filed at the request of the author  <b>08/30/2019</b> Passed Assembly Committee on Appropriations  <b>05/23/2019</b> Passed Senate floor  <b>01/08/2019</b> Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
<b>AB 2871</b> <b>Fong</b>	<b>Drug Medi-Cal Reimbursement Rates:</b> Would require the Department of Health Care Services to establish reimbursement rates for services provided through the Drug Medi-Cal program to be equal to rates for similar services provided through the Medi-Cal Specialty Mental Health Services program.	<b>03/05/2020</b> Referred to Committee on Health  <b>02/21/2020</b> Introduced	CalOptima: Watch

## TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>H.R. 4932</b> <b>Thompson</b>	<p><b>Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:</b> 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:</p> <ul style="list-style-type: none"> <li>■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary;</li> <li>■ Remove geographic and originating site restrictions for services like mental health and emergency medical care;</li> <li>■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and</li> <li>■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.</li> </ul>	<p><b>10/30/2019</b> Introduced; Referred to the Committees on Energy and Commerce; Ways and Means</p>	CalOptima: Watch AHIP: Support
<b>S. 2741</b> <b>Schatz</b>	<p><b>Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:</b> 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:</p> <ul style="list-style-type: none"> <li>■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary;</li> <li>■ Remove geographic and originating site restrictions for services like mental health and emergency medical care;</li> <li>■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and</li> <li>■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.</li> </ul>	<p><b>10/30/2019</b> Introduced; Referred to the Senate Committee on Finance</p>	CalOptima: Watch AHIP: Support
<b>AB 1676</b> <b>Maienschein</b>	<p><b>Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:</b> Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.</p>	<p><b>05/16/2019</b> Committee on Appropriations; Held under submission</p> <p><b>04/24/2019</b> Passed Committee on Health</p> <p><b>02/22/2019</b> Introduced</p>	CalOptima: Watch CAHP: Oppose
<b>AB 2007</b> <b>Salas</b>	<p><b>Telehealth Services for New Patients:</b> Would no longer require the first visit at a federally qualified health clinic to be an in-person visit. Instead, would allow the new patient the option to utilize telehealth services and become an established patient as their first visit.</p>	<p><b>02/14/2020</b> Referred to Committee on Health</p> <p><b>01/28/2020</b> Introduced</p>	CalOptima: Watch

## 2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>AB 2164</b> <b>Rivas</b>	<p>Telehealth Pilot Program: Would establish a five-year grant and pilot program, to establish the eConsult Services and Telehealth Assistance Program. The grant funding would be available to health centers and community clinics providing care in rural and underserved areas. The pilot program is projected to cost \$7.5 million over five-years and would be use for:</p> <ul style="list-style-type: none"> <li>■ Conducting infrastructure assessments, clinical objectives, and staffing plans;</li> <li>■ Procuring technology and software and implementing eConsult services; and</li> <li>■ Workforce training.</li> </ul>	<p><b>02/14/2020</b> Referred to Committee on Health</p> <p><b>01/28/2020</b> Introduced</p>	CalOptima: Watch

### TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<b>RN 2002918</b> <b>Trailer Bill</b> <b>– Medi-Cal Expansion</b>	<b>Medi-Cal Eligibility Expansion:</b> Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor’s Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost \$80.5 million (\$62.4 million General Fund) in 2021 and \$350 million (\$320 million General Fund) each year after, including the cost of In-Home Supportive Services.	<b>01/31/2020</b> Published on the Department of Finance website	CalOptima: Watch
<b>RN 2003830</b> <b>Trailer Bill:</b> <b>Drug Price Negotiations</b>	<b>Med-Cal Drug Pricing Negotiations:</b> Would authorize the Department of Health Care Services negotiate “best prices” with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	<b>01/31/2020</b> Published on the Department of Finance website	CalOptima: Watch
<b>RN 2006526</b> <b>Trailer Bill</b> <b>– Medication-Assisted Treatment</b>	<b>Medication-Assisted Treatment (MAT):</b> Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	<b>01/31/2020</b> Published on the Department of Finance website	CalOptima: Watch

\*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: March 17, 2020

### 2020 Federal Legislative Dates

<b>April 4–19</b>	Spring recess
<b>August 10–September 7</b>	Summer recess
<b>October 12–November 6</b>	Fall recess

### 2020 State Legislative Dates

<b>January 6</b>	Legislature reconvenes
<b>January 31</b>	Last day for bills introduced in 2019 to pass their house of origin
<b>February 21</b>	Last day for legislation to be introduced
<b>April 2–12</b>	Spring recess
<b>April 24</b>	Last day for policy committees to hear and report bills to fiscal committees
<b>May 1</b>	Last day for policy committees to hear and report non-fiscal bills to the floor
<b>May 15</b>	Last day for fiscal committees to report fiscal bills to the floor
<b>May 26–29</b>	Floor session only
<b>May 29</b>	Last day to pass bills out of their house of origin
<b>June 15</b>	Budget bill must be passed by midnight
<b>July 2–August 3</b>	Summer recess
<b>August 14</b>	Last day for fiscal committees to report bills to the floor
<b>August 17–31</b>	Floor session only
<b>August 31</b>	Last day for bills to be passed. Final recess begins upon adjournment
<b>September 30</b>	Last day for Governor to sign or veto bills passed by the Legislature
<b>November 3</b>	General Election
<b>December 7</b>	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).

## **Board of Directors Meeting April 2, 2020**

### **CalOptima Community Outreach Summary — March 2020**

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#### **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 public activities that meet at least one of the following criteria:

- **Member interaction/enrollment:** The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- **Branding:** The event/activity promotes awareness of CalOptima in the community.
- **Partnerships:** The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors 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 Event Update**

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima is transitioning how we engage with our community partners and will not be attending in-person Community Collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima has updated our participation in Community Collaborative meetings and community events. With respect to events for which sponsorship or registration fees have already been paid, we are working to determine if fees can be applied to future events.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or [tkaaiakamanu@caloptima.org](mailto:tkaaiakamanu@caloptima.org).

## Summary of Public Activities

**As of March 20, 2020, CalOptima participated in 16 community events, coalitions and committee meeting and does not anticipate in participating in any others during March.**

### TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

<b>Date</b>	<b>Events/Meetings</b>
3/02/2020	<ul style="list-style-type: none"><li>• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting</li></ul>
3/04/2020	<ul style="list-style-type: none"><li>• 25th Annual Condition of Children in Orange County Report Forum</li></ul>
3/05/2020	<ul style="list-style-type: none"><li>• Continuum of Care Homeless Provider Forum</li><li>• Garden Grove Community Collaborative Advisory Meeting</li></ul>
3/06/2020	<ul style="list-style-type: none"><li>• Covered Orange County General Meeting</li></ul>
3/09/2020	<ul style="list-style-type: none"><li>• Orange County Veterans and Military Families Collaborative — Children and Family Workgroup Meeting</li></ul>
3/10/2020	<ul style="list-style-type: none"><li>• Orange County Cancer Coalition Meeting</li></ul>
3/11/2020	<ul style="list-style-type: none"><li>• Orange County Communications Workgroup Meeting</li></ul>
3/12/2020	<ul style="list-style-type: none"><li>• Buena Park Collaborative Meeting</li><li>• Kid Healthy Community Advisory Committee Meeting</li><li>• State Council on Developmental Disabilities Regional Advisory Committee Meeting</li><li>• Garden Grove Community Collaborative Meeting</li></ul>
3/13/2020	<ul style="list-style-type: none"><li>• Orange County Diabetes Collaborative</li></ul>
3/17/2020	<ul style="list-style-type: none"><li>• Vendor Fair hosted by UC Irvine Health (Cancelled)</li><li>• North Orange County Senior Collaborative Meeting (Cancelled)</li><li>• Placentia Community Collaborative Meeting (Cancelled)</li></ul>
3/18/2020	<ul style="list-style-type: none"><li>• 2020 Special Enrollment Period Kickoff Event hosted by Covered California (Cancelled)</li><li>• La Habra Community Collaborative (Cancelled)</li><li>• Covered Orange County Steering Committee Meeting (Cancelled)</li><li>• Minnie Street Family Resource Center Professional Roundtable (Cancelled)</li><li>• Orange County Promotoras Meeting (Cancelled)</li></ul>

- 3/19/2020
  - Orange County Women’s Health Project Advisory Board Meeting (Cancelled)
  - Orange County Children’s Partnership Meeting (Cancelled)
- 3/20/2020
  - OC Youth Services Providers Consortium hosted by Laura’s House (Sponsor Fee of \$600 included one resource table for outreach at the event, 10 reserved admission tickets for staff to attend the event, agency's name and logo on marketing materials and event webpage and recognition as conference tote sponsor) (Postponed)
- 3/23/2020
  - Stanton Collaborative Meeting (Cancelled)
- 3/24/2020
  - Orange County Senior Roundtable (Cancelled)
- 3/25/2020
  - Santa Ana Unified School District Wellness Center Meeting (Cancelled)
- 3/26/2020
  - Orange County Care Coordination for Kids Meeting (Cancelled)
- 3/27/2020
  - Clinic in the Park Quarterly Collaborative Meeting (Cancelled)

**TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS**

<b>Date</b>	<b># Staff/ Volunteers to Attend</b>	<b>Events/Meetings</b>
3/01/2020	1	<ul style="list-style-type: none"> <li>• Metastatic Breast Cancer Conference hosted by Susan G. Komen Orange County</li> </ul>
3/05/2020	2	<ul style="list-style-type: none"> <li>• Spirituality Conference 2020: Vision of Diversity, Know Thy Neighbor hosted by Hoag Community Health, Health Ministries (Sponsorship Fee of \$750 included one resource table at event for outreach and two admissions to the conference)</li> </ul>
3/07/2020	1	<ul style="list-style-type: none"> <li>• Champions for Children Family Conference hosted by Fullerton Unified School District</li> </ul>
3/13/2020	0	<ul style="list-style-type: none"> <li>• Mental Health Resource Fair hosted by Casa de la Familia (Cancelled)</li> <li>• South Orange County Senior Day hosted by the Office of Senator Patricia Bates and Assemblyman Bill Brough (Sponsorship Fee of \$1,000 included one resource table at event for outreach and 1/4-page ad in event program booklet) (Event postponed with no new specific date)</li> </ul>
3/15/2020	0	<ul style="list-style-type: none"> <li>• 2020 Health Summit hosted by Family Voices of California (Sponsorship Fee of \$5,000 for two parent representatives to attend the summit and more marketing opportunity) (Rescheduled to 10/4 – 10/6)</li> </ul>

3/18/2020	0	<ul style="list-style-type: none"> <li>• Knowledge and Health Fair hosted by City of Costa Mesa (Registration Fee of \$300 included a resource table at the event for outreach and agency's name on expo passport) (Cancelled)</li> </ul>
	0	<ul style="list-style-type: none"> <li>• Health and Wellness Resource Fair hosted by Harbage Consulting (Cancelled)</li> </ul>
3/19/2020	0	<ul style="list-style-type: none"> <li>• Community Party and Resource Fair hosted by Jamboree Housing (Cancelled)</li> </ul>
3/21/2020	0	<ul style="list-style-type: none"> <li>• School Readiness Fair hosted by Pretend City Children’s Museum (Sponsorship Fee of \$1,000 for sponsorship recognition on stage, agency's logo and/or inclusion in marketing collateral and various media outlets, onsite, website and social media, one resource table for outreach at the event and 10 complimentary tickets to Pretend City) (Postponed with no new specific date)</li> </ul>
3/22/2020	0	<ul style="list-style-type: none"> <li>• Nowruz 2020: Persian New Year Celebration hosted by Iranian American Community Group (Sponsorship Fee of \$2,000 included agency's name and logo displayed on banner at event and in event program, announcement of sponsorship on stage, one resource table for outreach at the event and invitation to VIP tent of the event) (Cancelled)</li> </ul>
3/23/2020	0	<ul style="list-style-type: none"> <li>• Roadmap to Success hosted by Garden Grove Unified School District (Cancelled)</li> </ul>
3/26/2020	0	<ul style="list-style-type: none"> <li>• C.O.P.E Community Resource Fair hosted by CHOC Children’s (Cancelled)</li> </ul>
3/28/2020	0	<ul style="list-style-type: none"> <li>• Wellness Fair hosted by Placentia-Yorba Linda Unified School District (Cancelled)</li> </ul>

**As of March 20, 2020, CalOptima organized or convened 4 community stakeholder events, meetings and presentations and does not anticipate participating in any others during March:**

**TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS**

<b>Date</b>	<b>Events/Meetings/Presentations</b>
3/06/2020	<ul style="list-style-type: none"> <li>• Homeless Stakeholder Engagement Strategy Session</li> </ul>
3/19/2020	<ul style="list-style-type: none"> <li>• Health Network Forums (Cancelled)</li> </ul>
3/31/2020	<ul style="list-style-type: none"> <li>• CalOptima Community Resource Fair (Cancelled)</li> </ul>

**TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS**

<b>Date</b>	<b>Events/Meetings/Presentations</b>
3/04/2020	<ul style="list-style-type: none"> <li>• Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You</li> </ul>



- Population Health Management Continuing Medical Education Workshop — Topic: Diabetes Mellitus: Progress and New Concepts
- 3/11/2020 • Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You
- 3/14/2020 • OneCare Connect Member Retention Event (Cancelled)
- 3/18/2020 • Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You (Cancelled)
- Community-Based Organization Presentation for Placentia-Yorba Linda School District's school nurses and health clerks — Topic: Medi-Cal in Orange County (Cancelled)
- 3/25/2020 • Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You (Cancelled)
- 3/26/2020 • Community-Based Organization Presentation for Family Voices of California's members — Topic: Medi-Cal in Orange County (Cancelled)

**CalOptima provided three endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).**

1. Provide use of CalOptima logo for the Orange County Cancer Coalition webpage with the purpose to provide resources and services available that address all aspects of cancer from prevention to diagnosis, treatment, recovery and survivorship, financial and legal assistance.
2. Provide use of CalOptima logo to Jamboree Housing Inc. to announce the launch of their new child/teen mental health program in collaboration with Child Guidance Center.
3. Provide use of CalOptima logo to Korean Community Services Health Center and Multi-Ethnic Collaborative of Community Agencies to announce the launch of their new mobile dental unit services.

## **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.

### **CalOptima Community Event Update**

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima is transitioning how we engage with our community partners and will not be attending in-person Community Collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima has updated our participation in Community Collaborative meetings and community events. With respect to events for which sponsorship or registration fees have already been paid, we are working to determine if fees can be applied to future events.

\* *CalOptima Hosted*

1 – *Updated 2020-03-20*

+ *Exhibitor/Attendee*

++ *Meeting Attendee*

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](mailto:tkaaiakamanu@caloptima.org).

<h1>April</h1>				
Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Wednesday, 4/1 9–10:30 a.m. (Cancelled)	++ Orange County Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer’s Association 2515 McCabe Way Irvine
Wednesday, 4/1 10 a.m.–12 p.m. (Cancelled)	++ Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 4/1 10:30 a.m.–12 p.m. (Cancelled)	++ Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer’s Orange County 1515 McCabe Way Irvine
Thursday, 4/2 9–11 a.m. (Cancelled)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Friday, 4/3 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, 4/3 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
Friday, 4/3 6–7 p.m. (Exploring virtual format)	+ Coalition of OC Community Health Centers Annual Health Care Symposium - Resilient Systems for Empowered Communities	Health/Resource Fair Open to the Public	Sponsorship \$1000	Virtual Pending

\* CalOptima Hosted

2 – Updated 2020-03-20

+ Exhibitor/Attendee

++ Meeting Attendee

Saturday, 4/4 7–11:30 a.m. (Virtual format)	+ Crime Survivors Resource Center Superhero 5K Run/Walk Health and Safety Expo	Health/Resource Fair Open to the Public	N/A	Web Platform
Saturday, 4/4 9 a.m.–3 p.m. (Cancelled)	+ City of Westminster Spring Festival	Health/Resource Fair Open to the Public	1 Staff	Westminster Civic Center 8200 Westminster Blvd. Westminster
Saturday, 4/4 10 a.m.–2 p.m. (Postponed)	+ Orange County Veterans and Military Families Collaborative Month of the Military Child Celebration	Health/Resource Fair Open to the Public	Sponsorship \$1000 2 Staff	Mile Square Park Freedom Hall 16801 Euclid St. Fountain Valley
Sunday, 4/5 9 a.m.–4 p.m. (Postponed)	+ Access California Services Peace of Mind: A Family Wellness Event	Health/Resource Fair Open to the Public	Sponsorship \$2000 2 Staff	Delhi Center 505 E. Central Ave. Santa Ana
Monday, 4/6 1–4 p.m. (Cancelled)	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 4/7 9:30–11 a.m. (Cancelled)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 4/8 12–1:30 p.m. (Cancelled)	++ Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 4/8 1:30–3:30 p.m.	++ Health Care Task Force Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Wednesday, 4/8 3:30–4:30 p.m. (Conference Call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Various locations
Thursday, 4/9 10–11:30 a.m. (Exploring virtual format)	++ Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 4/9 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 St. Garden Grove

\* CalOptima Hosted

3 – Updated 2020-03-20

+ Exhibitor/Attendee

++ Meeting Attendee

Thursday, 4/9 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC Building C 1901 E. Fourth St. Santa Ana
Friday, 4/10 9:30–11 a.m. (Cancelled)	++ Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Monday, 4/13 1–2:30 p.m. (Virtual format)	++ 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
Monday, 4/13 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 4/14 10–11:30 a.m. (Virtual platform)	++ Orange County Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 4/14 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, 4/15 9:15–11 a.m.	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 4/15 11 a.m.–1 p.m.	++ Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	1300 McFadden Ave. Santa Ana
Wednesday, 4/15 1–4 p.m.	++ Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 4/16 8:30–10 a.m.	++ 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, 4/16 11:30 a.m.–1 p.m.	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove

\* CalOptima Hosted

4 – Updated 2020-03-20

+ Exhibitor/Attendee

++ Meeting Attendee

Thursday, 4/16 1–2:30 p.m.	++ Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center 18041 Goldenwest St. Huntington Beach
Thursday, 4/16 2–3:30 p.m.	++ Orange County Disability Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 4/16 2:30–4:30 p.m.	++ Orange County Women’s Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Saturday, 4/18 9 a.m.–4 p.m. (Cancelled)	+ Arts Orange County Dia del Nino Festival	Health/Resource Fair Open to the Public	Sponsorship \$2000 2 Staff	OC Fair & Event Center 88 Fair Dr. Costa Mesa
Saturday, 4/18 10 a.m.–2 p.m. (Postponed)	+ Second Baptist Church 2020 Health and Wellness Fair	Health/Resource Fair Open to the Public	Sponsorship \$500 1 Staff	Second Baptist Church 4300 Westminster Ave. Santa Ana
Saturday, 4/18 11 a.m.–3 p.m. (Cancelled)	+ Bikers Against Child Abuse Day of the Child	Health/Resource Fair Open to the Public	1 Staff	Boys & Girls Club 950 W. Highland St. Santa Ana
Tuesday, 4/21 11 a.m.–1 p.m. (Cancelled)	+ Santa Ana College Health and Resource Event	Health/Resource Fair Open to the Public	1 Staff	Santa Ana College, Central Mall 1530 W. 17th St. Santa Ana
Tuesday, 4/21 11 a.m.–12 p.m. (Cancelled)	++ Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Library Community Room 411 Chapman Ave. Placentia
Wednesday, 4/22 3:30–5 p.m. (Cancelled)	*Health Education Class: Shape Your Life	Community Presentation Open to the Public	N/A	Boys and Girls Club Wesly Center - 10540 Chapman Ave. Garden Grove
Thursday, 4/23 1:30–3:30 p.m. (Exploring virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	CHOC Centrum Building 1120 W. La Veta Orange

\* CalOptima Hosted

5 – Updated 2020-03-20

+ Exhibitor/Attendee  
++ Meeting Attendee

Thursday, 4/23 6:30–9 p.m. (Postponed)	+ Kid Healthy Cooking Up Change	Community Event Open to the Public	Sponsorship \$2500 2 Staff	Northgate Gonzalez Markets Corporate 1201 N. Magnolia St. Anaheim
Friday, 4/24 4:30–6:30 p.m. (Cancelled)	+ Project Access Health Fair 2020	Health/Resource Fair Open to the Public	1 Staff	Warwick Square Apartments 780 S. Lyon St. Santa Ana
Saturday, 4/25 9–11:30 a.m. (Cancelled)	+ City of Lake Forest Special Needs Resource Fair	Health/Resource Fair Open to the Public	1 Staff	Lake Forest Clubhouse 100 Civic Center Dr. Lake Forest
Saturday, 4/25 11 a.m.–3 p.m. (Cancelled)	+ YMCA Orange County Summer Open House	Health/Resource Fair Open to the Public	Sponsorship \$250 1 Staff	YMCA 2100 W. Alton Santa Ana
Monday, 4/27 9–11 a.m. (Exploring virtual format)	++ 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, 4/27 12:30–1:30 p.m. (Cancelled)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 4/28 7:30–9 a.m.	++ OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Wednesday, 4/29 3:30–5 p.m. (Cancelled)	*Health Education Class: Shape Your Life	Community Presentation Open to the Public	N/A	Boys and Girls Club Wesley Center 10540 Chapman Ave. Garden Grove

\* CalOptima Hosted

6 – Updated 2020-03-20

+ Exhibitor/Attendee

++ Meeting Attendee

[Back to Agenda](#)